HB

393

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
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Mail Stop 3101

State Capitol
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Deliveries to: 129 6th St., Rm. 329

MEMORANDUM February 15, 2006

SUBJECT: Revisions in CSHB 393(HES) (Work Order No. 24-LS0780\I)

TO: Representative Peggy Wilson
Chair of House Health, Education & Social Services Committee
Attn: Linda Miller

FROM: Dennis C. Bailey
Legislative Counsel

This memo accompanies the new version of CSHB 393(HES) per your request.

Following our conversation, at page 2, line 21, I have left the term "covered individual" in place. This is consistent with the remainder of the bill and is consistent with other statutory sections referencing specific coverage. I also changed "enrollee" at page 2, line 25 to "covered individual."

The committee's decision to remove "health care insurer" from page 2, line 21, raises an additional issue. I recommend clarification of the reference at page 2, line 21 to "health benefit plan," which is a term not otherwise used in proposed AS 21.42.377. "Health care insurance plan" is defined in AS 21.42.500 (which further refers to AS 21.54.500). Different definitions exist for "health benefit plan" and for "health care insurance plan" in AS 21.54.500, but the definition of "health benefit plan" is not included in AS 21.42. It appears that potential confusion might be fixed by including a reference to "health benefit plan" in AS 21.42.500 (that further references AS 21.54.500). Please clarify what is intended.

In a similar vein, I suggest one additional amendment modifying the new language you requested. If "health benefit plan" remains the phrase of choice, at page 2, line 24, "plan" should be inserted following "benefit." Again, please confirm what is intended.

"Health plan administrator" at page 2, line 25 probably refers to either a "health benefit plan" or a "health care insurance plan." The meaning should be clarified.

Thank you for closely reviewing these suggested changes. If I may be of further assistance, please advise.

DCB:lmb
06-064.lmb

Enclosure

Adopted

393 Y

Proposed Amendment

Page 2, Lines 20-25

(f) Each [HEALTH CARE INSURER OR] health benefit plan shall notify each enrollee annually of the coverage for colorectal cancer screenings and provide the [CURRENT] American Cancer Society guidelines for colorectal cancer screenings. The notice shall be [DELIVERED BY MAIL UNLESS THE ENROLLEE AND HEALTH CARRIER HAVE AGREED ON ANOTHER METHOD OF NOTIFICATION] included in health benefit handbooks or be provided by written or electronic communication between health plan administrators and enrollees.

[DELETED TEXT BRACKETED]
Inserted Text Underlined

IOUSE COMMITTEE REPO'

(7)
Date Referred to Committee: February 8, 2006 **FURTHER REFERRALS:**

Date of Committee Action: 2/14/06

The HEALTH, EDUCATION AND SOCIAL SERVICES Committee considered: **HB 393**

HOUSE BILL NO. 393 **INSURANCE FOR COLORECTAL CANCER SCREENING**

"An Act requiring that certain health care insurance plans provide coverage for the costs of colorectal cancer screening examinations and laboratory tests; and providing for an effective date."

Recommends it be replaced with [ ] HCS *or* [X] CS *for* HB 393 (HES)
For Senate Bills with new title: [ ] Technical Title [ ] New Title: HCR_____. **[ ] Same Title [ ] New Title**

[ ] attach amendments
[ ] add new referral to _____Committee
[ ] Letter of Intent_____Committee

List of Abbrev for Depts.:
ADM
CED
COR
CRT
EED
DEC
DFG
GOV
HSS
LEG
LAW
LWF
MVA
DNR
DPS
REV
DOT
UA

NEW **FISCAL NOTES** *Assigned by Chief Clerk's Office				
List by Dept(s):	*FN#	Fiscal	Indet.	Zero

PREVIOUS **FISCAL NOTES**				
List by Dept(s):	FN#	Fiscal	Indet.	Zero
CEO	1			X

Signing with recommendations	Printed Last Name	DP	DNP	NR	AM
Berta Gardner	Gardner	X			
[illegible]	CISSNA	X			
Tom Anderson	ANDERSON	X			
Carl Gatto	Gatto	X			
Paul R Seaton	SEATON	X			
Chair: Peggy Wilson	WILSON	X			
Chair:					

24-LS0780\Y
Bailey
2/13/06

CS FOR HOUSE BILL NO. 393( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FOURTH LEGISLATURE - SECOND SESSION

BY

Offered:
Referred:

Sponsor(s): REPRESENTATIVES ANDERSON, Lynn, Gruenberg, LeDoux, Kapsner, Guttenberg, Crawford, Kerttula, McGuire, Wilson

A BILL

FOR AN ACT ENTITLED

"An Act requiring that certain health care insurance plans provide coverage for the costs of colorectal cancer screening examinations and laboratory tests; and providing for an effective date."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

*** Section 1.** The uncodified law of the State of Alaska is amended by adding a new section to read:

SHORT TITLE. This Act may be known as the Colorectal Cancer Screening Coverage Act of 2006.

*** Sec. 2.** AS 21.42 is amended by adding a new section to read:

Sec. 21.42.377. Coverage for colorectal cancer screening. (a) Except for a fraternal benefit society, a health care insurer that offers, issues for delivery, delivers, or renews in this state a health care insurance plan shall provide coverage for the costs of colorectal cancer screening examinations and laboratory tests under the schedule described in (b) of this section. The coverage required by this section is subject to

standard policy provisions applicable to other benefits, including deductible or copayment provisions.

(b) The minimum coverage required under (a) of this section for colorectal cancer screening includes coverage for colorectal cancer examinations and laboratory tests specified in American Cancer Society guidelines for colorectal cancer screening of asymptomatic individuals. Coverage shall be provided for all colorectal screening examinations and tests that are administered at a frequency identified in the American Cancer Society guidelines for colorectal cancer.

(c) Coverage provided under this section applies to a covered individual who is

(1) at least 50 years of age; or

(2) less than 50 years of age and at high risk for colorectal cancer.

(d) All screening options identified in (b) of this section shall be covered by the insurer, with the choice of option determined by the covered individual in consultation with a health care provider.

(e) For individuals considered at average risk for colorectal cancer, coverage or benefits shall be provided for the choice of screening, so long as it is conducted in accordance with the specified frequency. For individuals considered at high risk for colorectal cancer, screening shall be provided at a frequency determined necessary by a health care provider.

(f) Each health care insurer or health benefit plan shall notify each covered individual annually of the coverage for colorectal cancer screenings and provide the current American Cancer Society guidelines for colorectal cancer screenings. The notice shall be delivered by mail unless the covered individual and health carrier have agreed on another method of notification.

(g) In this section, "individual considered at high risk for colorectal cancer" means an individual who faces a high risk for colorectal cancer because of

(1) family history;

(2) prior experience of cancer or precursor neoplastic polyps;

(3) a history of chronic digestive disease condition, including inflammatory bowel disease, Crohn's Disease, or ulcerative colitis;

(4) the presence of any appropriate recognized gene markers for colorectal cancer; or

(5) other predisposing factors.

* **Sec. 3.** This Act takes effect January 1, 2007.

HOUSE COMMITTEE REPORT

(7)
Date Referred to Committee: January 25, 2006 — FURTHER REFERRALS: HES

Date of Committee Action: February 6, 2006

The LABOR AND COMMERCE Committee considered: HB 393

HOUSE BILL NO. 393 — INSURANCE FOR COLORECTAL CANCER SCREENING

"An Act requiring that certain health care insurance plans provide coverage for the costs of colorectal cancer screening examinations and laboratory tests; and providing for an effective date."

Recommends it be replaced with [ ] HCS or [X] CS for HB 393 (L&C)
For Senate Bills with new title: [ ] Technical Title [ ] New Title: HCR____ [ ] Same Title [ ] New Title

[ ] attach amendments
[ ] add new referral to ____________Committee
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DOT
UA

NEW FISCAL NOTES
*Assigned by Chief Clerk's Office

List by Dept(s):	*FN#	Fiscal	Indet.	Zero
CED				X

PREVIOUS FISCAL NOTES

List by Dept(s):	FN#	Fiscal	Indet.	Zero

Signing with recommendations	Printed Last Name	DP	DNP	NR	AM
Harry B. Crawford Jr.	CRAWFORD	X			
[signature]	LYNN	X			
Pete Kott	KOTT			✓	
Gabrielle LeDoux	LeDOUX	X			
[signature]	GUTTENBERG	X			
[signature]					X
Chair: Tom Anderson	ANDERSON	X			
Chair:					

ALASKA STATE HOUSE OF REPRESENTATIVES

Labor & Commerce Committee, Chair

Administrative Regulation Review, Chair

Judiciary Committee, Vice-Chair

Health, Education and Social Services

716 W 4th Ave
Suite 610
Anchorage, AK 99501

Phone (907) 269-0265
Fax (907) 269-0264

Representative Tom Anderson

Sponsor Statement
HB 393

"An Act requiring that certain health care insurance plans provide coverage for the costs of colorectal cancer screening examinations and laboratory tests; and providing for an effective date."

Current Alaska state law requires that health insurance policies cover screening for breast, cervical, and prostate cancer. ***Colon cancer is the only cancer with a recommended screening test available that is not on this list.*** This bill completes the list, increasing Alaskans' access to all life-saving, recommended cancer screenings.

Colon cancer (technically known as colorectal cancer) is the second leading cause of cancer deaths in Alaska and across the nation. An estimated 57,000 Americans died from the colon cancer in 2005. Screening has the potential to drastically reduce this number. Consider these facts:

- When caught through routine screening at the localized stage, the 5-year survival rate from colon cancer is over 90%.
- If not caught until it has distant metastasis, when symptoms are likely to appear, the 5-year survival rate is only 10%.
- Colonoscopy is over 90% effective at detecting colon cancer and can remove pre-cancerous polyps, actually ***preventing cancer*** from ever developing.

In addition to saving lives, colon cancer screening is cost-effective. National studies confirm that the cost of these screenings spread across the insured population is minimal. Covering screenings also has the potential for long-term savings by avoiding treatment costs. These long-term savings will likely continue to grow as new and dramatically more expensive drugs become the standard treatment for this disease. Some of these newer drugs are estimated to cost *$250,000 a year*, making the case for screening and prevention all the more pressing.

In practice, many insurance plans cover some, but not all of the range of recommended screening options listed in the nationally-recognized American Cancer Society guidelines. While not the right test for everyone, access to colonoscopy is critical because of its ability to actually prevent cancer by removing polyps. For the general population, ***colonoscopies are required only once every ten years starting at age 50.*** Medicare picks up coverage for the full range of screenings, including colonoscopy, when a person becomes Medicare eligible. These facts underscore the cost-effectiveness of covering what for most people will be two colonoscopies between ages 50 and 65.

The promise of screening in reducing suffering and death from colon cancer is tremendous. ***The Institute of Medicine reports that the death rate from colon cancer could drop by up to 80% if the majority of Americans were regularly screened.*** Screening can be cost-prohibitive to an individual without insurance coverage for these procedures. Eighteen states, including Texas, Missouri and Nevada, have already adopted similar legislation requiring screening coverage. Alaskans deserve access to all recommended cancer screenings, including life-saving colon cancer screening tests.

I urge your support of this legislation.

FISCAL NOTE

STATE OF ALASKA
2006 LEGISLATIVE SESSION

Fiscal Note Number: 1
Bill Version: CSHB 393(L&C)
(H) Publish Date: 2/8/06

Revision Date/Time (Note if correction):
Dept. Affected: Commerce
Title: Insurance for Colorectal Cancer Screening
RDU: Insurance (116)
Component: Insurance Operations
Sponsor: Anderson et al
Requester: House Labor & Commerce
Component No.: 354

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type--Do not abbreviate)						
TOTAL	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2006) cost: 0.0

Mark this box (X) if funding for this bill is included in the Governor's FY 2007 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

This legislation requires certain health care insurance plans to provide coverage for the costs of colorectal cancer screening examinations and laboratory tests. It does not impact the operations of the division.

Prepared by: Linda S. Hall, Director
Phone: 907.269.7900
Division: Insurance
Date/Time: 2/1/06 4:13 PM
Approved by: William Noll, Commissioner
Date: 2/1/2006
Agency: Commerce, Community, and Economic Development

Amendment #1 adopted by the House Labor & Commerce Committee

Sponsored by Rep. Anderson

Page 2, delete lines 5-14 and insert:

"coverage for colorectal cancer examinations and laboratory tests specified in current American Cancer Society guidelines or United States Preventative Services Task Force guidelines for colorectal cancer screening of asymptomatic individuals."

FISCAL NOTE

STATE OF ALASKA
2006 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: HB 393
(Publish Date:

Revision Date/Time (Note if correction):
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Prepared by: Linda S. Hall, Director
Phone 907.269.7900
Division: Insurance
Date/Time 2/1/06 4:13 PM
Approved by: William Noll, Commissioner
Date 2/1/2006
Agency: Commerce, Community, and Economic Development

Colorectal Cancer Screening Coverage Saves Lives

The Promise of Screening:
Almost 57,000 people died from colorectal cancer in 2005. If the majority of Americans age 50 or older were screened regularly for colorectal cancer, the death rate from colorectal cancer could plummet by up to 80%.[1]

This stunning drop in mortality is possible because colorectal cancer is easily prevented through the identification and removal of pre-cancerous polyps, detectable only by screenings. Yet, despite the lifesaving potential of colorectal screening tests, a majority of Americans are not screened for the disease. Only half of US adults 50 or older have been screened recently for colorectal cancer.[2]

The Need for Insurance Coverage:
While there are many reasons for the low rate of colorectal cancer screening, low insurance coverage is a contributing factor, since lack of coverage creates a financial barrier to screening.

Thanks to the American Cancer Society, Medicare already covers the full range of colorectal cancer screening tools, but coverage remains an issue for many in the under 65, privately insured population. To date, 18 states and the District of Columbia have enacted legislation ensuring coverage for the full range of colorectal cancer screening tools. However, there are still many Americans in the other 32 states and those covered by health plans outside of state jurisdiction who do not have the full range of coverage. In addition to anecdotal evidence from people who have personally experienced the frustration of being denied coverage for colorectal cancer screening tools – colonoscopy in particular -- studies have shown that limits on covered benefits impede an individual's ability to benefit from early detection of or screening for cancer.[3,4] The less extensive the prevention coverage, the less likely a person is to get screened. Furthermore, doctors often do not refer people for tests if they believe those tests are not covered by insurance.[5]

A report prepared for the Health Insurance Association of American (HIAA), acknowledges that health plans are currently not providing coverage for the full range of screening tests. Specifically, the report notes that, "Most private insurers will only cover colonoscopies for high risk populations." The report also confirms that health insurance coverage is a factor in low

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[1] Institute of Medicine. Curry S., Byers T. and Hewitt M., eds. 2003. *Fulfilling the Potential of Cancer Prevention and Early Detection.* Washington, DC: National Academy Press, p. 403.
[2] Behavioral Risk Factor Surveillance System Public Use Data Tape 2004, National Center for Disease Prevention and Health Promotion, Centers for Disease Control and Prevention, 2005.
[3] Agency for Health Care Policy and Research. Women's Use of Preventive Screening Services: A Comparison of HMO Versus Fee-for-Service Enrollees. July 1997.
[4] Faulkner LA, Schauffler HH. The Effect of Health Insurance Coverage on the Appropriate Use of Recommended Clinical Preventive Services. *Am J Prev Med* 1997;13(6):453-8.
[5] J.D. Lewin and D.A. Asch, "Barriers to Office-Based Screening Sigmoidoscopy: Does Reimbursement Cover Costs?" Annals of Internal Medicine, vol. 130, no. 6 (Mar. 1999), pp. 525-30.

screening rates.[6] Furthermore, an analysis by The Lewin Group of the many health plans participating in the Federal Employee Health Benefit Program (FEHBP) in 2002 confirms that while most plans were covering FOBT and flexible sigmoidoscopy, hardly any were covering colonoscopy screening. While ACS has worked hard to ensure that health plans participating in the FEHBP now provide coverage, the bottom line is clear: without intervention, plans do not tend to cover screening colonoscopy and are not covering the full range of colorectal cancer screening tools according to the American Cancer Society's guidelines.

