11542 HOUSE LABOR & COMMERCE

21. SUBSIDIARY OF COLLATERAL AGREEMENTS

a. Identify additional agreements relating to the project from any nonparty agencies or persons.

OUTLINE FOR AN AUTHORITY CREATED UNDER A JOINT GOVERNMENT AGREEMENT

The following outline's the elements to be incorporated in an agreement establishing a new authority, if needed, to oversee the tasks and responsibilities established in the Joint Government Agreement.

1. **PURPOSE** - describe what the authority is to do i.e. provide regional solid waste transportation, solid waste pickup, landfill construction and operation and or recycling as appropriate. Be flexible in description to allow for some evolution of the project.
2. **ESTABLISHMENT OF THE AUTHORITY** – clearly state that the authority is being established - AS 29.35.010 and Article X, Section 13 Alaska Constitution.
3. **MEMBERSHIP** – describe the membership of the governing body and how members join.
    a. Decide if there is to be a critical mass clause that states that no parties are bound unless and until at least "X" other potential parties also join in.
    b. Are there to be alternate roles such as non voting member, customers
    c. Describe who can't participate.
4. **VOTES** – determine how many votes each member/community will have. Determine if each community will have one vote or if communities with larger populations and thus a greater contribution of solid waste will have more than one vote. Determine if the community hosting the landfill, if there is one, will have more than one vote.
5. **QUORUM** – determine what constitutes a quorum for conducting business.
6. **TERMS OF OFFICE** - determine the length of each member's term in office.
7. **ALTERNATES** – describe how many and how they are to be empowered.
8. **OFFICERS OF THE AUTHORITY BOARD** – describe who the officers are, how they are elected and what their responsibilities are.
9. **MEETINGS** – determine how often and where meetings of the authority are to occur.
10. **POWERS AND FUNCTIONS**- describe the powers given to the authority such as:
    a. Acquisition, assumption and management of facilities, such as a landfill and solid waste transportation system.
    b. Planning, construction of facilities such as a landfill
    c. Preparation of plans,
    d. Establishment of rates, fees, charges and surcharges,
    e. Granting of franchises, concession, licenses and other rights and entitlements,
    f. Exercise of power of eminent domain to acquire and dispose of property if applicable,
    g. Ability to apply for and receive grants,
    h. Ability to issue revenue bonds or other obligations,
    i. Ability to adopt by-laws,
    j. Ability to obtain permits.
    k. Describe what the entity cannot do.
11. **ASSUMPTION OF PROGRAM RESPONSIBILITIES** – explain if the authority is taking responsibility for management of any assets.
12. **BUDGETS** – describe the budgetary process for the authority.
13. **RATES** – describe the process of rate setting if applicable. Determine if the landfill host community receives any benefits when rates are set.
14. **LIMITATION OF LIABILITY** – state that the debts, liabilities or obligations of the authority do not constitute the debts, liabilities or obligations of the communities participating. Discuss the liability of waste transporters, if transporters, are not the authority.

15. **LAND USE RESTRICTIONS** - describe any land use issues associated with actions of the authority, if applicable.
16. **TERMS AND WITHDRAWL** – describe the terms of the authority and how a party can withdraw if possible.
17. **TERMINATION OF THE AUTHORITY** - describe how and when the authority can be terminated.
18. **DISPOSITION OF AUTHORITY ASSESSTS AND LIABILITIES UPON TERMINATION** – describe what happens to holdings and obligations when the authority is terminated.
19. **AMENDMENTS** - describe how the agreement can be amended.
20. **RESTRICTIONS OF AUTHORITY** – describe if this agreement restricts or alters any of the parties' authorities.
21. **DEFINTIONS** – define all the terms used in the agreement.
22. **EFFECTIVE DATE**- establish the date the agreement becomes effective.

BAXTER BRUCE & SULLIVAN P.C.
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(907) 789-1913 (fax)
dlawrence@baxterbrucelaw.com

MEMORANDUM

TO: Rollo Pool, Executive Director, Southeast Conference

FROM: David A. Lawrence

SUBJECT: Legal Review – Solid Waste Regional Entity Project

DATE: July 20, 2005

Southeast Conference ("SEC") retained this law firm to provide legal review and analysis of several issues related to the formation of a new entity to plan and provide solid waste transportation, processing, recycling, and disposal services in Southeast Alaska, which also could be a model for similar organizations elsewhere in the State. This Memorandum constitutes our report to SEC.