We know that colorectal cancer screening saves lives and that too few Americans are currently being screened for colorectal cancer. Ensuring coverage for these tools removes financial barriers and puts the decision about appropriate screening back into the hands of physicians and patients.

Colorectal Screening is Cost Effective:

Mathematical models prepared by the Congressional Office of Technology Assessment and others have shown that the cost-effectiveness of colorectal screening is consistent with many other kinds of preventive services and is lower than some common interventions.[7] For example, a polyp can be removed during screening for about $1,500, but if the patient is not diagnosed until the disease has metastasized, the patient's survival drops to 10 percent and the costs of care can add up to $58,000 over the patient's lifetime.[8] With sharp cost increases possible as new treatments, such as Avastin and Erbitux, become standards of care, the cost-effectiveness of screening is likely to become even more attractive.[9]

Our nation is missing an opportunity to achieve a large health impact for good value in colorectal cancer screening. In the interest of saving lives, the legislative solution to colorectal cancer is clear: make colorectal screening coverage available for all according to ACS screening guidelines.

Interestingly, The Lewin Group conducted a study of the cost of colorectal cancer screening, measuring costs in terms of per member per month costs – the price tag of a benefit to a health plan member. The data indicate that colonoscopy done once every 10 years is actually less costly in terms of Per Member Per Month (PMPM) costs than flexible sigmoidoscopy every 5 years combined with annual FOBT. Over the short term, colonoscopy every 10 years is actually *11 cents less* costly in terms of PMPM costs. A more detailed explanation of the study is attached.

When the cost study is considered together with the Lewin analysis of the Federal Employee Health Benefit Program mentioned above, it becomes readily apparent that expanding coverage to include colonoscopy can save additional lives at little or no additional cost to insurers. Given that insurers largely are already offering FOBT and flexible sigmoidoscopy, there is no compelling economic reason not to expand coverage to offer screening colonoscopy as well. Adding colonoscopy allows doctors and patients to choose the best test for that individual. Best of all, it is not only cost effective – it saves lives.

National Government Relations Department
December 2001 - updated January 2006

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[6] Mohr P., Mueller C., et al. "The Impact of Medical Technology on Future Health Care Costs." Health Insurance Association of America. <http://membership.hiaa.org/pdfs/Appendix2.pdf>, p. A4-58;59. February 28, 2001.

[7] U.S. Congress, Office of Technology Assessment (April 1995). *Cost-effectiveness of Colorectal Cancer Screening in Average-Risk Adults*. OTA-BP-H-146.

[8] Frazier AL, Colditz GA, Fuchs CS, and Kuntz KM (2000). Cost-effectiveness of Screening for Colorectal Cancer in the General Population. *Journal of the American Medical Association*, 284(15):195 -61.

[9] Schrag D (July 2004). The price tag on progress--chemotherapy for colorectal cancer. *New England Journal of Medicine*, 351(4):317-9.

American Cancer Society

Colon Cancer Fact Sheet

General Facts

- Colorectal cancer (commonly referred to as "colon" cancer) develops in the lower part of the digestive system, also referred to as the gastrointestinal, or GI, system. The digestive tract processes the food you eat and rids the body of solid waste matter. This cancer usually develops from precancerous changes or growths in the lining of the colon and rectum. These growths in the colon or rectum are called *polyps*.

- In 2005, an estimated 145,290 new cases of colon cancer will be diagnosed in the United States. Of these new cancer cases, 104,950 will be colon cancer and 40,340 will be rectal cancer.

- An estimated 56,290 deaths due to colon cancer are expected to occur in 2005, accounting for about 10 percent of cancer deaths this year in the United States.

- Overall, colon cancer is the third most common cancer in men and in women, and the second leading cause of cancer death among men and women combined in the United States.

- Colon cancer is the second most common cancer among African American women and the third most common cancer among African American men.

- Colon cancer is the second most commonly diagnosed cancer in both Hispanic Latino men and women.

- African Americans have the highest death rate from colon cancer of any racial or ethnic group in the United States.

- Colon cancer is the second leading cause of cancer deaths among African American men and women combined

- Colon cancer is the second leading cause of cancer death among Hispanic Latino men and women combined.

Risk Factors

- Age: The risk of colon cancer increases with age. More than 90 percent of cases are diagnosed in individuals over the age of 50.

- Family History: A personal or family history of colorectal cancer or polyps or of inflammatory bowel disease of significant duration increases the likelihood of having colorectal cancer. Also, there are certain genetic factors that increase the likelihood of having colon cancer, including conditions called familial adenomatous polyposis (FAP), Gardner's syndrome, hereditary non-polyposis colorectal cancer, and being of Ashkenazi Jewish descent.

- Race: African Americans have the highest colon cancer rates and the highest rate of death from the disease of any racial or ethnic group in the United States.

- Other risk factors include:
  - Smoking
  - Alcohol consumption
  - Obesity
  - Physical inactivity
  - Diet high in fat and/or red meat
  - Diet low in fruits and vegetables

Symptoms

Early colon cancer usually causes no symptoms and can be detected by available colorectal cancer screening tests. However, as colorectal cancer progresses, the disease may cause symptoms. People with the following symptoms should see their doctor immediately:

- A change in bowel habits, such as diarrhea, constipation, or narrowing of the stool, that lasts for more than a few days
- A feeling that you need to have a bowel movement that doesn't go away even after you do have a bowel movement
- Bleeding from the rectum or blood in the stool
- Cramping or gnawing stomach pain
- Decreased appetite
- Weakness and fatigue
- Jaundice (yellow-green color of the skin and white part of the eye)

Note: Signs and symptoms of colon cancer typically occur in advanced stages of the disease.

Testing/Detection

There are several colon cancer early detection tests. According to the American Cancer Society guidelines for the early detection of colon cancer, starting at age 50 both men and women should discuss the full range of testing options with their doctor or health care professional and choose one of the following testing options:

- Yearly fecal occult blood test (FOBT)
- Flexible sigmoidoscopy every five years
- Yearly FOBT and flexible sigmoidoscopy every five years (preferred over either FOBT alone, or flexible sigmoidoscopy alone)
- Double-contrast barium enema every five years
- Colonoscopy every 10 years

Note:
All positive tests should be followed up with colonoscopy. People with a family or personal history of colon cancer or polyps, or history of chronic inflammatory bowel disease should be tested earlier, and may need to undergo testing more often.

Common Treatments

- Surgery is the most common form of treatment for colon cancer. For cancers that have not spread, it frequently controls the disease.

- Chemotherapy or chemotherapy with radiation treatment is given before or after surgery to most patients whose cancer has spread into the bowel wall or to the lymph nodes.

- A permanent colostomy (creation of an abdominal opening for elimination of body wastes) is very seldom needed for colon cancer and is frequently not required for rectal cancer.

Survival

- When colon cancers are detected at an early (i.e. localized) stage, the five-year survival rate is approximately 90 percent; however, because screening rates are so low, only 39 percent of colorectal cancers are detected at this stage.

- There is a 67 percent chance of five-year survival when the cancer has spread only to nearby organs or lymph nodes.

- Once the cancer has spread to other parts of the body, the five-year survival rate is about 10 percent.

The American Cancer Society and Colon Cancer

- Research: As of July 2004, the American Cancer Society has funded 90 colon cancer-related grants totaling approximately $49.6 million. The Society has also conducted national surveys to learn more about the public's knowledge, attitudes, and practices associated with colorectal cancer testing.

- Education: The Society delivers health information to the public so that individuals can make informed personal decisions. Examples include printed materials, media coverage, community-based outreach programs, and free, nationwide services such as the www.cancer.org Web site and a 24-hour information and support line at 1-800-ACS-2345. The Society also delivers health information to health care professionals, including testing guidelines.

- Awareness: In early 2005, the Society will be kicking off a nationwide colon cancer public awareness advertising campaign raise awareness of the personal need to get tested for colon cancer. The campaign will target both consumers and doctors and will appear in print, radio, television, and online.

- Advocacy: With the help of grassroots volunteers in communities across the country, the Society advocates action at both the state and federal levels to ensure responsible health policies and to increase funding for research and access to screening tests and treatment. For example, the Society was instrumental in securing coverage for the full-range of colon cancer screening tests for Medicare beneficiaries, for many federal employees, and for privately insured individuals in 15 states and the District of Columbia. The Society is continuing to lead the charge at the federal and state levels to ensure all Americans have coverage for the full range of colon cancer screening tests for people age 50 and older.

- Service: The Society works to improve quality of life for people living with cancer through a variety of support services and programs helping patients and families cope with the disease.

- Collaboration: Along with the Centers for Disease Control, the American Cancer Society established the National Colorectal Cancer Roundtable, an organization consisting of more than 50 organizations dedicated to working together to increase colorectal cancer testing.

The American Cancer Society is dedicated to eliminating cancer as a major health problem by saving lives, diminishing suffering and preventing cancer through research, education, advocacy, and service. Founded in 1913 and with national headquarters in Atlanta, the Society has 14 regional Divisions and local offices in 3,400 communities, involving millions of volunteers across the United States. For more information, call **1-800-ACS-2345** or visit **www.cancer.org**.

# # #

American Cancer Society

Cancer Reference Information

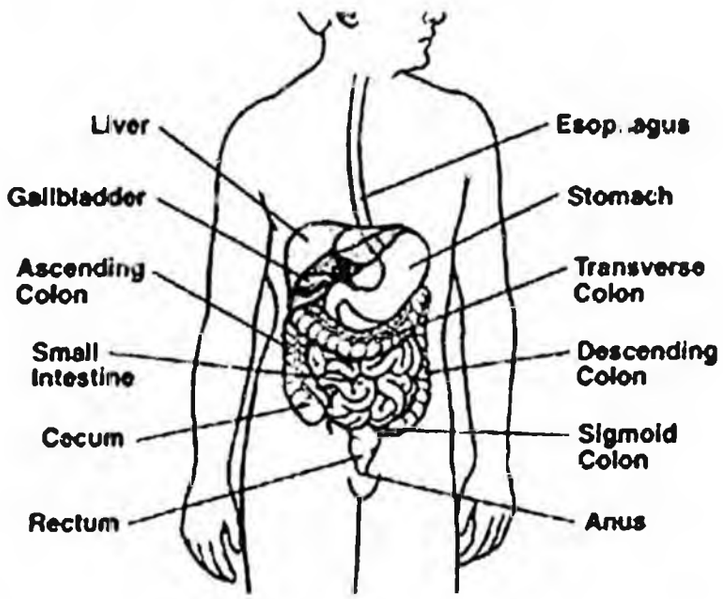
print
close

Colorectal Cancer: Early Detection

What Is Colorectal Cancer?

Colorectal cancer (cancer of the colon or rectum) develops in the digestive tract, which is also called the gastrointestinal or GI tract. The digestive system processes food for energy and rids the body of solid waste matter (fecal matter or stool). After food is chewed and swallowed, it travels through the esophagus to the stomach. There it is partly broken down and then sent to the *small intestine,* also known as the *small bowel.* The word "small" refers to the diameter of the small intestine, which is narrower than that of the large bowel. The small intestine is actually the longest segment of the digestive system – about 20 feet. The small intestine continues breaking down the food and absorbs most of the nutrients. The *liver* and the *pancreas* release bile and enzymes into the small bowel to aid in this process.

The small intestine joins the *large intestine* or *large bowel,* a muscular tube about 5 feet long. The first part of the large bowel, called the *colon* continues to absorb water and mineral nutrients from the food matter and serves as a storage place for waste matter. The waste matter left after this process goes into the *rectum,* the final 6 inches or so of the large bowel. From there it passes out of the body through the *anus.*



The colon has 4 sections. The first section is called the *ascending colon.* It extends upward on the right side of the abdomen. The second section is

called the *transverse colon* since it goes across the body to the left side. There it joins the third section, the *descending colon,* which continues downward on the left side. The fourth section is known as the *sigmoid colon* because of its S-shape. The sigmoid colon joins the rectum, which in turn joins the anus, or the opening where waste matter passes out of the body.

Cancer can develop in any section of the colon or in the rectum. Cancer beginning in these different areas may cause different symptoms. Some tests are better at finding cancer on the right side of the colon while others work better at finding cancer on the left side of the colon or in the rectum.

Colorectal cancers are thought to develop slowly over a period of several years. Before a true cancer develops, it usually begins as a polyp, which may eventually change into cancer. A polyp is a growth of tissue into the center of the colon or rectum. Having a certain kind of these polyps, called adenomatous polyps, also known as *adenomas,*increases a person's risk of developing cancer, especially if there are many polyps or they are large. There are other kinds of polyps called *hyperplastic* and *inflammatory* polyps. Inflammatory polyps are not precancerous. Neither are most hyperplastic polyps. But recently it was discovered that some *hyperplastic* polyps may be precancerous, particularly if they grow in the right or ascending colon. Another kind of precancerous condition is called dysplasia. This is usually seen in people with diseases such as ulcerative colitis which cause chronic inflammation of the colon.

In contrast to the inward growth of a polyp, a true cancer can grow inward toward the hollow part of the colon or rectum, and/or outward through the wall of these organs. If not treated, cells from the tumor may break away and spread through the bloodstream or lymph system to other parts of the body. There, they can form "colony" tumors. This process is called metastasis.

Importance of Prevention and Early Diagnosis

Colorectal cancer is the third most common cancer diagnosed in both American men and in American women. About 104,950 new cases of colon cancer (48,290 in men and 56,660 in women) and 40,340 new cases of rectal cancer (23,530 in men and 16,810 in women) will be diagnosed in 2005.

About 56,290 deaths are expected due to colorectal cancer in 2005. The death rate from colorectal cancer has been going down for about the past 15 years. This may be because there are fewer cases, more of the cases are found early, and treatments have improved.

The goal of screening for colorectal cancer is to find polyps and cancers before they cause symptoms. These tests offer the best opportunity to detect colorectal cancer at an early stage when successful treatment is likely, and to prevent some cancers by detection and removal of polyps.

There are several tests used to screen for colorectal cancer and different options for those with an average risk of colorectal cancer. Ask your doctor which tests are available where you live and which option is best for you.

Risk Factors for Colorectal Cancer

A risk factor is anything that increases your chance of getting a disease such as cancer. Different cancers have different risk factors. For example, unprotected exposure to strong sunlight is a risk factor for skin cancer and smoking is a risk factor for cancers of the lungs, larynx, mouth, throat, esophagus, kidneys, bladder and several other organs. Researchers have identified several risk factors that increase a person's chance of developing colorectal cancer.

A family history of colorectal cancer: If you have a first-degree relative (parent, sibling, or offspring) who has had colorectal cancer your risk for developing this disease is increased. The risk increases even further if the relative is affected before the age of 60, or if more than one relative is affected (at any age). About 5% of patients with colorectal cancer have an inherited genetic abnormality that causes the cancer. One abnormality is called *familial adenomatous polyposis (FAP)* and a second is called *hereditary nonpolyposis colorectal cancer (HNPCC)*. These abnormalities are described further on in this document. No other clearly identified genetic abnormalities have been described.

Most families with colorectal cancer do **not** have one of these known genetic syndromes. Accurate identification of people with these syndromes is important. Then doctors can recommend specific measures such as screening at an early age. This will help catch it early and may even block the cancer from developing because polyps may be found before they change into cancer. All people with colorectal cancer should check their family history for the disease. People with a family history suggesting a colorectal cancer syndrome should consider genetic counseling. This will help decide about getting screened at an early age.

The American Cancer Society and several other medical organizations recommend earlier screening for people with increased colorectal cancer risk that differ from those generally recommended for people at average risk. For more information, talk with your doctor and/or refer to the table in the "Can Colorectal Cancer Be Found Early?" section of this document.

Familial colorectal cancer syndromes

Familial adenomatous polyposis is a disease where people typically develop hundreds of polyps in their colon and rectum. Usually this occurs between the ages of 5 and 40. Cancer usually develops in one or more of these polyps beginning at age 20, affecting nearly all people with this disorder by age 40, if preventive surgery is not done. *Familial adenomatous polyposis* is sometimes associated with Gardner's syndrome, a condition that has benign (not cancerous) tumors of the skin, soft connective tissue, and bones. About 1% of all colorectal cancers are due to this syndrome.

Hereditary nonpolyposis colon cancer is the other clearly defined genetic syndrome. It accounts for 3% to 4% of all colorectal cancers. This also develops when people are relatively young. These people also have polyps, but they only have a few, not hundreds. Women with this condition also have a very high risk of developing cancer of the endometrium (lining of the upper part of the uterus).

Doctors have found that families with this syndrome have certain characteristics. 1) at least 3 relatives have colorectal cancer, 2) 2 successive generations are involved, 3) one of these had their cancer when they were younger than 50, and 4) at least 2 of the people are first-degree relatives. If this is true of your family, then you might want to seek

genetic counseling.

Doctors are also suspicious of this syndrome if instead of colorectal cancer the family members have other cancers associated with this gene mutation. These are endometrial cancers, ovarian cancers, small bowel cancers, or cancer of the lining of the kidney or the ureters. Still, one member must have been diagnosed with colorectal cancer under age 50.

Ethnic background: Jews of Eastern European descent (Ashkenazi Jews) are thought to have a higher rate of colorectal cancer. Recent research has found a genetic mutation leading to colorectal cancer in this group. This DNA change occurs much more commonly than the 3 other colorectal cancer syndromes and is present in about 6% of American Jews. In one study about 10% of colorectal cancers in Jews of Eastern European descent were associated with this mutation. This gene change is called the I1307K APC mutation. It isn't clear though that this genetic change is responsible for the increased number of colorectal cancers in Ashkenazi Jews.

A personal history of colorectal cancer: If you have had colorectal cancer, even though it has been completely removed, you are more likely to develop new cancers in other areas of the colon and rectum. The chances of this happening are much greater if you had your first colorectal cancer when you were age 60 or less.

A personal history of intestinal polyps: Some types of polyps (inflammatory polyps) do not increase the risk of colorectal cancer. Other types, such as adenomatous polyps and perhaps hyperplastic polyps in the ascending colon do increase the risk of colorectal cancer. This is especially true if the polyps are large or there are many of them.

A personal history of chronic inflammatory bowel disease: Chronic inflammatory bowel disease (ulcerative colitis or Crohn's colitis) is a condition in which the colon is inflamed over a long period of time. If you have chronic inflammatory bowel disease, your risk of developing colon cancer is increased. You should start being screened at a young age and it should be repeated frequently. Often the first sign that cancer may be developing is called *dysplasia*. Dysplasia means the cells lining your colon or rectum look as if they will turn into cancer.

Aging: Your chances of developing colorectal cancer increase markedly after age 50. About 90% of people found to have colorectal cancer are older than 50.

A diet mostly from animal sources: A diet mostly of foods that are high in fat, especially from animal sources, can increase your risk of colorectal cancer. Instead, the American Cancer Society recommends choosing most of your foods from plant sources and limiting your intake of high-fat foods such as those from animal sources. The ACS also recommends eating at least 5 servings of fruits and vegetables every day and several servings of other foods from plant sources such as breads, cereals, grain products, rice, pasta, or beans. Many fruits and vegetables contain substances that interfere with the process of cancer formation.

Physical inactivity: If you are not physically active, you have an increased risk of developing colorectal cancer.

Obesity: If you are very overweight, your risk of developing colorectal

cancer is increased. This is particularly true if you are fatter in your waist area than in your thighs or hips. Researchers suggest that the excess fat changes metabolism in a way that increases growth of cells in the colon and rectum, and that fat cells in the waist area have the largest impact on metabolism.

Diabetes: People with diabetes have a 30% to 40% increased chance of developing colon cancer. They also tend to have a higher death rate after diagnosis.

Smoking: Recent studies indicate that smokers are 30% to 40% more likely than nonsmokers to die from colorectal cancer. Smoking may be responsible for causing about 12% of fatal colorectal cancers. Almost everyone knows that smoking causes cancers in sites in the body that come in direct contact with the smoke, such as the mouth, larynx, and lungs. However, some of the cancer-causing substances are swallowed and can cause digestive system cancers, such as esophageal and colorectal cancer. Some of these substances are also absorbed into the bloodstream and can increase the risk of developing cancers of the kidneys, bladder, cervix, and other organs.

Alcohol intake: Colorectal cancer has been linked to the heavy use of alcohol. While some of this may be due to the effects of alcohol on folic acid in the body (see below), it still would be wise to avoid heavy alcohol use.

American Cancer Society Recommendations for Early Colorectal Cancer Detection

Beginning at age 50, both men and women at **average risk** for developing colorectal cancer should follow 1 of the 5 screening options below:

1. Fecal occult blood test (FOBT)* or fecal immunochemical test (FIT) every year
2. Flexible sigmoidoscopy every 5 years
3. FOBT* or FIT every year plus flexible sigmoidoscopy every 5 years

Of these first 3 options, the American Cancer Society prefers option 3, the combination of FOBT or FIT every year plus flexible sigmoidoscopy every 5 years.

4. Double contrast barium enema every 5 years
5. Colonoscopy every 10 years

*For FOBT, the take-home multiple sample method should be used.

Although a **digital rectal examination** or DRE (the process of a doctor inserting a gloved, lubricated finger into your rectum) is included as part of a routine physical exam, it is not recommended as a stand-alone test for colorectal cancer. However, your doctor should do a DRE before inserting the sigmoidoscope or a colonoscope. DRE, which is not painful, can detect masses in the anal canal or lower rectum. But by itself, it is not a very sensitive test for detecting colorectal cancer due to its limited reach.

If the FOBT or FIT finds blood in the stool or the sigmoidoscopy finds a polyp, colonoscopy should be done. Colonoscopy is also recommended if the x-ray studies find anything abnormal. All positive tests should be

lowed up with colonoscopy.

You should begin colorectal cancer screening earlier and/or undergo screening more often if you have any of the following colorectal cancer risk factors:

- A strong family history of colorectal cancer or polyps (cancer or polyps in a first-degree relative younger than 60 or in 2 first-degree relatives of any age). Note: a first degree-relative is defined as a parent, sibling, or child.
- A known family history of hereditary colorectal cancer syndromes (familial adenomatous polyposis and hereditary non-polyposis colon cancer, or
- A personal history of colorectal cancer or adenomatous polyps, or
- A personal history of chronic inflammatory bowel disease.

The table below suggests screening guidelines for those with **increased or high risk** of colorectal cancer based on specific risk factors. Some people may have more than one risk factor. Refer to the table below and discuss these recommendations with your doctor. Based on your individual situation and any risk factors you may have, your doctor can suggest the best screening option for you as well as any changes in the schedule based on your individual risk.

American Cancer Society Guidelines on Screening and Surveillance for the Early Detection of Colorectal Adenomas and Cancer -- Women and Men at Increased Risk or at High Risk

Risk Category	Age to Begin	Recommendation	Comments
INCREASED RISK			
People with a single, small (< 1 cm) adenoma	3-6 years after the initial polypectomy	Colonoscopy[1]	If the exam is normal, the patient can thereafter be screened as per average risk guidelines.
People with a large (1 cm +) adenoma, multiple adenomas, or adenomas with high-grade dysplasia or villous change.	Within 3 years after the initial polypectomy	Colonoscopy[1]	If normal, repeat examination in 3 years; If normal then, the patient can thereafter be screened as per average risk guidelines.
Personal history of curative-intent resection of colorectal cancer	Within 1 year after cancer resection	Colonoscopy[1]	If normal, repeat examination in 3 years, If normal then, repeat examination every 5 years.
Either colorectal cancer or adenomatous polyps, in any first-degree relative before age 60, or in two or more first-degree relatives at any age (if not a hereditary syndrome).	Age 40, or 10 years before the youngest case in the immediate family	Colonoscopy[1]	Every 5-10 years. Colorectal cancer in relatives more distant than first-degree does not increase risk substantially above the average risk group.
HIGH RISK			
Family history of familial adenomatous	Puberty	Early surveillance with endoscopy,	If the genetic test is positive, colectomy is

polyposis (FAP)		and counseling to consider genetic testing	indicated. These patients are best referred to a center with experience in the management of FAP.
Family history of hereditary non-polyposis colon cancer (HNPCC)	Age 21	Colonoscopy and counseling to consider genetic testing	If the genetic test is positive or if the patient has not had genetic testing, every 1-2 years until age 40, then annually. These patients are best referred to a center with experience in the management of HNPCC.
Inflammatory bowel disease Chronic ulcerative colitis Crohn's disease	Cancer risk begins to be significant 8 years after the onset of pancolitis, or 12-15 years after the onset of left-sided colitis	Colonoscopy with biopsies for dysplasia	Every 1-2 years. These patients are best referred to a center with experience in the surveillance and management of inflammatory bowel disease.

[1]If colonoscopy is unavailable, not feasible, or not desired by the patient, double contrast barium enema alone, or the combination of flexible sigmoidoscopy and double contrast barium enema are acceptable alternatives. Adding flexible sigmoidoscopy to double contrast barium enema (DCBE) may provide a more comprehensive diagnostic evaluation than DCBE alone in finding significant lesions. A supplementary DCBE may be needed if a colonoscopic exam fails to reach the cecum, and a supplementary colonoscopy may be needed if a DCBE identifies a possible lesion, or does not adequately visualize the entire colorectum.

Symptoms of Colorectal Cancer

Some colorectal cancers can also be found early if people report any symptoms right away to their doctors. Other conditions such as infections, hemorrhoids, and inflammatory bowel disease can also cause these symptoms. But only a doctor can determine the cause of the same symptoms. It is important to talk to your doctor since finding colorectal cancer early makes successful treatment more likely. It is also possible to have colon cancer and not have any symptoms. If the doctor suspects colon cancer, more tests will need to be done.

Symptoms may include:

- A change in bowel habits such as diarrhea, constipation, or narrowing of the stool that lasts for more than a few days
- A feeling that you need to have a bowel movement that is not relieved by doing so
- Rectal bleeding or blood in the stool
- Cramping or steady abdominal (stomach area) pain
- Weakness and fatigue

Colorectal Cancer Screening Tests

One or more of the following tests may be used to screen for colorectal cancer based on your risk of colorectal cancer and which tests are available where you live. These tests as well as others are also used when people have symptoms of colorectal cancer and other digestive diseases.

Fecal occult blood test: The fecal occult blood test (FOBT) is used to find occult (hidden) blood in feces. Blood vessels at the surface of colorectal polyps or adenomas or cancers are often fragile and easily damaged by the passage of feces. The damaged vessels usually release a small amount of blood into the feces. Only rarely is there enough bleeding to color the stool red. The FOBT detects blood through a chemical reaction. The traditional version of this test cannot tell whether blood is from the colon or from other portions of the digestive tract (i.e., the stomach). Therefore, if this test is positive, additional testing is needed to see if there is a cancer, polyp, or other cause of bleeding such as ulcers, hemorrhoids, diverticulosis (tiny pouches that form at weak spots in the colon wall), or inflammatory bowel disease (colitis). Even foods or drugs can affect the test, so you should try to avoid the following:

- Non-steroidal anti-inflammatory drugs such as ibuprofen (Advil), naproxen (Aleve), or aspirin (more than 1 adult aspirin per day) for 7 days before testing (cause bleeding)
- Vitamin C in excess of 250 mg from either supplements or citrus fruits, and juices for 3 days before testing (they can affect chemicals in the test)
- Red meats for 3 days before testing (the red material in the meat looks like blood)

However, research has shown that some people never do the FOBT test or don't give it to their doctor because they worry that something they ate may interfere with the test. For this reason, many doctors tell their patients it isn't essential to follow these restrictions in their diet. The most important thing is to get the test done. People should try to avoid taking aspirin or related drugs for minor aches. But if you take these medications daily for heart problems or other conditions, don't stop them for this test without approval from your doctor.

People having this test will receive a kit with instructions that explain how to take a stool or feces sample at home (usually 3 specimens smeared onto a small square of paper). The kit is then returned to the doctor's office or a medical laboratory for testing. It is not necessary that the kit be returned immediately because the test is still accurate if the smeared feces have dried. A test of a stool sample that your doctor took from a digital rectal exam is not an adequate substitute.

A newer kind of stool blood test kit is another screening option. Known as a **fecal immunochemical test** (FIT), it detects a specific portion of a human blood protein. This test is done essentially the same way as conventional FOBT but is more specific and reduces the number of false positive results. The fecal immunochemical test is not affected by vitamins or foods, and some forms require only 2 stool specimens (as opposed to 3 for conventional FOBT), so people may find it easier to use. The fecal immunochemical test has some of the same drawbacks as conventional FOBT, such as an inability to detect a tumor that is not bleeding.

How to get a stool sample for an FOBT test:

Have all of your supplies ready and in one place. Supplies will include test cards or slides and a wooden applicator.

You will need to obtain a sample from a bowel movement. You can lay a long sheet of plastic wrap across the toilet bowl to catch the stool or you can remove the stool from the toilet bowl. Do not contaminate the stool specimen with toilet tissue or urine. After you obtain a stool, you can flush

the remaining stool down the toilet.

Use a wooden applicator to smear a thin film of the stool sample onto one of the slots in the test card or slide.

Next collect a specimen from a different area of the same stool and smear a thin film of the sample onto the other slot in the test card or slide.

Close the slots and put your name and the date on the test kit. Return the card or slide to your doctor or laboratory as soon as possible.

Repeat the test on your next 2 bowel movements if instructed. Most tests require collecting samples from 3 separate bowel movements. This improves the accuracy of the test because many cancers bleed intermittently and blood may not be present in all stool samples.

If this test result is positive, more testing is needed to find the source of the bleeding and its cause. Colorectal cancer is not the only cause of blood in the stool so a positive test result does not necessarily mean that a polyp or cancer is present. Other causes of bleeding include hemorrhoids and diverticulitis.

Sigmoidoscopy: A sigmoidoscope is a flexible, hollow, lighted tube about the thickness of a finger. It is inserted through your rectum into the lower part of your colon. Not only can your doctor look through this to find any abnormality, the sigmoidoscope can be connected to a video camera and video display monitor for a better view. This test may be somewhat uncomfortable, but it should not be painful. Because it is only 60 centimeters (around 2 feet) long, the doctor is able to see less than half of the colon.

The colon and rectum must be empty and clean so your doctor can view the lining of the sigmoid colon and rectum. Your doctor will give you specific instructions to follow. To prepare for sigmoidoscopy, you may be asked to do the following:

- Use 2 enemas before the exam.
- Drink only clear liquids for a day or 2 before the exam, in addition to an enema before the exam.

A sigmoidoscopy usually takes 10 to 20 minutes. Bleeding and puncture of the colon are possible complications of sigmoidoscopy. However, such complications are uncommon. You may receive medicine before the test to help you relax but you will be awake for the test. You may be placed on your side or on your back with your knees positioned near your chest. Your doctor may also have a special table that rotates positions.

The sigmoidoscope is lubricated so it is easy to insert into your rectum. Your right buttock will be raised as the sigmoidoscope is inserted into your rectum. It may feel cool. To ease discomfort and the urge to have a bowel movement, it helps to breathe deeply and slowly through your mouth. The sigmoidoscope may stretch the wall of the colon so you may feel muscle spasms or lower abdominal pain. Air will be placed into the sigmoid colon through the sigmoidoscope so the doctor can see the colon better. The air can cause gas. During the procedure, you might feel pressure and slight cramping in your lower abdomen. You will feel better afterward when the air leaves your colon.

Colonoscopy: A colonoscope is a long version of a sigmoidoscope. It is inserted through the rectum into the colon and allows your doctor to see the lining of your entire colon. The colonoscope is also connected to a video camera and video display monitor so the doctor can closely examine the inside of the colon.