First, it discusses the choice of form for the entity, building upon the work already performed by Ecology & Environment, Inc. ("E&E"). Second, it discusses two outlines related to a joint government agreement. Third, it discusses the possible need for statutory or regulatory changes to accommodate the recommended form(s) for the new organization. Finally, it renders an opinion on the potential legal liability of members of the new solid waste entity.

We appreciate the opportunity to work with SEC in this important project, and would be pleased to provide additional assistance in any way we can in future phases of this and other regional development initiatives.

Scope and Assumptions

We have reviewed the documents provided by SEC on this topic, including the June 2, 2005, memorandum from Stephanie Pingree of E&E and the attached Entity Matrix

("E&E Memo"), and the outlines for an agency created under a joint government agreement and for a joint government agreement. In addition, we have reviewed Alaska statutes and case law related to key issues, including: liability of participants, owners, or members of various types of entities; the ability of unorganized or unincorporated government entities to participate in joint government agreements; and existing statutes for entities such as port authorities. We have not attempted to replicate the work already done by E&E, such as a survey of approaches taken in other parts of the country to coordinate solid waste programs on a regional basis.

We have assumed for purposes of our analysis that the primary participants in a new solid waste entity will be local units of government, and not private businesses or other non-government entities. A parallel assumption is that new entity needs to be qualified to receive a variety of state and federal grants to fund the planning and implementation of new solid waste transportation, treatment, and disposal projects. We also have assumed that the potential range of activities for a regional solid waste entity are very broad, and that one of its purposes will be to explore the feasibility of a wide range of coordinated services that could be provided both to its members and to non-members. Finally, we have assumed that services related to solid waste could be provided by the new entity to members and non-members under separate service contracts.

Choice of Entity

The choice of form for a new organization is highly dependant on the nature of the participants, their reasons for associating, and the activities they plan to pursue. The E&E matrix sets out some of the many considerations that underlie the choice. We believe that the overall recommendations of E&E as discussed in the E&E Memo are correct, though we have additional thoughts and concerns on the topic.

Business Corporation. This is not the recommended form for several reasons, including taxability of income, disqualification for grants, and the general requirement that returns must be proportional to dollar investment. If the participants were primarily private parties involved in the solid waste industry for profit, this would a possible form to use, though even then an LLC would be the better choice.

Nonprofit Corporation. Nonprofits are often used for charitable, educational and community purposes, but typically not for carrying out proprietary government functions such as solid waste collection and disposal. It may not qualify for tax exempt status (which is a very separate issue from non-profit status under state law), and if such an entity did not qualify, it would have the same tax drawback as a business corporation without the advantage of being well-designed to raise capital through issuing equity and

debt instruments. Since the new entity may be supported partly with debt financing, this is not an attractive choice.

Limited Liability Company. If the participants in the enterprise were going to be primarily private parties and not government entities, we would recommend this form. The reason is that it provides the liability shield of a corporation with the pass through taxation feature of a partnership (avoiding company-level taxes and allowing tax exempt members to avoid all income taxes). It also provides the maximum freedom to those forming the company to specify who invests, controls, and shares in any distributions. For example, there an LLC provides the flexibility to have different percentages of initial funding, voting control, and entitlement to distributions, in whatever way works best for the members. The members can manage the company themselves or through one or more managers who may or may not be members. However, if the solid waste entity is not in business for profit and wants to qualify for government grants to the maximum extent possible, this would not be the best choice.

Cooperative Corporation. The cooperative form has most of the good and bad points of the LLC. One advantage may be that if a cooperative is formed, it may be possible to get at least limited funding from the federal government for forming and operating the cooperative. This appeared to be a strong consideration of SEC in using this form for the new intertie entity. Two disadvantages are a requirement that every member be allowed an equal vote, even if their sizes, investments, and purchases of services are very different, and the requirement that to be a member one must contract for services from the cooperative. While it may be that eventually all of the communities in Southeast will purchase services from a solid waste entity, at first there will be few, if any, services, so many communities would be barred from membership, which could detract from their interest in participating at all.