If you are going to have a colonoscopy, you will need to take laxatives and an enema to clean your colon so that there will not be any stool to block the view. Your doctor will give you specific instructions. The instructions usually also include the following:

- Drink only clear liquids (water, apple, or cranberry juice, and any gelatin except red and grape) for a day
- or 2 before the exam.
- Do not eat or drink anything after midnight the night before your test.

Colonoscopy may be done in a hospital outpatient department, in a clinic or in a doctor's office, and usually takes 15 to 30 minutes, although it may take longer if a polyp is found and removed. You will get an I.V. (intravenous line) so that medicine can be given through a vein. The medicine will relax you and make you feel sleepy. You will probably be awake, but you may not be aware of what is going on and may not remember the procedure afterward. You should arrange for someone to drive you home from the test because the sedative can affect your ability to drive. You will be placed on your side with your knees flexed and a drape will cover you. Your blood pressure, heart rate, and breathing rate will be monitored during and after the test. Bleeding and puncture of the colon are possible complications of colonoscopy. However, they are uncommon.

The colonoscope is lubricated so it can be easily inserted into the rectum. Once inserted into the rectum, the colonoscope is passed through the transverse colon and into the ascending colon and rectum. You may feel an urge to have a bowel movement when the colonoscope is inserted or pushed further up the colon. To ease any discomfort it helps to breathe deeply and slowly through your mouth. The colonoscope will deliver air into the colon so that it is easier to see the lining of the colon and use the instruments to perform the test. Suction will be used to remove any blood or liquid stools.

If a polyp is found, the doctor may remove it. Polyps, even those that are not cancerous, may eventually become cancerous. For this reason, they are usually removed. This is done by passing a wire loop through the colonoscope to cut the polyp from the wall of the colon using an electrical current. The polyp can then be sent to a lab to be checked under a microscope to see if it has any areas that have changed into cancer.

If your doctor sees a large polyp or tumor or anything else abnormal, a *biopsy* will be done. In this procedure, a small piece of tissue is taken out through the colonoscope. Examination of the tissue can help determine if it is a cancer, a benign (non-cancerous) growth, or a result of inflammation. Colonoscopy can be uncomfortable. If a polyp is removed or a biopsy is done during the colonoscopy, you may notice some blood in your stool after the test.

Medicare now covers colonoscopy for people at average risk. For more information on this coverage, see the section, "Medicare Coverage for Colonoscopy" below.

Barium enema with air contrast: This procedure is also called a *double contrast barium enema.*

A laxative or enema may be given before the procedure to make sure your colon is empty. Barium sulfate, a chalky substance, is used to partially fill and open up the colon. The barium sulfate is given through a small tube placed in your anus. When the colon is about half-full of barium, you will be turned on the x-ray table so the barium spreads throughout the colon. Then air is pumped into your colon through the same tube to make it expand. This produces the best pictures of the lining of your colon to be taken. You may be asked to change positions so that different views of the colon and rectum can be seen on the x-rays. The doctor can then see the size and shape of the colon and rectum. The procedure takes about 30 to 45 minutes to perform. The barium can cause constipation and your stool may appear grey or white for a few days after the procedure.

Your doctor will give you specific instructions, be sure to follow them. To prepare for a barium enema you may be asked to do the following:

- Have a liquid diet for 2 days before the procedure and clear liquids the day before the procedure
- Avoid eating or drinking dairy products the day before the test
- Do not eat or drink anything after midnight the night before the procedure
- Clean your bowel the night before with laxatives and take an enema the morning of the exam

What Are the Advantages and Disadvantages of These Tests?

Tests	Advantages	Disadvantages
Fecal Occult Blood Test or Fecal Immunochimeical Test	▪ No direct risk to the colon ▪ No bowel preparation ▪ May do sampling at home ▪ Inexpensive ▪ Proven effective in clinical trials	▪ May miss many polyps and some cancers ▪ May produce false-positive test results ▪ May have pre-test dietary limitations ▪ Should be done annually, alone or in addition to a flexible sigmoidoscopy every 5 years ▪ More tests will be needed if abnormal
Flexible Sigmoidoscopy	▪ Fairly quick and safe ▪ Minimal bowel preparation ▪ Only done every 5 years ▪ Not that uncomfortable ▪ Doesn't require a specialist	▪ Views only about a third of the colon ▪ Can't remove all polyps ▪ Very small risk of infection or bowel tear ▪ Should be done every 5 years, alone or in addition to an annual fecal occult blood test ▪ More tests will be needed if abnormal
Barium Enema	▪ Can usually view entire colon ▪ Relatively safe	▪ Can miss small polyps ▪ Full bowel preparation needed

	■ Done every 5 years ■ No sedation needed	■ Some false-positive test results ■ Cannot remove polyps during testing ■ More tests will be needed if abnormal
Colonoscopy	■ Can usually view entire colon ■ Can biopsy and remove polyps ■ Done every 10 years ■ Can diagnose other diseases	■ Can miss small polyps ■ Full bowel preparation needed ■ Can be expensive ■ You may miss a day of work ■ Sedation of some kind is needed ■ Small risk of bowel tears or infection

Colorectal Cancer Screening: State Coverage Laws

The Benefits of Early Detection Colorectal Cancer Screening

Non-cancerous polyps that develop in the colon can be found through colorectal cancer screening and removed before they become cancerous. If colorectal cancer does occur, early detection and treatment dramatically increase chances of survival. The relative 5-year survival rate for colorectal cancer, when diagnosed at an early stage, is **90%** opposed to an only 67% survival rate when diagnosed after the cancer has spread to involve nearby organs or lymph nodes.

Not only does colorectal cancer screening save lives, but it also reduces health care costs. It is estimated that when colorectal cancer is detected early, treatment costs around $10,000. Colorectal cancer detected and treated at late stage of disease can cost as much as $100,000.

What Is Needed to Increase the Use of Colorectal Cancer Screening?

Despite the availability of effective colorectal cancer screening tests, not enough people have them. Some factors affecting their use could include lack of public and health professional awareness of screening tools, financial barriers, and inadequate health insurance coverage and/or benefits.

The American Cancer Society believes that all people should benefit from cancer screenings, without regard to health insurance coverage . Limitations on covered benefits should not block your ability to benefit from early detection of cancer. To that end, the Society supports policies that give all people access to and coverage of early detection screening for cancer. These benefits should be age and risk appropriate and based on current scientific evidence as outlined in the American Cancer Society's early detection guidelines.

State Activity

In 1998, Illinois became the first state to pass a law requiring health insurers to provide coverage for colorectal cancer screening with sigmoidoscopy or fecal occult blood testing once every three years for persons who are at least 50 years old. Missouri passed a comprehensive

ancer screening law including coverage of colorectal cancer screening in ay 1999. The bill requires insurers to provide coverage for early detection colorectal cancer screening according to American Cancer Society guidelines. In the year 2000, momentum picked up in many state houses regarding this very important issue Currently around 16 state legislatures, as well as the District of Columbia, have passed laws requiring insurance coverage for screening for colorectal cancer. These states are:

- Texas
- Maryland
- Virginia
- Missouri
- Indiana
- Rhode Island
- California
- North Carolina
- New Jersey
- West Virginia
- Delaware
- Connecticut
- Georgia
- Wyoming
- Oklahoma

Laws on coverage vary by state.

Medicare Coverage for Colonscopy

Less than a year ago, Medicare started paying for colonoscopy in people 50 and older. Previously, Medicare only covered the exam for people in a narrow definition of "high risk". While family history of the disease does put some people at high risk, the greatest risk by far is simply getting older.

The American Cancer Society led the efforts to expand Medicare's coverage of colonoscopy. With this accomplishment, people on Medicare can now get the full range of screening tests for colorectal cancer.

What Colorectal Cancer Screening Does Medicare Cover?

- Fecal occult blood test (FOBT) annually for all beneficiaries 50 and over
- Flexible sigmoidoscopy (flex-sig) every 4 years for beneficiaries 50 and over at average risk
- Colonoscopy once every 10 years for beneficiaries age 50 and over at average risk
- Double contrast barium enema (DCBE) as an alternative if a physician determines that its screening value is equal to or better than flexible sigmoidoscopy or colonoscopy

What Would a Medicare Beneficiary Expect to Pay for a Colorectal Cancer Screening Test?

- FOBT: People over 50 pay no coinsurance and no Part B deductible
- Flexible sigmoidoscopy: Patient pays 20% of Medicare-approved amount after the yearly Part B deductible
- Colonoscopy: Patient pays 20% of Medicare-approved amount

after the yearly Part B deductible
- DCBE: When substituted for flexible sigmoidoscopy or colonoscopy, patient pays 20% of Medicare-approved amount after the yearly Part B deductible

Medicaid

States are authorized to cover colorectal screening under their Medicaid programs. Unlike Medicare, however, there is no federal assurance that all state Medicaid programs must cover colorectal cancer screening in people without symptoms. Medicaid coverage for colorectal cancer screening varies state by state. Some states cover fecal occult blood testing (FOBT), others cover colorectal cancer screening if a doctor determines the test to be medically necessary and in some states, coverage varies depending in which Medicaid managed care plan a person is enrolled.

What's New in Colorectal Cancer Screening?

Earlier Diagnosis: Studies continue to evaluate the effectiveness of current colorectal cancer screening methods and evaluate new approaches to informing the public about the importance of taking advantage of these methods. Less than half of Americans over 50 have any colorectal cancer testing at all. If everyone were tested, tens of thousands of lives could be saved each year. The American Cancer Society and other public health organizations are working to increase awareness of colorectal cancer screening among the general public and health care professionals. Meanwhile, new imaging and laboratory tests are also being developed and tested.

Researchers have recently found DNA mutations that often affect certain genes (such as the APC gene, K-ras oncogene, and p53 tumor suppressor gene) of colorectal cancer cells. Studies are testing new ways to recognize these DNA mutations in cells found in stool samples, to see if this approach is useful in finding colorectal cancers at an earlier stage.

Cells from the lining layer of the colon and rectum are constantly shed into the stool and replaced by new cells. The cells that slough off of the lining typically undergo *apoptosis,* a specific type of cell death that causes recognizable changes in the cells' DNA. Cells that slough off from the surface of colon cancers do not usually undergo these changes. Finding intact-appearing DNA (that lacks the changes of apoptosis) in stool samples appears to be useful in finding colorectal cancers. Recent studies that have combined DNA tests to look for gene mutations and for intact-appearing DNA have shown promising results. Nonetheless, more research is needed to confirm the accuracy of these tests before widespread use can be recommended.

In 2001, the FDA approved a new procedure for diagnosing problems in the small intestines. This procedure involves the patient swallowing a vitamin-sized pill that contains a tiny camera. The pill moves through the digestive tract just like food does. The camera takes 2 pictures each second and sends these through an antenna to a device worn around the waist. After 8 hours, the patient returns the device to the doctor who then transfers the pictures to a computer to study. The pill is then passed out of the body through the rectum and can be flushed away. This test has not yet been studied for its use in diagnosing colorectal cancer and is not recommended as a replacement for current screening tests.

Virtual colonoscopy: This can be considered as a super x-ray of the colon. The preparation is the same as for a barium enema x-ray or colonoscopy. No contrast agent is used. Only air is pumped into the colon to distend it. Then a special CT scan called helical CT or spiral CT is done. This is probably more accurate than the barium enema but not quite as good as colonoscopy for finding smaller polyps. The potential advantages are believed to be that the test can be done quickly, with no sedation, and at a lower cost than colonoscopy. A disadvantage is that if a polyp or growth is found, a biopsy or polyp removal cannot be done during the same examination. Virtual colonoscopy is currently not included among the tests recommended by ACS for early detection of colorectal cancer. This procedure should still be regarded as experimental, and at this time we do not have solid scientific evidence that it is as effective, or more effective at finding early cancers compared with currently recommended screening tests. More studies are needed before it could be recommended as a screening test for the general public.

References

American Cancer Society. *Cancer Facts & Figures 2005*. Atlanta, Ga: American Cancer Society; 2005.

Byers T, Levin B, Rothenberger D, Dodd GD, Smith RA. American Cancer Society Guidelines for Screening and Surveillance for Early Detection of Colorectal Polyps and Cancer: Update 1991. *CA Cancer J Clin*. 1997;47:154-160.

Cahill M et al. *Handbook of Diagnostic Tests*. 2nd ed. Springhouse, Pa: Springhouse Corporation; 1999.

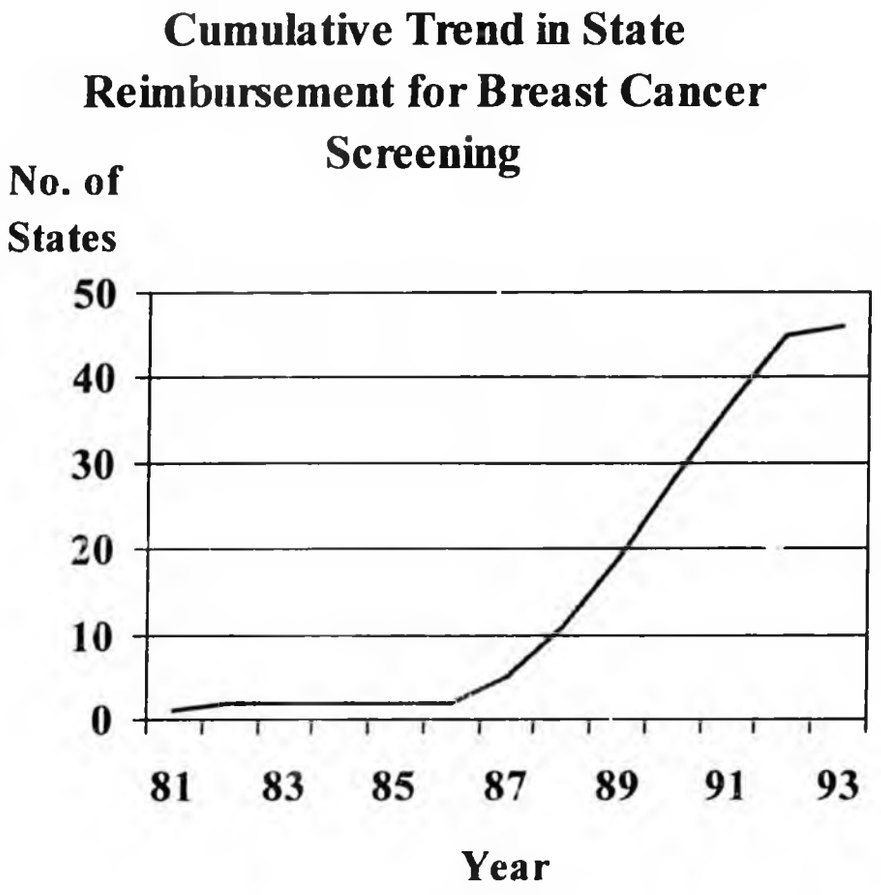
Colorectal Cancer Column Series: Impacting Action on Colorectal Cancer Legislation: What Can I Do? Available at www.preventcancer.org.

Diagnostic Tests. Bethesda, Md: National Digestive Diseases Information Clearinghouse; 1998. Available at www.niddk.nih.gov/digest/pubs/diagtest/logi.htm.

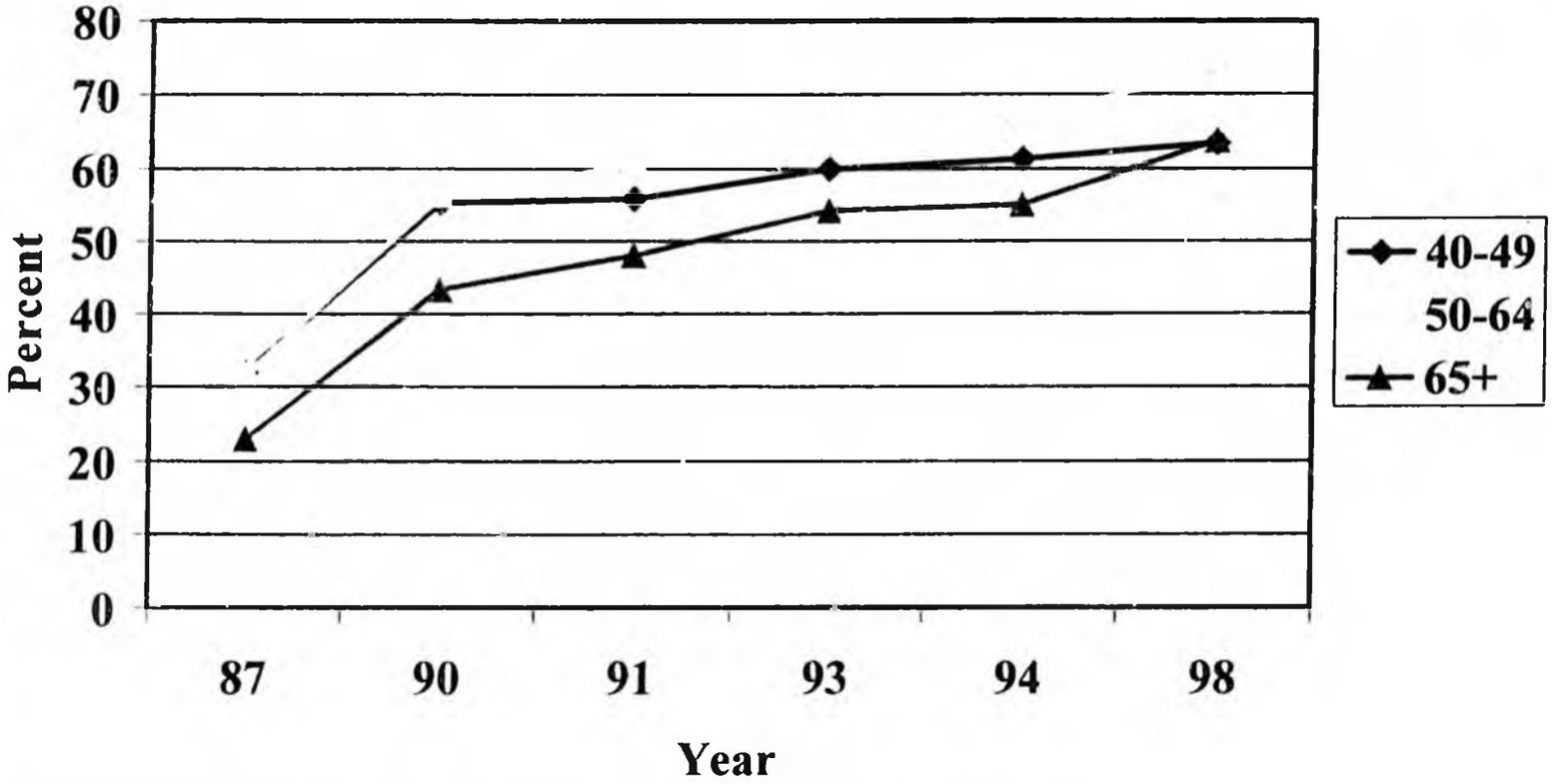
Revised: 1/6/05

State Legislation Requiring Coverage for Breast Cancer Screening

- 1981 Illinois was the first state to pass legislation requiring coverage
- 1987-1992 43 states pass coverage laws
- By 5/2000, 49 states & D.C. have coverage laws

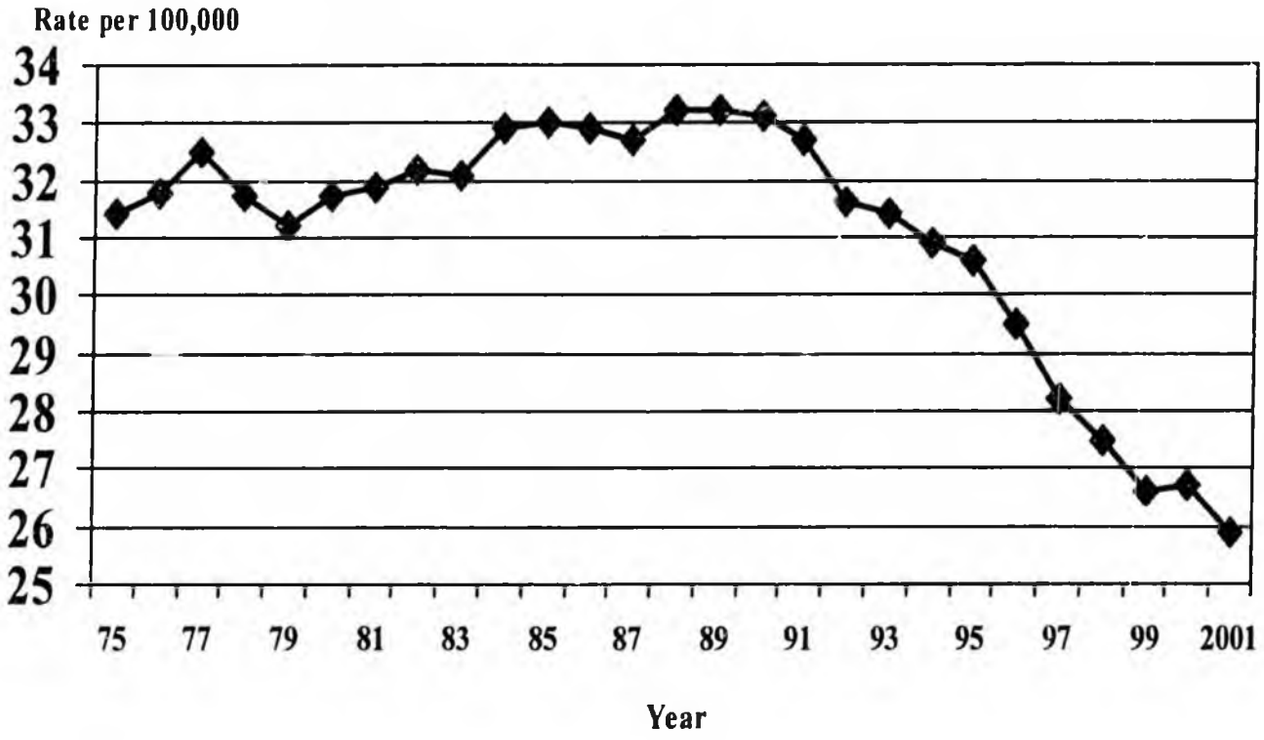


Rate of US Women Having Regular Mammograms By Age, 1987-1998



Source: CDC Behavioral Risk Factor Surveillance System, 7/2000

Breast Cancer Death Rates (Age-adjusted), US Females, 1975-2001



Source: National Cancer Institute. SEER Cancer Statistics Review 1975-2001
Rates are per 100,000 age-adjusted to the 2000 U.S. standard population.

January 30, 2006

Representative Tom Anderson
Alaska House of Representatives
State Capitol Building
Juneau, Alaska

Subject: Testimony for HB 393 – Colorectal Cancer

Dear Rep. Anderson:

As an oncology nurse in Juneau for over 20 years, I strongly support HB 393.

I have always believed that cancer screening and early detection is cost effective – both in lives saved, quality of life, and financially. In the long run it costs less to treat a cancer that is found early than later. Early detection saves lives. That is why we have mandatory payment for breast cancer by mammograms and for prostate cancer with PSAs. We need mandatory payment for colon cancer screening as well.

I also write to you in a personal vein. My maternal great-grandmother died from colon cancer. My maternal grandmother died from colon cancer. My mother had colon cancer at age 62 and because it was found early, she is 88 years old and cancer free. I have colonoscopies every 3 years at the advice of my doctor. I know my demons and act to prevent colon cancer by having polyps removed before they can turn malignant.

Colonoscopies are effective because they can find an existing cancer before it goes thru the wall of the colon. Cancers found this way can be removed surgically and usually no other expensive treatment such as chemotherapy is needed. This is what happened with my mother. And she has been free of colon cancer for 26 years. Colonoscopies also prevent colon cancer. If a polyp is found in the colon it can be removed before it becomes malignant.

Both from a professional and personal perspective I urge the passage of HB 393 into law.

Thank you.

Sincerely,

Carole S. Edwards, RN
Juneau, Alaska

RICHARD M. FARLEIGH, M.D., P.C.
GASTROENTEROLOGY / LIVER DISEASE
4120 LAUREL STREET, SUITE 202 / ANCHORAGE, ALASKA 99508
TELEPHONE (907) 561-4293

House Labor and Commerce Committee
February 1, 2006

Dear Chairman and Members:

I wish to thank the sponsors of HB 393 and strongly urge all members to pass this important legislation for the benefit of all Alaskans. I have been a practicing gastroenterologist in Anchorage for over twenty-five years, and can attest to the importance of screening for and removing colon polyps in preventing colon and rectal cancer.

Colorectal cancer and polyp screening is also cost-effective, and compares favorably in that regard with other widely accepted and effective preventive health measures such as mammography and pap smears (Pignone, et al, Annals of Internal Medicine137(2):96-104, 16 July, 2002)

The American College of Gastroenterology also strongly supports this type of legislation.

Sincerely,

Richard Farleigh, M.D., F.A.C.P.,
Alaska Governor, American College of Gastroenterology

February 1, 2006

Rep. Tom Anderson
Chairman, House Labor and Commerce Committee
State Capitol Building
Juneau, Alaska 99801

Dear Chairman Anderson and Members of the House Labor and Commerce Committee;

I am writing to urge your support for House Bill 393, Covering Colorectal Screening.

Colon cancer in the United States is increasing due to the sedentary and high fat content of American diets. We can expect to see an increase in childhood colon cancer cases as adult problems, such as type 2 diabetes, are now appearing at earlier ages.

Colon cancer is the second leading cause of cancer in Alaska. Screening for this disease results in a 90% survival rate. It actually makes the disease manageable and helps reduce health care costs if the disease can be detected in its early stages.

I think it is the responsibility of all representative and senators to reduce health care costs in Alaska and assist in detecting this disease as early as possible.

Thank you for your time and attention to this important issue. I urge your support for HB 393.

Sincerely,

Linda McCarter
Analyst Programmer IV
State of Alaska

cc. Rep. Pete Kott
Rep. Gabrielle LeDoux
Rep. Bob Lynn
Rep. Norman Rokeburg
Rep. Harry Crawford
Rep. David Guttenburg

To the Represenative Sponsors of HB 393
Representative Anderson
Representative Lynn
Representative Gruenberg
Representative Le Doux
Representative Crawford
Representative Kapsner
Representative Guttenberg

February 2, 2006

I am writing to commend each of you on your sponsorship of HB 393, an act requiring health care insurers provide for the costs of colorectal cancer screening and laboratory costs.

A little over one year ago, I was diagnosed with a large pre-cancerous polyp in my lower colon. This diagnosis was made only after numerous doctor visits and ultimately, two colonoscopies. The first colonoscopy was performed at my insistence after a close friend, a practicing physician, recommended this course of care. At the time of the diagnosis and the subsequent surgery I was forced to undergo, I was covered under an individual health care plan for which I was paying high monthly premiums.

Fortunately, my insurer covered most of the costs of the colonoscopies and many of the associated laboratory costs. Ultimately, I was forced to appeal for various laboratory costs and the anesthesia costs incurred during both the colonoscopy and the surgery. As a non-practicing attorney, I am comfortable navigating the complex procedural and policy language within insurance policies. Ultimately, my appeal was successful and I am now healthy and active once again. However this experience afforded me a unique look at what many Americans face on a daily basis – the risk of facing enormous health costs with little or no insurance coverage.

I write of this experience for two reasons. One, while I was personally fortunate that not only my carrier covered the costs of the colonoscopy, but that I was aware of my rights under the policy and advocated accordingly, I know there are many individuals who are less are fortunate. Secondly, as a 29-year-old woman, who with a healthy lifestyle and no known genetic predisposition was not your "average patient" seeking colorectal care. The colonoscopy, while not widely encouraged and often expensive to perform, was instrumental in preserving my health and ensuring I was not placed at further risk to develop colon cancer. Statistics show that more and more young women are now being confronted with a host of colorectal conditions and diseases including Chron's, ulcerative colitis, and cancerous and pre-cancerous polyps. This bill is therefore an issue that in addition to being one of public health, is also of particular importance to womens' health care.

I applaud you for your sponsorship of this bill and encourage you to move it forward with expediency. Thank you.

Sincerely,

Janell Hafner
326 4th Street, Apt 910
Juneau, AK 99811
Home (907) 523-2972
Work (907) 465-3855
Email janellhafner@hotmail.com

COMMUNITY
HEALTH SERVICES
SouthEast Alaska Regional Health Consortium

222 Tongass Drive, Sitka, AK 99835
907 966-8710 • www.searhc.org

February 2, 2006

Rep. Tom Anderson
Chairman, House Labor and Commerce Committee
State Capitol Building
Juneau, Alaska 99801

Dear Chairman Anderson and Members of the House Labor and Commerce Committee;

On behalf of the SouthEast Alaska Regional Health Consortium (SEARHC) I am writing to strongly urge your support for House Bill 393, Covering Colorectal Screening.

As the leader in providing health care to Alaska Natives living in southeast Alaska we are in support of HB 393 for the following reasons:

- Colo-rectal cancer was the second most common cause of cancer diagnosis for Southeast Alaska Native men and women in 1998-2000.
- (For the whole state) Alaska Native colo-rectal cancer incidence rates are more than twice the rates for US Whites.
- In addition to saving lives, colon cancer screening is cost-effective. (When compared to the cost of treatment.)
- 90% survival rate with routine screenings vs. if not screened in time.

Thank you for your time and attention to this important issue. I urge your support for HB 393.

Sincerely,

Mark Gorman
Vice President, SEARHC Community Health Services

cc. Rep. Pete Kott
Rep. Gabrielle LeDoux
Rep. Bob Lynn
Rep. Norman Rokeburg
Rep. Harry Crawford
Rep. David Guttenburg

AMERICAN COLLEGE OF GASTROENTEROLOGY

6400 Goldsboro Road, Suite 450, Bethesda, Maryland 20817-5846; P: 301-263-9000; F: 301-263-9025

February 2, 2006

The Honorable Tom Anderson
Alaska State Legislature
State Capitol, Room 408
Juneau, AK 99801-1182

Dear Representative Anderson:

I was very encouraged to hear from the American College of Gastroenterology's Governor for Alaska, Richard M. Farleigh, M.D., FACG, that you have introduced legislation, HB 393, in the Alaska State Legislature to require private health insurance plans to cover a preventive screening colonoscopy to all patients 50-years of age and older or for those at a high-risk for colon cancer. Simply put, your legislative proposal, if enacted, could be responsible for saving dozens of lives in the State every year.

As you know, colorectal cancer (colon cancer) is our nation's second leading cause of cancer death. This year, according to the American Cancer Society, 145,000 Americans will be diagnosed with colon cancer and 56,290 will die from the disease. Unlike most cancers, however, colon cancer is highly treatable and curable if detected early. Furthermore, through the use of colonoscopy, gastroenterologists are able to detect and remove precancerous polyps and actually prevent colon cancer. Up to 93% of colon cancer could be eliminated through adherence to screening colonoscopy according to published guidelines.

Screening through colonoscopy is proven to be a cost-effective and life-saving tool but only if it can be and is utilized by the citizenry. Representative Anderson, this is why your legislation is so important. It is inherently more difficult for Dr. Farleigh and his colleagues to prevent colon cancer in Alaska if private insurers do not cover colonoscopy. Congress recognized the need to cover at-risk populations and passed laws in 1997 and 2000 to provide colon cancer screening coverage, including colonoscopy, for Medicare beneficiaries.

The American College of Gastroenterology (ACG) has been at the forefront of this legislative effort nationwide. In fact, ACG President-Elect David Johnson, M.D., FACG, worked hand-in-hand with the late Virginia State Senator Emily Courie on passing the first colon cancer screening coverage law in the country. Although incredible strides have been made since the Virginia law was enacted in 2000, more than 30 states still have no meaningful screening coverage laws for colon cancer.