General Partnership. This option was not discussed in the E&E Memo. From a legal standpoint, it would be very similar to an agency created by contract, which was discussed by E&E. The advantage is great flexibility regarding ownership and sharing of benefits. There are, however, two significant drawbacks. The first is that typically all of the members are also co-equal managers of the daily operations, so there is a potential lack of focused management. The second is that it provides no liability protection to the members for claims and liabilities of the partnership – there is joint and several liability. In a worst case this means that if there are ten partners and nine are insolvent, the tenth is liable for 100% of the partnership obligations. This concern is discussed further below under the Joint Government Agreement section.

Limited Partnership. The benefits and detriments for this form of organization are similar to the LLC. It has the additional drawback, however, of the unlimited liability

of the one or more general partners. That is why the general partner of an LP is typically a corporation formed to serve as the general partner, so its corporate status protects its ultimate owners from liability for the organizations debts. The E&E Memo observes that most participants will not be satisfied with the necessarily passive management role of the limited partners, though that may not turn out to be true if their main concern is having an entity to provide them services. If the job is being done well, they may not feel a strong need to have a major management role. On the other hand, it is not likely that they will want to take on the significant liability of a general partner in order to play the managing role of a general partner. That is why an LLC would be the better choice between the two. As discussed above, however, unless the solid waste entity will have significant non-government members, the LLC form is not the best choice either.

Federation and Commission. As described in the E&E Memo, a federation is essentially like a port authority, with specific enabling legislation and purposes. We do not view it as a materially different option. From the brief discussions, it appears that E&E viewed a commission to be something like the Federal Communications Commission. SEC is undoubtedly familiar with a variety of governmental agencies with regulatory and rulemaking powers. There already is an Alaska agency which oversees solid waste, DEC, yet it is not constituted to undertake the kinds of initiatives and projects envisioned by the SEC for solid waste in the region. Therefore, we do not believe a commission as described in the E&E Memo is advisable for the solid waste entity.

Joint Government Agreement. While we agree for the most part with the E&E discussion of the joint government agreement option, we do not believe it is as good a form as the use of an authority created under specific enabling legislation. We note E&E's concern about the potential difficulty of having an unincorporated municipality involved in ownership and control. However, this may not be the problem it first appears because an unorganized or unincorporated government entity, while not specifically mentioned in AS 29.35.010, may be considered "local government" under Art. X, Sec. 13 of the Alaska Constitution. There are, though, two other serious concerns we have about using a joint government agreement. First, a non-government entity could not be a party to the agreement because, under both the statute and Constitution, this kind of agreement may only be made among government units (while the enabling legislation for an authority could allow for participation of at least a minority number of non-government units). The second reason is that a joint government agreement, absent some special legislation, will not provide limitations on liability of the parties for the liabilities and debts of the entity. The legal status of a joint agreement is akin to a general partnership. The parties by agreeing among themselves that they will limit their liability cannot bind or curtail the right of third parties, be they creditors, persons injured at a solid waste disposal site, or landowners whose groundwater is claimed to be contaminated by

operation of a solid waste facility. While there are some statutory limitations on liability exposure of government subdivisions, such as those found in AS 9.65.070, the activities of a solid waste entity would for the most part not come under the scope of that protection. As a consequence, other than operating to minimize risk and maintaining generous insurance coverage, the municipal parties could all be jointly and severally liable for the entity's debts and obligations. Since there are many potential large liabilities in operating solid waste facilities, including pollution fines, personal injuries, property damage, service contract violations, and employment-related claims, we believe participating units of government will be better served, and will be more eager to participate, if they did not take on unlimited liability. This seems to be more important than the advantage of not requiring new legislation, though it is a judgment call to be made by the potential participants.

Authority. The E&E Memo did not find any drawbacks for the use of a statutorily constituted authority serving as the solid waste entity, other than the obvious point that it would require new legislation. The existing legislation for other kinds of authorities is far too limiting to be used for a solid waste entity. Since there are good statutory models to follow, unless there is some particular political opposition to enabling legislation that would all

Anticipated Participants via Teleconference

Wrangell LIO
Petersburg LIO
Anchorage LIO
Sitka LIO

Various participants via the bridge.