We have all learned much, though, from the trails blazed by advocacy groups battling against breast cancer and prostate cancer. ACG is working with numerous organizations, including the American Cancer Society and the Entertainment Industry Foundation, to pass colon cancer screening coverage laws in every state modeled on the wisdom of the original law drafted by Senator Couric and Dr. Johnson. The most recent success was in August when Governor Kathleen Blanco of Louisiana signed a colon cancer screening coverage bill into law alongside of the ACG Governor for Louisiana, Dr. Elwyn Lyles, who worked with a Louisiana state representative and the American Cancer Society to get the proposal through the Louisiana State Legislature.

Once again, on behalf of ACG's 9,000 members, I applaud your effort to enact the model colon cancer screening coverage legislation in Alaska. Through Dr. Farleigh and other ACG members in the State, we stand ready to assist you in enacting this life-saving legislation.

Sincerely,

Jack D. Palma

Jack A. DiPalma, M.D., FACG
President, the American College of Gastroenterology

JAD:mhr

February 2, 2006

Dear Representative Anderson and Members of the House Labor and Commerce Committee:

I am writing in support of HB 393, requiring health care insurance plans to cover colorectal cancer screening. Eight years ago, I was diagnosed with colorectal cancer. I was 45 years old at the time.

I had no idea that I could get cancer. Of all my siblings, I was the healthiest – never smoked, exercised, was never sick. I had some very minor symptoms, nothing that would have concerned me or lead me to a doctor's office; in fact, I ignored them at first. But I knew that my grandfather had died of colorectal cancer – also at the age of 45! My doctor urged me to get a full colonoscopy given my family history. But without insurance coverage for the procedure and given its expense (I had 2 kids in daycare at the time!), I'm sure I would kept postponing it and my cancer would have been much further developed. As it was, my cancer was in its earliest stages and able to be surgically removed, although complications resulted in four major abdominal surgeries over a 5 month period. Thank God for insurance coverage.

Over the past 8 years, I've had 4 colonoscopies and numerous pre-cancerous polyps removed – all covered by my insurance. I've been able to keep my cancer from recurring as a result of this. Colorectal cancer is very slow-growing – and that's why it is so treatable. But screening procedures are expensive for those who don't have insurance coverage, and the competing financial demands of your family often mean you put your own health needs at the bottom of the list. Requiring insurance coverage to include colorectal cancer screenings is a guaranteed means of reducing cancer in Alaska. I strongly urge you to pass this bill. Early detection – made possible by my insurance coverage – saved my life, and I know it will save others.

Sincerely,

Molly McCammon

Molly McCammon
3320 W. 31st Ave.
Anchorage, AK 99517
907.248.9468

PeaceHealth

Ketchikan
General Hospital

February 2, 2006

Rep. Tom Anderson
Chairman, House labor and Commerce Committee
State Capitol Building
Juneau, Alaska 99801

Dear Chairman Anderson and Members of the House Labor and Commerce Committee,

I am writing to urge your support for House Bill 393, covering colorectal screening

We are employees of Ketchikan General Hospital and support House Bill 393.

Colorectal cancer is 90% treatable if caught early, and the one and only form of cancer that can be removed before it becomes a cancer just by removing a polyp (a grapelike growth inside the colon). The most common symptom of colon cancer is no symptom at all. Everyone 50 years of age or older needs a colonscopy, no matter how they feel. Those under age 50 with any family history of colorectal cancer should be included in this coverage. The cost of a colonscopy and early intervention (if required) is cost effective and allows for a quality of life versus no screening and a late diagnosis.

Our Alaska natives have the highest rate of colorectal cancer in the country and Alaska has the second highest rate of colorectal cancer in the country. I urge you to be proactive and let's reduce the rate of this preventable cancer in our state.

Thank you for your time and attention to this important issue. Please pass House Bill 393.

Sincerely,

Peggy Pennington
Dixie Riley
Denise D. Perry
Shila Cullen
Debra Curier
Bob Gerzholt MD, PhD, FACS

PeaceHealth

Ketchikan
General Hospital

February 2, 2006

Rep. Tom Anderson
Chairman, House labor and Commerce Committee
State Capitol Building
Juneau, Alaska 99801

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Thank you for your time and attention to this important issue. Please pass House Bill 393.

Sincerely,

Jeri Shoemaker
Bobby Swirek

3100 Tongass Ave.
Ketchikan, AK 99901-5794

Tel. (907) 225-5171

PeaceHealth

Ketchikan
General Hospital

February 2, 2006

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Chairman, House labor and Commerce Committee
State Capitol Building
Juneau, Alaska 99801

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Sincerely,

Suzanne Mate
Vicki J Campbell
Joanna K DeSanto
Mary French
Cal W
Anita Nelson
Kay Kay
Gloria Manuel
Ruby Jones
Grace Hilse
Maria Lowry
Ramona Glover
Lois Kralis
Mary Beverly

3100 Tongass Ave.
Ketchikan, AK 99901-5794

Tel. (907) 225-5171

PeaceHealth

Ketchikan
General Hospital

February 2, 2006

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Chairman, House labor and Commerce Committee
State Capitol Building
Juneau, Alaska 99801

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Sincerely,

Ronnie Walker RRT
Kevin McCormick RRT
Janie Cochnower RN
Sandra Sieg
Brian S. Underwood
Elizabeth Kane CRNP

3100 Tongass Ave.
Ketchikan, AK 99901-5794

Tel. (907) 225-5171

PeaceHealth

Ketchikan
General Hospital

February 2, 2006

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Chairman, House labor and Commerce Committee
State Capitol Building
Juneau, Alaska 99801

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Thank you for your time and attention to this important issue. Please pass House Bill 393.

Sincerely,

GK

Dr. Ann Hupe, D.O.

My aunt died of Colon Cancer, I am high risk.

3100 Tongass Ave.
Ketchikan, AK 99901-5794

Tel. (907) 225-5171

PeaceHealth

Ketchikan
General Hospital

February 2, 2006

Rep. Tom Anderson
Chairman, House labor and Commerce Committee
State Capitol Building
Juneau, Alaska 99801

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Sincerely,

Marie McElott, RN
Richard S. Sayer, RN
Elizabeth Delbridge RN
Rebecca Baeling RN
Alisha Shull CNA
Angela Burleyc CNA
RN

3100 Tongass Ave
Ketchikan, AK 99901-5794

Tel. (907) 225-5171

PeaceHealth

Ketchikan
General Hospital

February 2, 2006

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Chairman, House labor and Commerce Committee
State Capitol Building
Juneau, Alaska 99801

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Sincerely,

Rebecca Woolsey, Janelle Nelson, Shelley Kerbey, Wanda L.B., Geneva Hand, K Middaugh RN, Carla R. Houtary-Gilmartin, Aleah Wheatley, Neta Mutart, Katherin E. Arca, MD Ernest Meloche, MA

3100 Tongass Ave.
Ketchikan, AK 99901-5794

Tel. (907) 225-5171

PeaceHealth

Ketchikan
General Hospital

February 2, 2006

Rep. Tom Anderson
Chairman, House labor and Commerce Committee
State Capitol Building
Juneau, Alaska 99801

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Thank you for your time and attention to this important issue. Please pass House Bill 393.

Sincerely,

Tandra Holland

3100 Tongass Ave.
Ketchikan, AK 99901-5794

Tel. (907) 225-5171

February 1, 2006

Rep. Tom Anderson
Chairman, House Labor and Commerce Committee
State Capitol Building
Juneau, Alaska 99801

Dear Chairman Anderson and Members of the House Labor and Commerce Committee;
I am a three-year cancer survivor. I volunteer for The National Patient Advocate Foundation and have been to Washington DC On several occasions in support of legislation pending in congress. I am writing to urge your support for House Bill 393, Covering Colorectal Screening. Early detection of cancer is key to survival. There is a 90% survival rate with routine screenings. Screening is a cost effective measure especially when compared to the cost of treatment. As Colon Cancer is the second leading cause of cancer in Alaska and Alaska Natives have the highest rate of any group in the country I urge you to support House Bill 393. It will save lives, possibly someone you know. Thank you for your time and support.

Sincerely,

Ian Ives
3-Year AML Survivor

Cc. Rep. Pete Kott
Rep. Gabrielle LeDoux
Rep. Bob Lynn
Rep. Norman Rokeburg
Rep. Harry Crawford
Rep. David Guttenburg

HB

396

HOUSE COMMITTEE REPO

(7)

Date Referred to Committee: January 25, 2006 **FURTHER REFERRALS: Finance**

Date of Committee Action: Apr. 27, 2006

The HEALTH, EDUCATION AND SOCIAL SERVICES Committee considered: **HB 396**

HOUSE BILL NO. 396 **ALASKA COMMISSION ON HEALTH CARE**

"An Act establishing the Alaska Commission on Health Care; and providing for an effective date."

Recommends it be replaced with [ ] HCS *or* [ ] CS *for* _____ _____(_____)
For Senate Bills with new title: [ ] Technical Title [ ] New Title: HCR_____ !] Same Title [ ] New Title

[ ] attach amendments
[ ] add new referral to _____ _Committee
[ ] Letter of Intent_____Committee

List of Abbrev for Depts.:
ADM
CED
COR
CRT
EED
DEC
DFG
GOV
HSS
LEG
LAW
LWF
MVA
DNR
DPS
REV
DOT
UA

***NEW* FISCAL NOTES**
*Assigned by Chief Clerk's Office

List by Dept(s):	*FN#	Fiscal	Indet.	Zero
HSS		X		
ADM				X

***PREVIOUS* FISCAL NOTES**

List by Dept(s):	FN#	Fiscal	Indet.	Zero

Signing with recommendations	Printed Last Name	DP	DNP	NR	AM
[signature]	CISSNA	✓			
Berta Gardner	Gardner	X			
Lia Kohring	Kohring			✓	
Chair: Peggy Wilson	WILSON			✓	
Chair:					

Alaska State Legislature

Representative Ethan Berkowitz

Sponsor Statement
House Bill 396
"Establishing the Alaska Commission on Health Care"

Alaskans are looking for quality, affordable health care. When you get sick or hurt, you shouldn't have to choose between going to the doctor and going broke. In Alaska and nationwide, escalating medical costs pose a serious threat to businesses, government budgets and family health.

HB 396 creates the Alaska Commission on Health Care to bring interest groups together in an effort to produce quality, affordable health care.

A panel composed of representatives from a broad range of health care related interests will select the commission. The commission will develop strategies and recommendations to improve public health and health care and reduce health care costs for Alaska businesses and citizens. It will address:

- an affordable, effective and quality health care system for Alaska;
- access to affordable health insurance;
- issues of wellness and individual responsibility for personal health;
- disease prevention and management;
- workforce shortages among health care providers;
- health care providers shifting costs among patient groups to make up for insufficient reimbursements and the costs of the uninsured;
- improving public health;
- the public availability of health care cost information;
- the development of a statewide health information technology network; and
- the establishment of a state health care court system.

We can find health care solutions that will improve the quality and reduce the cost of care. We just have to do the work to start developing and implementing them now.

For additional information, see:

Health Care Solutions: http://nchc.org/
Information Technology: http://www.os.dhhs.gov/healthit/
http://www.state.de.us/dhcc/information/dhin.shtml
Health Courts: http://cgood.org/brochure-hcare.html

Alaska State Capitol, Juneau, AK 99801• (907) 465-4919

FISCAL NOTE

STATE OF ALASKA
2006 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: HB3[illegible]-DHSS-FMS-04-21-06
( ) Publish Date:

Revision Date/Time (Note if correction):
Dept. Affected: Health & Social Services

Title: ESTABLISHING THE ALASKA COMMISSION ON HEALTH CARE
RDU: Departmental Support Services
Component: Health Planning & Infrastucture

Sponsor: BERKOWITZ
Requester: HOUSE (HES)
Component No.: 2765

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Personal Services	235.6	242.0	249.3	256.8	264.5	272.4
Travel	84.7	42.1	42.1	42.1	42.1	42.1
Contractual	86.2	86.2	86.2	86.2	86.2	86.2
Supplies	15.0	15.0	15.0	15.0	15.0	15.0
Equipment	20.0					
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	**441.5**	**385.3**	**392.6**	**400.1**	**407.8**	**415.7**
CAPITAL EXPENDITURES						
CHANGE IN REVENUES (0)						

FUND SOURCE (Thousands of Dollars)						
1002 Federal Receipts						
1003 GF Match						
1004 GF	441.5	385.3	392.6	400.1	407.8	415.7
1037 GF/Mental Health						
Other(Specify Type-do not abbreviate)						
Other(Specify Type-do not abbreviate)						
TOTAL	**441.5**	**385.3**	**392.6**	**400.1**	**407.8**	**415.7**

Estimate of any current year (FY2006) cost:
Mark this box (X) if funding for this bill is included in the Governor's FY 2007 budget proposal:

POSITIONS

Full-time	3	3	3	3	3	3
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

House Bill 396 would create, in the Governor's Office, the Alaska Commission on Health Care. The commission would meet at least quarterly to develop strategies and recommendations to improve public health and health care, and to reduce health care costs for Alaska residents and businesses. The commission would conduct statewide outreach to assess health care needs and solicit ideas for improving care and reducing costs. The charge in the bill is broad, even requiring the commission to explore the efficacy of establishing health courts in Alaska and to research and design a statewide health information network to benefit all Alaskans.

To carry out its many duties, the commission would need professional staff which is assumed to be hou[illegible]d in the Department of Health and Social Services: an Executive Director (Range 22 - $96,306 for salary and benefits; an H&SS Planner II (Range 19 - $82,700) and an Administrative Assistant (Range 13 - $56,600). (cont. on Page 2)

Prepared by: Richard Mandsager, M.D. Phone 465-3092
Division: Public Health Date/Time 02/10/2006
Approved by: Karleen Jackson, Commissioner Date 04/21/2006
Agency: Department of Health and Social Services

STATE OF ALASKA
2006 LEGISLATIVE SESSION

ANALYSIS CONTINUATION

That totals $235.6 in the Personal Services line for FY07. In subsequent years, the Personal Services line is increased by 3 percent annually.

Other costs for HB 396:

Travel: $84.7 ($42.1: 13 commissioners and 2 staff to four quarterly meetings: $600 airfare + $42 per diem + $26 car rental + $20 parking/incidentals = 60 trips at $688 per trip). It is assumed commission staff will be based in Juneau, and that the quarterly meetings will be held in different regions of Alaska. It is also assumed the Special Committee on Health Courts would hold two face-to-face meetings in FY07 ($19.2.: 12 members + 2 staff = 28 trips at $688 each), as would the Special Committee on Health Information Technology ($23.4: 15 members + 2 staff = 34 trips at $688 each). Because the special committees sunset after one year, their travel costs are not included for FY08 and beyond.

Contractual: $86.2 - Statewide surveys and assessments of health care needs ($10.0); other contracts entered into by state agencies as requested by commission ($10.0); preparation and distribution of annual reports ($15.0); professional services contract(s) on development of health information network ($25.0); teleconferences among staff, commissioners, special committees ($5.1: estimated 51 teleconferences at $100 per call); lease costs / rent for 3 full-time staffers ($19.1); facility costs for 4 regional meetings ($2.0).

Supplies: $15.0 for basic needs of 3 full-time staff and commission and special committee members.

Equipment: $20.0 for start-up costs in FY07 for 3 full-time staff (computers, furntiture, phones, etc.)

FISCAL NOTE

STATE OF ALASKA
2006 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: HB396-DOA-CO-04-24-06
() Publish Date:

Revision Date/Time (Note if correction): 4/21/06 9:09 a.m.
Dept. Affected: Administration

Title: An act establishing the Alaska Commission on Health Care:...
RDU: Centralized Administrative Services
Component: Commissioner's Office

Sponsor: Representative Berkowitz
Requester: (H) HES
Component No.: 45

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Personal Services	0.0	0.0	0.0	0.0	0.0	0.0
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF	0.0	0.0	0.0	0.0	0.0	0.0
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type--Do not abbreviate)						
TOTAL	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2006) cost: 0.0
Mark this box (X) if funding for this bill is included in the Governor's FY 2007 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

HB 396 would create, in the Governor's Office, the Alaska Commission on Health Care. The commission would meet at least quarterly to develop strategies and recommendations to improve public health and health care, and to reduce health care costs for Alaska residents and businesses. The commission would conduct statewide outreach to assess health care needs and solicit ideas for improving care and reducing costs. Travel and other related costs associated with the Commission will be requested through the Department of Health & Social Services; therefore, a zero note is being submitted.