STATE OF ALASKA

DEPARTMENT OF LAW

OFFICE OF THE ATTORNEY GENERAL

Frank H. Murkowski, Governor

P.O. BOX 110300
JUNEAU, ALASKA 99811-0300
PHONE: (907)465-3600
FAX: (907)465-2075

January 9, 2006

Representative Peggy Wilson
Alaska State Legislature
State Capitol, Room 108
Juneau, Alaska 99801

Re: Comments on Regional Solid Waste Authority Legislation

Dear Representative Wilson:

This letter provides additional comments from the Department of Law regarding the proposed regional solid waste authority legislation, based on a joint review by the Departments of Law and Environmental Conservation. We appreciate the efforts that you and Alaska communities and organizations have undertaken to find solutions to challenging waste disposal issues.

The draft bill is crafted similar to other existing statutes, such as Alaska's port authority act. (AS 29.35.600, *et. seq.*) Please see our earlier comments. This comment letter focuses on the environmental regulation of facilities that would be constructed, operated or closed by Authorities established under the bill.

Based on the joint review between DEC and Law, we believe 46.03.100 (including its financial assurance requirements for municipal solid waste disposal facilities), as well as other applicable state and federal laws and regulations governing environmental matters for waste management and disposal facilities, would apply to an Authority's facility. It is our understanding that you and other supporters of the bill share this view, as well. If this is not the case, please advise me as soon as possible, as we would want to discuss this matter in greater detail and provide additional State input.

On a related point, the draft legislation states that the Authority may "regulate land use within the boundaries of the authority." See AS 29.35.820 (15)). This is very broad language, and very likely would lead to conflicts with

other state laws or municipal ordinances that may involve land use regulation. Given this potential for conflicts, the legislature should consider whether it would be prudent to more explicitly define the scope of an Authority's power to regulate land use within the boundaries of the authority.

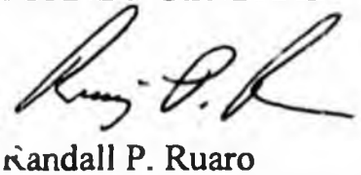
Further, proposed AS 29.35.870(a) states the following: "The real and personal property of an authority and its assets, income, and receipts are exempt from all taxes and special assessments of the state or a political subdivision of the state." The term "special assessment" is not defined in the legislation and could be interpreted quite broadly. The legislature should consider clarifying language that this term does not include fees charged by regulatory agencies.

We have one other observation regarding the draft legislation. It currently provides that a liability of the regional waste authority can only be satisfied from the assets or revenue of the authority. "A creditor or other person does not have a right of action against the state or a municipality participating in an authority because of a debt, obligation, or liability of an authority." AS 29.35.850. There is some question as to whether this limitation would protect an individual member of an Authority from potential liability in circumstances where there is a hazardous release to the environment from a facility. See AS 46.03.822. Thus, the legislature should make clear, perhaps through hearing testimony and the legislative history for the bill, whether it intends for this legislation to protect individual members of an authority from recovery actions for such environmental releases. In raising this issue, we have not analyzed how the limitation on liability provision would be treated under federal law.

We hope you find these and our earlier comments helpful. Please do not hesitate to contact me if you need any additional assistance on this important piece of legislation.

Sincerely,

DAVID W. MÁRQUEZ
ATTORNEY GENERAL

By: 
Randall P. Ruaro
Legislative Liaison to the Attorney General

HB

393

HOUSE COMMITTEE REPORT

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
[ ] 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
CED				X

***PREVIOUS* FISCAL NOTES**

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

Signing with recommendations	Printed Last Name	DP	DNP	NR	AM
Harry J. Crawford Jr.	CRAWFORD	X			
[illegible]	LYNN	X			
Pete Kott	KOTT			—	
Gabrielle LeDoux	LeDOUX	X			
[illegible]	GUTTENBERG	X			
Norm Rokeberg					X
Chair: Tom Anderson	ANDERSON	X			
Chair:					

LEGAL SERVICES

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

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM February 1, 2006

SUBJECT: Delegation of legislative power (CSHB 393(L&C))
(Work Order No. 24-LS0780\F)

TO: Representative Tom Anderson
Attn: Josh Applebee

FROM: Dennis C. Bailey DCB
Legislative Counsel

I have incorporated the language you requested in the new CS. However, at page 2, lines 5 - 6, using the "current . . guidelines" of the association implies that those guidelines will change over time. Therefore the law would change depending upon the changes made by the American Cancer Society. Providing that rules made in the future by a private organization are binding may amount to an unconstitutional delegation by the legislature of its lawmaking powers.

Similar attempts to adopt building codes which were modified by private entities were rejected as an unconstitutional delegation of legislative power. In the Alaska case, *Northern Lights Motel v. Sweaney*, 561 P.2d 1176 (Alaska 1977), reh. den. 563 P.2d 256, the Alaska Supreme Court considered whether adoption of the Uniform Building Code including "all future amendments thereto" was an unconstitutional delegation of power to a private, nongovernmental organization. As the court stated, "Adopting a code written by a private national organization generally does not raise delegation of authority problems as long as the code, organization and edition are clearly specified, and no attempt is made to adopt future amendments." Richardson, *Building Codes: Reducing Diversity and Facilitating the Amending Process*, 1A Sutherland, *Statutes and Statutory Construction* 549, 555 (4th ed. Sands 1972). *Northern Lights Motel* at 1181, n.3. The court avoided deciding the case on constitutional grounds, but discussed the delegation issue, labeling the delegation issue "a serious one." *Northern Lights* at 561 P.2d 1181. The court expressed distress that when amendments may be adopted by the private group, the public does not receive notice, nor do they have the opportunity to comment on or criticize the amendments as it does when they are adopted by the legislature or under the Alaska Administrative Procedure Act. *Id.*

Similarly, in an earlier Alaska Supreme Court case *Kingery v. Chapple*, 504 P.2d 831, 836-37 n. 13 (Alaska 1972), the court upheld a regulation which incorporated the motor cycle helmet and face wear quality standards of the United States Standards Institute

Safety Code, but indicated that had the Institute been empowered to adopt standards in the future, the provisions would have been invalid.

The current bill may be criticized because of the future binding effect of testing criteria established outside the Alaska legislative or administrative process. It compares with the objections the Supreme Court expressed with the mandatory adoption of amendments to building codes.

The problem may be remedied by adopting only the version of the agencies in effect on the day of enactment of the bill, not future amendments, or by resorting to the specific criteria similar to that removed by the new amendment.

If I may be of further assistance, please advise.

DCB:ljw
06-064.ljw

HB393 - COLON SCREENING

- HEATH

- EMILY NENON
  AM. CANCER SOCIETY
  - 2ND LEADING CAUSE OF CANCER DEATH IS U.S.
  - AK NATIVES HAVE HIGH RATES
  - COLONSCOPY - 90% EFFECTIVE IN CATCHING COLON CANCER

18 STATES HAVE ENACTED THIS

- IN AK BREAST, CERVICAL & PROSTATE

AFTER 65 - EVERYONE COVERED - MEDICAID

★ NR 118,000 COVERED LIVES FROM THIS PEOPLE
17% EFFECTED

OR.

- BRIAN SWEENEY, JR.
  SCREENING CAN PREVENT CANCER & UNLIKE OTHER SCREENINGS DETECT CANCER.
  ★ MOST COST-EFFECTIVE

P.1

LARGE STUDY -
MAYO CLINIC

- CLAUDIA CHRISTENSEN
  AK NATIVE TRIBAL HEALTH
  CONSORTIUM

SUPPORTS

IHS - COVERS SCREENING

- DR. SWEENEY
  COLONOSCOPY
  IS $2500

- STEPHEN WARREN
  SITKA COMMUNITY HOSP.
  BROTHER - COLON CANCER

- RICK URION -
  CANCER SURVIVOR
  FROM EARLY 00

- REED STOOPS - AM. HEALTH INSUR.
  ASSOC.