Prepared by: Gary Zepp, Budget Analyst
Phone: 465-5654
Division: Administrative Services
Date/Time: 4/21/06 9:09 a.m.

Approved by: Michael Tibbles, Deputy Commissioner
Date: 4/24/2006
Agency: Administration

(Revised 9/7/2005 OMB)

STATE OF ALASKA
Department of Health & Social Services
OFFICE OF THE COMMISSIONER

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MEMORANDUM

TO: The Honorable Peggy Wilson
Alaska House of Representatives
State Capitol, Room 108

THRU: Karleen Jackson
Commissioner
Department of Health and Social Services

FROM: Richard Mandsager, M.D.
Director, Division of Public Health
Department of Health and Social Services

DATE: February 21, 2006

SUBJECT: HB396 – Alaska Commission on Health Care

You have asked for a quick review of projects, initiatives and special emphasis underway in Alaska to address the issues of improving public health and health care and reducing health care costs. As you are aware, much of the work on these broad topics occurs outside the purview of the Division of Public Health (DPH).

Here is a very general list of work being undertaken in Alaska that involves staff from the Department of Health and Social Services (DHSS). This is by no means intended to be a comprehensive analysis but instead a broad-brush outline.

This listing of ongoing work involving the Department is organized according to the issues identified in Sec. 44.19.277 of HB396, which describes the fundamental powers and duties of the proposed commission:

1) Establishment of an affordable, effective, and quality healthcare system

- Revision of Certificate of Need regulations, standards and methodology to assure that new facilities and services are built only in response to need.
- Obtaining federal funds for support of the primary care and rural health systems to:

    - Provide data support for Community Health Center and other safety net provider applications, and improve data availability through diverse means;
    - Complete health professional shortage area designations;
    - Coordinate recruitment efforts (National Health Service Corps, J-1 visa program, 3R-Net, SEARCH);
    - Conduct workforce studies; and
    - Support quality improvement and network development in the health care system (rural hospitals, primary care providers, integrated services for primary care and behavioral health, emergency medical services).
- DHSS Commissioner has co-chaired the Alaska Telehealth Advisory Council and Department staff work to support telemedicine development to reduce costs and improve quality of care.
- Establishment of a Regional Health Information Organization/Health Information Exchange workgroup.
- Work with Denali Commission to ensure funding for improvements in the health care infrastructure.
- Through the Denali Commission, coordinate regional planning efforts in the Mat-Su, on Prince of Wales Island and the Copper River region.
- Assist small rural hospitals to evaluate the possibility of converting to Critical Access Hospital classification.
- Foster the development through grant funding of the Alaska Hospital and Nursing Home Association in the establishment and development of the Alaska Small Hospital Improvement Program in meeting member hospitals' PPS, HIPAA and QI collective needs.
- Support the Alaska Hospital Performance Improvement Project, focusing on three small hospitals to identify potential improvements in reimbursement and patient care.
- Much work is underway in the Division of Behavioral Health in the area of integrating substance abuse and mental health treatment. This applies not just to adults, but also to children (DHSS' Bring the Kids Home initiative).
- Participation as a member of the All-Alaska Pediatric Partnership with the goal of improving and further developing the delivery of medical services to children.

2) Access to affordable health care

- Creation of Denali KidCare.
- Expansion of the federal Section 330 Community Health Center program in Alaska.
- Evaluating progress toward Healthy Alaskans 2010 goal to cover the uninsured through household and employer surveys, identifying who is

uninsured and why, and inter-departmental work on insurance issues and options for improving access to affordable insurance and care. (Health Planning and Systems Development work is now underway with HRSA funds to expand these efforts, to display and explain the nature of the problem, and the direct and indirect costs of people being uninsured.)

- Telemedicine support and coordination that provides for greater degree of on-site care provision with less travel costs and less use of antibiotics.
- Telehealth expansion plans that will result in availability of clinical telehealth services in Community Health Centers.
- TeleBehavioral Health Program.
- Worked with the Anchorage Access to Healthcare Coalition to develop Anchorage Project Access, which is a volunteer provider network to increase access to individuals who cannot afford care and do not qualify for any assistance programs.

3) Individual responsibility for personal health and wellness; and

4) Disease prevention and management

The Section of Chronic Disease Prevention and Health Promotion in DPH includes several programs *(Cancer Prevention and Control Program, Diabetes Prevention and Control Program, Arthritis Program, Hearth Disease and Stroke Program, Obesity Prevention and Control Program, Tobacco Prevention and Control Program, School Health Program and the Health Promotion Program)* that are currently addressing the issue of disease prevention and management as well as the promotion of health and wellness. An overarching goal of all of the Section's programs is that they focus their efforts on creating and establishing policy and environmental changes that enable individuals to make healthy lifestyle choices. Additionally many of the programs are working with communities, businesses, healthcare providers and other partners to support and sustain these efforts. Evidence based public health practices support this approach, which will enable long term and sustainable changes in societal norms and health behavior that will ultimately result in improved health outcomes.

Here are some examples of program activities:

- Worksite Wellness Project - This is a collaborative project between all of our chronic disease programs and Aetna to implement a pilot project with four small businesses to determine a set of best practices for developing worksite wellness programs in Alaska.

- Chronic Disease Self Management - This is a collaborative project with all of our chronic disease programs that provides training to health care

providers statewide to teach them how to work more closely with patients to address their patients ability to manage their chronic disease(s).

- Obesity and School Health programs are working with schools and communities to address the surging epidemic of childhood obesity.

5) Workforce shortages among health care providers

- Work with the Alaska Workforce Investment Board and conduct workforce studies.
- Partnership between the University of Alaska and the health care industry to expand the number of nurses graduating from UAA.
- In cooperation with the university, establishment of the Alaska Physician Supply Task Force.
- Maintaining current Health Professional Shortage Area applications for health, mental health and dental designations throughout Alaska.
- Coordinate recruitment efforts that focus on opportunities for loan repayment, scholarships and student/resident rotations (National Health Service Corps, J-1 visa program, 3R-Net, SEARCH student rotations).
- Coordinate and lead Comprehensive Integrated Mental Health Program Plan to help improve access to care for Alaskans with behavioral health needs and developmental disabilities.

6) Cost shifting by health care providers caused by insufficient reimbursement or lack of insurance

- Collaboration amongst the Medicaid program and the tribally administered programs so that cost efficiencies are maximized.
- Integrating tribal and community supported health care providers to maximize local dollars minimize redundant/competing systems. The "Tribal Program" in DHSS is an effort to provide state government responsiveness and assistance to solve problems, build and maintain capacity to assure access, and encourage efficiency.
- Establishment of State Planning Grant to document issues related to the uninsured and underinsured residents in Alaska.
- Distribution of Disproportionate Share Hospital funding allocations.

7) Need for courts with specialized jurisdiction to consider health issues

- Nothing is underway in Alaska that we are aware of; however, this is actually a question for the Department of Law and Alaska Court System.

8) Improvements in public health

- The passage of a comprehensive new public health law to better protect the public while strengthening due process rights. The new statutes (incorporated by HB95, passed by the 2005 Legislature) are critically important to public health practice because they provide the framework within which governmental public health agencies operate, as well as the legal authorities required to monitor health status in communities, identify health threats, and to control the spread of disease.
- A newly consolidated certification and licensing function in state government that better protects the public safety by coordinating background check functions, on-site reviews and other requirements to make hospitals, nursing facilities and assisted living homes as safe as possible.
- Pending construction of a modern virology laboratory in Fairbanks to replace an outdated, overcrowded facility. The safe and efficient operation of the virology lab is vital to the detection, treatment and control of highly infectious and serious diseases in Alaska.
- Creation of statewide plan to prepare for the possibility of pandemic flu in Alaska. The plan describes a coordinated strategy to prepare for and respond to an influenza pandemic in five key areas: surveillance and investigation; health care systems; community disease control; vaccines and antiviral medications; and communications.

9) Public availability of health care cost information

- The Department publicly reports the annual cost of Medicaid services in Alaska and regularly cites estimates from the federal government of costs associated with various health problems (i.e., according to CDC, Alaska's annual medical costs for tobacco use are approximately $132 million).
- As for public information about costs and comparisons for specific types of medical care or procedures, nothing substantive is underway in Alaska that we are aware of.

Cc: Sherry Hill
Special Assistant
Office of the Commissioner
Department of Health and Social Services

Patricia A. Carr, MPH
Health Planning and Systems Development
Alaska Office of Rural Health
Office of the Commissioner
Department of Health and Social Services

HOME
What is DHCC?
Newsroom
Programs / Initiatives
FAQs
Employment
Calendar of Events
Related Links
Contact Information
Office Locations
Agency Site Map

SERVICES
State Loan Repayment Program
Opportunities for Health Professionals

INFORMATION
Who Serves on the DHCC?
Uninsured Action Plan
CHAP
Information & Technology
DHIN
Health Professional Workforce Development
DIMER
DIDER
SLRP
Documentation
Minutes & Agenda
Publications
Presentations

WHAT IS THE DELAWAR HEALTH CARE COMMISSION?

The Delaware General Assembly created the Delaware Health Care Commission in June of 1990 to develop a pathway to basic, affordable health care for all Delawareans.

The Delaware Health Care Commission embodies the public/private efforts which have traditionally spelled success for problem solving in Delaware. Four government officials - the Secretary of Finance, Secretary of Health & Social Services, Secretary of Children, Youth & Their Families and the Insurance Commissioner - are joined by six private citizens appointed either by the Governor, the Speaker of the House or the President Pro Tempore of the Senate. The composition is a balance between the executive and legislative branches of government and the public and private sectors.

By creating the Commission as a policy-setting body the General Assembly gave it a unique position in state government. It is intended to allow creative thinking outside the usual confines of conducting day-to-day state business. The Commission is expressly authorized to conduct pilot projects to test methods for catalyzing private-sector activities that will help the state meet its health care needs. To achieve its goals, the Commission strives to balance various viewpoints and perspectives.

The Commission generally has followed a strategy built on the notion that initial efforts should target areas most in need and gradually build toward a more comprehensive plan. Since 1995, the Commission has used a committee system as a means of reaching out to the community and involving those impacted by its decisions in the consensus building process.

In 1996, the Commission assumed administrative responsibility for the Delaware Institute of Medical Education and Research, which serves as an advisory board to the Commission. Placing the administration of DIMER within the Commission enhanced its ability to accomplish its primary goal of providing Delaware residents greater opportunity for a medical education, while also expanding its mission to help the state meet its broader health care needs.

In 1997, the Commission assumed responsibility for the creation and maintenance of the Delaware Health Information Network (DHIN). The DHIN is a public instrumentality of the state charged with the design, operation and maintenance of facilities for public and private use of health care information. A community-based health information network for communicating patient clinical and financial information, the DHIN's purpose is to increase the efficiency and quality of health care in Delaware.

The Commission strives to balance access, quality and cost concerns and develop recommendations that represent the best policy for the most Delawareans.

For More Information Contact:

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Last Updated: Friday, 21-Oct-05 16:51:21

THE DELAWARE HEALTH INFORMATION NETWORK (DHIN)

Click here to learn more

The DHIN was created in July 1997 as a public instrumentality of the state to advance the creation of a statewide health information and electronic data interchange network for public and private use. It functions under the direction and control of the Health Care Commission. It addresses Delaware's needs for timely, reliable and relevant health care information.

A statewide health information network such as is envisioned by this legislation would coordinate public and private efforts related to the collection, exchange, analysis and dissemination of access, cost, and quality utilization and other performance data. This can be used to reduce costs, stimulate competition based on quality, improve access and help determine the most appropriate ways to target resources.

The Delaware Health Care Commission in 1998 moved the Delaware Health Information Network from conceptual idea to reality. Building on the 1997 legislation which enabled the DHIN's creation, the Commission impaneled a DHIN Board of Directors which elected officers, established standing committees and adopted a mission statement. The DHIN Technology Committee will help the Board facilitate the development of uniform standards for the electronic interchange of health information and assist with the compatibility of technology. The Policy and Procedures Committee will assist with the development of guidelines and the promulgation of regulations governing the manner that the DHIN conducts business. In addition, this committee will address issues pertaining to the privacy and confidentiality concerns of health information.

Reflecting the breadth of the DHIN's importance, the mission of the DHIN as adopted by the Board is as follows: "To facilitate the design and implementation of an integrated, statewide health data system to support the information needs of consumers, health plans, policymakers, providers, purchasers and research to improve the quality and efficiency of health care services in Delaware."

Working with the Technology Committee, the DHIN drafted a "Plan of Study" which is designed to yield an initial strategic plan for development and implementation of an electronic data interchange network for public and private use. As a first step, the plan called for assessing existing health information, by examining both state and national efforts, and determining their compatibility. The second step is to determine what additional data or information is needed. A key challenge in accomplishing this task will be determining the questions that the information should answer. This will be necessary to determine additional data needed and avoid unnecessary data collection or analysis.

Through the Policy and Procedures Committee, the DHIN drafted regulations to address the duties of officers of the Board, terms of office, establishment and

powers of an executive committee, meeting notice publications, public access to records regarding DHIN activities as well as health data and health information of the DHIN, conflicts of interest and resolution of disputes among Board members.

The DHIN in 1998 also adopted the following tasks for the organization, agreeing that the short-term and long-term tasks can be tackled simultaneously. The DHIN also recognized the short-term activities related to electronic transactions among payers and providers will help provide the infrastructure necessary to carry out the long-term goals.

Short-term goals of the DHIN should be limited to and focused on tasks which can be accomplished with relative ease, will establish trust and result in early success. Specifically, the DHIN should promote the use of electronic data interchange to enable providers to electronically exchange the following information, which for the most part is currently moved via paper transactions:

- Query eligibility of covered benefits, i.e. co-pays and deductibles.
- Send and receive referral authorizations for approval and routing to specialty providers.
- Submit electronic claims.
- Receive electronic payment vouchers.
- Receive electronic mail, such as capitation lists and other notices.
- Send claims inquiries and receive responses.

In accomplishing these tasks, the DHIN agreed to promote the use of uniform transmission standards, keeping in mind that national standards are under development, and in some cases already exist, and that "re-inventing the wheel" should be avoided.

Long-term concept goals relate to research and policymaking activities, and include, but are not limited to, having the information needed to:

- Identify and understand health care problems.
- Measure and understand changes in health status.
- Develop a more competitive and consumer-oriented health care marketplace, within which value can be gauged in terms of cost, quality and access.
- Analyze comparative information on health status and socioeconomic indicators.
- Utilize national regional and "best practice" benchmarks.
- Make comparisons between actual circumstances and ideal situations.

DHIN Board of Directors

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Robert F. Miller
Delaware Health Care Commission

Vice-Chair
Joseph M. Letnaunchyn
Delaware Healthcare Association

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Catherine Bonuccelli, MD
Delaware Health Care Commission

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Michael S. Katz, MD
Medical Society of Delaware

William E. Kirk, III, Esq.
Delaware Health Care Commission

Joseph A. Lieberman, IIII, MD, MPH
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Vincent P. Meconi
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Faith Rentz
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Scott C Reynolds
Delaware Health Care Commission

Paul Silverman, DrPH
Ex-Officio Director of Public Health or Designee

Robert J. Varipapa, MD
Medical Society of Delaware

Robert J. White
Delaware Health Care Commission

DHIN UTILITY

What is the clinical information sharing utility?