  MAKES LESS AFFORDABLE
  FOR PATIENTS

Q

A WILL GET COST INFO. TO INSURED

- DIV. OF INSUR.
  JEFFREY [redacted] TROWETT

- MANDATES - NOT SUPPORTED NOR ACTIVELY OPPOSE

- AVERAGE STOP/LOSS CARRIER DEDUCTIBLE ?
  DOESN'T KNOW
  ★ WILL SUPPLEMENT

OF INSUR. COs
  AETNA/BLUE CROSS HAVE LIONS

(3)

ALASKA STATE HOUSE OF REPRESENTATIVES

716 W. 4th Ave
Anchorage, AK 99501
Room 610

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

Representative Tom Anderson

FACSIMILE

To:	Legislative Legal	Fax:	465-2029
From:	Josh Applebee	Date:	2/7/2006
Re:	Changes to HB 393		
CC:			

☐ Urgent ☐ For Review ☐ Please Comment ☐ Please Reply ☐ Please Recycle

Good Morning ,

Attached is the amendment adopted by the House L&C Committee to HB 393. Please let me know if you have any questions. Please incorporate the amendments and send the final to Room 408.

Let me know if there is anything else you need.

-Josh

465-4954

HOUSE BILL NO. 393

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FOURTH LEGISLATURE - SECOND SESSION

BY REPRESENTATIVES ANDERSON, Lynn, Gruenberg

Introduced: 1/25/06
Referred: Labor and Commerce, Health, Education and Social Services

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

(1) a fecal occult blood test or fecal immunochemical test conducted annually;

(2) a flexible sigmoidoscopy conducted every five years;

(3) a combination of a fecal occult blood test or fecal immunochemical test conducted annually along with a flexible sigmoidoscopy conducted every five years;

(4) a colonoscopy conducted every 10 years;

(5) a double-contrast barium enema every five years; or

(6) any additional medically recognized screening tests for colorectal cancer as required by the commissioner of health and social services.

(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 to be 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 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.

(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.

§ 56-7-2363. Colorectal cancer; early detection AM. #1

(a) All individual and group health insurance policies providing coverage on an expense incurred basis, individual and group service contracts issued by a health maintenance organization, all self-insured group arrangements to the extent not preempted by federal law and all managed health care delivery entities of any type or description, that are delivered or issued on or after January 1, 2004, in this state shall include, or shall offer to ~~prospective policyholders and existing policyholders~~ on renewal, as an optional benefit, *coverage for colorectal cancer examinations and laboratory tests specified in current American Cancer Society guidelines or United States Preventive Services Task Force guidelines for colorectal cancer screening of asymptomatic individuals.*

INCL #1

(b) *The benefits required by this section shall be subject to the annual deductible and co-insurance established for all other similar benefits within the policy or contract; provided, that the annual deductible and co-insurance for the benefits required by this section are no greater than the annual deductible and co-insurance established for all other similar benefits within that policy or contract of insurance.*

DELETE
PG. 2
LINES [redacted] 5-13

ADOPTED

FISCAL NOTE

STATE OF ALASKA
2006 LEGISLATIVE SESSION

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

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

(Revised 9/7/2005 OMB)

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

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

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 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

AARP Alaska

February 3, 2006

The Honorable Tom Anderson, Chair
House Labor and Commerce Committee
Alaska State Capitol, Room 408
Juneau, AK 99801-1182

RE: HB 393 (Anderson)--Support

Dear Chair Anderson:

On behalf of the members of AARP in Alaska, we encourage you and your colleagues on the House Labor and Commerce Committee to support your bill HB 393, co-sponsored by your Committee members Lynn, LeDoux, Guttenberg, Crawford as well as Representatives Kerttula, Gruenberg, and Kapsner.

HB 393 would follow the model of other approved screening and make colorectal cancer screening a covered health insurance provision. AARP takes positions for or against issues when there is "evidence-based research" to support our position. In the case of colorectal screening, the scientific evidence is in. This screening will save lives and health care costs. The federal CDC estimates that, with screening, at least one third of deaths could be avoided.

Colorectal cancer is the fourth most common cancer diagnosed among both men and women in Alaska. However, it is the second leading cause of cancer-related deaths. It is most commonly found through screening of Alaskans over age 50. Insurance coverage for such screenings makes good public health sense and will undoubtedly save Alaskan lives.

We urge an "AYE" vote on HB 393.