The clinical information sharing utility will offer a way to connect patients (and their personal health information) electronically with their health care providers for the purposes of getting medical care. The utility, when developed, will be a computerized network by which a patient can consent to have hospitals, labs, diagnostic facilities (e.g.., x-ray facilities) and insurers make their clinical information available, to the patient's health care providers at the time and place they are getting care, any time of the day or week. The information will be sent in a "near real time" environment.

A distributed model for data-sharing will include lab, radiology, prescription, diagnosis, procedure and allergy information. That is, the data will reside within the organization at which the data originated. DHIN will not develop a database or data repository for the purpose of the Utility. Additional components to the Utility likely will include a patient portal, a disease management/decision support module, audit trail and billing functions, claims retrieval and processing, and secured messaging/email to facilitate improved provider-to-provider and patient-to-provider communication.

These DHIN partners have remained committed to the vision of creating and implementing a system by which clinical information may be shared among providers for the purpose of improved patient care and clinical outcomes, improved privacy and security of health information, improved patient-practitioner relationships, and controlled healthcare costs.

Our Partners

An assembly of public and private organizations is involved in the development of the utility. The DHIN is the oversight body and is comprised of representation from:

- Consumers
- Delaware Health Care Commission
- Delaware Healthcare Association
- Delaware State Chamber of Commerce
- Delaware Department of Health and Social Services
- Delaware Department of Insurance
- Delaware State Budget Office
- Insurance providers, including Aetna, Blue Cross Blue Shield and Delaware Physicians Care
- Large employers, including AstraZeneca, Dupont and MBNA
- Medical Society of Delaware

In addition to the DHIN board, other project participants include: the offices of Congressman Michael Castle and Senator Thomas Carper, three hospital organizations-Bayhealth Medical Center (including two acute care and one behavioral health hospitals); Beebe Medical Center (a rural health system, including an acute care hospital, home health services and satellite lab and imaging); and Christiana Care Health System (an urban health system, including two acute care and one rehabilitation hospitals, a long term care facility, home health care and a health plan)-as well as, the Department of Technology and Information and the Medicaid program overseen by the Division of Social Services.

Why is it important to share Health information?

Healthcare in Delaware, as in much of the Nation, is provided by a dynamic and increasingly complex array of caregivers. While receiving care, a patient frequently encounters primary care physicians (i.e., a family doctor), hospitalists, specialists (e.g., cardiologist), ancillary providers (e.g., physical therapist, etc.,) pharmacies, home care providers, hospitals, free-standing surgical centers, laboratories, imaging centers and public health facilities. To further complicate matters, the majority of these caregivers function within their own information silos, and even though the patients may move from place to place in the healthcare environment, their information frequently does not. Therein lays the potential for an error-prone and inefficient healthcare delivery system.

Providers attempt to share information by telephone, fax, mail, or print but, when faced with the difficulties of locating and obtaining the information, physicians frequently resort to ordering duplicate studies and tests rather than searching for results that may or may not exist. The time and effort spent manually processing this information reduces efficiency, increases duplication of effort, and adds considerably to the cost of providing care.

Why benefits will the DHIN Utility bring to the citizens of Delaware?

When healthcare providers and consumers have access to a complete health and treatment history as proposed for the DHIN Utility, there is the potential for a significant improvement in the delivery of health care.

- **Improved quality of care** - when a doctor or hospital has information about a patient's prescription medications, medical history, treatment history and allergies, he/she can make better clinical decisions, which result in better health outcomes for the patient.

- **Improved patient-provider communication** - When a patient has access to more information, he/she is more likely to engage his/her health care providers in communication about treatment options and wellness opportunities. As a result, the patient is more involved in treatment decisions, improving compliance and overall health outcomes.

- **Reduced duplication of services and treatments** - Two of the most significant cost drivers in the health care industry are prescription drugs and high technology diagnostic and testing services, such as MRIs and CT scans. Compounding these costs is the potential for duplication of these treatments or tests. For example, a prescribing provider is unaware that the patient has been prescribed a medication by another doctor and he/she prescribes the same drug or one of the same drug class. At best, this is an added expense; at worst, it can lead to potentially deadly interactions or overdosing. With respect to diagnostic testing: unbeknownst to the provider, a test has been completed on a patient recently. The provider, unaware of the results, requests a duplicate test.

What does it mean to me as a patient?

The following real-life scenarios illustrate the need for and benefit of sharing your clinical health information among your attending providers-your family doctor, your specialist, your pharmacist, the emergency room doctor, the lab where you get your blood drawn, and the facility that takes your x-rays.

A patient with severe back pain requiring the use of narcotics is seen at a clinic. The staff attempts to take a complete history, but the patient is not fully capable of cooperating because of the combined sedative effects of muscle relaxants and narcotic analgesics. An MRI of the spine is ordered and more narcotics are prescribed until further assessment of the problem can be made. Several weeks later the clinic staff finds that the patient already had an MRI done, which was prescribed by another doctor just two weeks prior to the patient's first visit. The other physician is unaware of the clinic visit and is still seeing the patient and is also prescribing narcotics. As a result, the patient receives two expensive and identical tests and twice the narcotics he needed.

* * *

A patient with severe hypertension is discharged from the hospital on three out of her four blood pressure medications. The fourth was withheld during her hospitalization because she was acutely ill from another illness and did not require her usual dose of blood pressure medication. When she was next seen by her regular doctor, her blood pressure was very high. When questioned, she stated she was taking all the medications as instructed; she forgot to mention instructed by whom-the hospital or her doctor. Because the doctor thought she was still taking all four of her medications, he began adding new and considerably more expensive medications to her

regimen. This resulted in higher pharmaceutical costs, a greater chance of side effects, several extra office visits to titrate medications, and longer exposure to high blood pressure for the patient

* * *

A patient brought into the emergency room (ER) unconscious from a car accident is unable to give the doctors a list of his allergies and current prescription drugs he is taking. The hospital in the next county has information on file that the patient has a severe allergy to the dye used for the MRI. The emergency room doctor caring for the accident victim, having no medical history available to him on this patient, orders an MRI to evaluate for internal injuries. The MRI is administered using the dye and the patient goes into heart failure. This complication could have been avoided if the patient's medical information from the hospital in the next county had been available to the emergency room doctor when making critical medical decisions.

iser_publications-admin@lists.uaa.alaska.edu wrote:

Date: Wed, 08 Mar 2006 14:26:14 -0900
To: iser_publications@lists.uaa.alaska.edu
From: iser_publications-admin@lists.uaa.alaska.edu
Subject: [Research Matters] ISER Research Matters No. 13

ISER Research Matters is our effort to quickly let Alaskans know about research findings from the Institute of Social and Economic Research (ISER), at the University of Alaska Anchorage. We'll post these periodically on our Web site and also distribute them by e-mail. If you'd like to be removed from our e-mail list, send us a message at ResearchMatters@uaa.alaska.edu.

ISER Research Matters No. 13. Alaska's $5 Billion Dollar Health Care Bill—Who's Paying?
March 8, 2006

Spending for health care in Alaska was an estimated $5.3 billion in 2005, up from about $1.6 billion in 1991. Taking population growth into account, that's an increase of more than 170% per person in 15 years. Those are among the findings of a new ISER research summary, "Alaska's $5 Billion Health-Care Bill—Who's Paying?" The authors are Mark Foster and Scott Goldsmith. The 8-page summary also reports:

- The $5.3 billion spent for health-care in Alaska in 2005 was about one-third the value of North Slope oil exports—in a year when oil prices were high. It's one-sixth the value of everything Alaska's economy produced last year.
- Individual Alaskans spent about $1 billion of the total in 2005, up from $360 million in 1991.
- Employers (government and private) spent over $2 billion in 2005. For comparison, employers spent about $11.8 billion for wages last year.
- Government programs paid $2.2 billion of the $5.3 billion total. Medicaid alone made up nearly $1 billion of that spending.
- National data show that just 5% of patients account for nearly half of all U.S. health-care spending. The average high-cost patient is middle-aged, sees doctors several times a year, is in the hospital for a few days for surgery, and spends considerable money on prescription drugs.
- Health-care spending in Alaska could double again by 2013, if current trends continue.

Click here to see the entire research summary.

Study: Already high health care costs on track to double

By Melissa Campbell
Alaska Journal of Commerce
Publication Date: 03/19/06

Alaska businesses and their employees are paying more than ever in health care costs, according to a new study. And if current trends continue, their costs will double by 2013.

This comes as no big surprise as current trends go, but the study, conducted by the University of Alaska Anchorage's Institute of Social and Economic Research, put some tangible numbers to a gnawing concern held by employers across the state.

Future research will attempt to determine what is driving the costs, and that could lead to ideas on how to stem the flow.

Spending for health care hit $5.3 billion in 2005, compared to $1.6 billion in costs in 1991, the last time ISER reviewed health care costs. That averages about 9 percent growth a year.

Health-care spending included such costs as hospital stays, doctor and dentist visits, prescription drugs, as well as program administration and public health programs. It does not include capital spending, which would include a new hospital wing or the medical equipment to fill it.

Part of the increase in spending can be attributed to the state having more people. Alaska has grown from a population of 570,000 in 1991 to about 665,000 last year. Costs for goods and services in general have also increased, by about 43 percent nationwide and nearly 40 percent in Anchorage.

Still, the price of medical care nearly doubled during that time frame, the report said. And Anchorage's costs for health care rose faster than the national average. Overall medical costs are about 25 percent higher in Alaska than elsewhere in the country.

In 2005, some 80 percent of health care costs were paid by governments, as well as by for-profit and nonprofit businesses. The study noted, however, that individuals indirectly pay for these costs as well, as they buy goods and services, own businesses and pay taxes, all of which cost more because employers pass the costs of doing business along to their customers or constituents.

"These soaring costs are taking a growing share of family and government budgets, increasing labor costs, and putting businesses at a competitive disadvantage," the study said.

Private and government employers spent about $2 billion for employee health-care coverage, the study said. Of that, private business paid about 17 percent of the total costs, about $922 million. By comparison, they spent $11.8 billion in total wages.

Governments in 2005 spent $2.2 billion for health care programs - such programs as Medicaid or Medicare - compared to $736 million in 1991. Medicaid spending hit nearly $1 billion.

The remaining 20 percent in health care costs were paid by individual Alaskans, for a total of more than $1 billion, through payroll deductions and out-of-pocket expenses, items such as deductibles, co-pays and for some care not covered by a company health plan.

In 1991, Alaska households paid $361 million for their health care. That equates to about $2,900 per person, compared to the nearly $8,000 each Alaskan spent in 2005.

Premium impacts

About 87 percent of Alaskans have some form of health-care coverage, either through private insurance or government programs. That compares to 68 percent nationwide.

In 2003, insurance premiums for family coverage at private firms were about $10,500 in Alaska and $9,200 nationwide. That's a steep incline from 1993, when premiums cost $6,200 in Alaska and $4,800 nationwide.

In 2005, national premiums rose to more than $11,000. The updated figure was not available for the state.

As high as premiums seem, Alaskans tend to pay a smaller share. As of 2003, employees at private firms in Alaska paid 11 percent of the premiums for single-person coverage and 17 percent for families.

That compares to 17 percent for single coverage and 25 percent for families on a nationwide basis.

With costs rising, however, employers - especially smaller companies - are shifting more of the insurance costs to workers. A 2005 survey referenced in the ISER report said that employees of businesses nationwide paid 43 percent of the premiums for family coverage.

Small Alaska businesses are less likely to offer insurance coverage at all, the report said. Only about a third of companies with fewer than 50 employees offer coverage, compared to 43 percent nationwide.

The study also noted that rising costs are causing more businesses and governments to turn toward self-insuring rather than going through an insurance company in an effort to stem some of the costs.

Good investment?

It costs about 25 percent more for treatment in Alaska when compared to the national average, the study said.

Overall costs of medical and surgical procedures in Alaska were about 18 percent above the national average in 2001 and dental procedures were 37 percent more.

Average costs of a doctor's visit were 30 percent higher in Alaska. Costs of hospital care rose faster in the state than in the nation between 2000 and 2003. In 2003 average expenses for a day in an Alaska hospital were 42 percent above the U.S. average, compared to 30 percent in 2000.

And while Alaskans take fewer prescription drugs, we pay an average of 25 percent more.

Whatever the costs, it seems that Alaskans are getting a fairly good return on their health care investments. The study showed that Alaskans tend to be healthier in most aspects.

The rates of infectious disease, infant mortality and deaths from heart disease have declined in the past decade. The obesity rate, however, has increased slightly. Obese people are more likely to eventually require treatment for diabetes and high blood pressure.

"We have made significant gains," the study's author, Mark Foster, told members of Commonwealth North at a recent luncheon in Anchorage. "We have the ability to treat diseases that we couldn't treat before."

But finding ways to further improve on health care investments - keeping costs down while offering Alaskans the health care services they demand - will be complicated, he said.

"If we are getting more healthy, (are rising costs) a bad thing so long as the economy can increase its production?" he said. "There have been a number of reform efforts to control the costs, but few last more than a year or two. The demand for better care overtakes the cost concerns."

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Building a Better Health Care System

SPECIFICATIONS FOR REFORM

A Report from the National Coalition on Health Care

National Coalition on Health Care

1200 G Street, NW, Washington, DC 20005, 202-638-7151

Preface

The United States is on the cusp of a major new debate — a necessary debate — about the future of our health care system.

In 1993 and 1994, our nation had such a debate — in Congress, the press, and the polity — about a variety of proposals, from many quarters, for health care reform. Political leaders in both parties agreed that the problems confronting health care then — in particular, rising costs and increasing numbers of Americans without health insurance — constituted a genuine crisis and warranted an urgent policy response. That debate ended without legislative action. The health care system was not reformed, its problems remained unchecked, and the sense of urgency that had animated and permeated the debate dissipated.

The system-wide problems that triggered an intense national debate more than a decade ago are larger now than ever. The growth of these problems has overwhelmed incremental measures meant to alleviate them. If we needed comprehensive health care reform in 1993 and 1994 — and we did — we need it even more today.

The recommendations for comprehensive reform that you are about to read come not from a single organization of interest, not even from one sector of American society. They were developed, in a year of study and deliberations, by the National Coalition on Health Care, which brings together many interests and sectors. The Coalition is an organization of organizations — of nearly one hundred of America's largest businesses, unions, health care providers, associations of religious congregations, pension and health funds, insurers, and groups representing patients and consumers. Collectively, the Coalition is the nation's largest and broadest alliance working for the achievement of comprehensive health care reform. Our members represent — as employees, members, or congregants — at least 150 million Americans. They speak for a cross-section — and a majority — of our population.

The organizations that belong to the Coalition are united by their commitment to the pursuit of five principles or goals for a reformed health care system:

- Health Care Coverage for All
- Cost Management
- Improvement of Health Care Quality and Safety
- Equitable Financing
- Simplified Administration.

The Coalition is rigorously non-partisan. Its honorary co-chairmen are former Presidents George H.W. Bush, Jimmy Carter, and Gerald R. Ford. Its co-chairmen are former Iowa Governor Robert D. Ray, a Republican, and former Florida Congressman Paul G. Rogers, a Democrat. Our members believe that an effective response to the crisis in American health care is urgently needed and that it will require leadership from both political parties and a willingness to compromise across ideological, economic, and social divides.

It is in that spirit that we offer a series of interconnected specifications for reform. This brief document does not describe one plan, one potential course of action. Instead, it sets out objectives for reform, criteria by which alternative proposals can be assessed, and options for policymakers and the public to consider. Our hope is that these specifications will help to accelerate and frame a renewed national debate about how to build a better American health care system — and that they will help to embolden political leaders to act soon.

The specifications summarized here are tough, thorough, and ambitious. Our members have set aside their preconceptions and predispositions in order to forge a consensus document. Individual members may have different first preferences on some of the items addressed, but they recognize that for progress to be possible, a compelling national interest — in the assurance of excellent and affordable health care for all Americans, in the creation of a health care system that can serve us all well in the decades to come — has to be given precedence over narrow self-interest. They are unified in believing that these specifications represent a sound and sensible set of concepts and precepts for a public-private partnership to reform American health care.