Should you have any questions about our position, please feel free to contact me (586-3637) or Patrick Luby, AARP Advocacy Director (907-762-3314).

3601 C Street, Suite 1420 | Anchorage, AK 99503 | toll-free 866-227-7447 | 907-341-2270 fax | toll-free 877-434-7598 TTY
Marie F. Smith, President | William D. Novelli, Chief Executive Officer | www.aarp.org/ak

Thank you for your consideration.

Sincerely,

Marie Darlin

Marie Darlin, Coordinator
AARP Capital City Task Force
415 Willoughby Avenue, Apt. 506
Juneau, AK 99801
586-3637 (voice)
463-3580 (fax)

CC: Representative Pete Kott
Representative Gabrielle LeDoux
Representative Bob I
Representative Norman Rokeberg
Representative Harry Crawford
Representative David Guttenberg

Alaska Primary Care Association, Inc.
903 West Northern Lights, Suite 200
Anchorage, Alaska 99503
Phone: (907) 929-2722
Fax: (907) 929-2734

Alaska Primary Care Association
Board of Directors

RESOLUTION 2006-04

Title: Support of HB 393 Colon Cancer Screening

WHEREAS, current Alaska law requires that health insurance policies cover screening for breast, cervical, and prostate cancer, which all have recommended screening tests, and colon cancer is the only cancer with a recommended screening test that is not required to be covered by Alaska law; and

WHEREAS, HB 393 Colon Cancer Screening would complete the list of insurance-covered, recommended screening tests and increase Alaskans' access to all life-saving, recommended cancer screenings; and

WHEREAS, colon cancer is the second leading cause of cancer deaths in Alaska and across the nation, with an estimated 57,000 Americans dying from the colon cancer in 2005, and screening has the potential to drastically reduce this number; and

WHEREAS, when caught through routine screening at the localized stage, the 5-year survival rate from colon cancer is over 90% and if not caught until it has distant metastasis, when symptoms are likely to appear, the 5-year survival rate is only 10%; and

WHEREAS, colonoscopy is over 90% effective at detecting colon cancer and can remove pre-cancerous polyps, actually preventing cancer from ever developing; and

WHEREAS, colon cancer screening is cost-effective, as studies confirm that the cost of these screenings spread across the insured population is minimal, as the potential for long-term savings exist through the avoidance of treatment costs, as additional new, expensive drugs are developed which are estimated to cost as much as $250,000 a year; and

WHEREAS, colonoscopies are required only once every ten years starting at age 50 and Medicare picks up coverage for colonoscopies for those Medicare-eligible, underscoring the cost-effectiveness of coverage for what most people will need: only two colonoscopies between ages 50 and 65; and

WHEREAS, 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 and Alaskans deserve access to all recommended cancer screenings, including life-saving colon cancer screening tests; and

THEREFORE BE IT RESOLVED, that the Alaska Primary Care Association supports passage of HB 393 Colon Cancer Screening by the Alaska State Legislature, Second Session, and supports legitimate and appropriate efforts necessary by its staff and members to ensure its passage.

SUBMITTED BY: Shelley Hughes, APCA Policy Analyst DATE: February 3, 2006

DONE AND DATED this 3 day of February, in the year 2006.

SIGNED BY Jean L Fisher

Jean Fisher, APCA Board President

Testimony of Patricia Hong, MA, RN, CCRN
House Labor and Commerce Committee
February 3, 2006

HB 393 – An Act requiring certain health care insurance plans provide coverage for the costs of colorectal cancer screening examinations and laboratory tests

A heartfelt thanks to the co-sponsors of HB 393, which will have a huge impact on saving Alaskan lives.

Colorectal cancer is the second most common cause of cancer deaths across the United States. Of the more than145,000 new cases of colorectal cancer in 2005, 91% (131,950) occurred in persons over the age of 50 years. In 2005 the American Cancer Society estimated that 94% of the expected 56,000 deaths (52,640) from colorectal cancer would occur in individuals over the age of 50. Screening for colorectal cancer would reduce the number of deaths by a large percentage. Identifying and treating colorectal cancer in its earliest stages (within 10 years of polyp occurrence) would reduce the number of dollars spent on cancer treatment. The cost of treating colorectal cancer in its later stages can be $100,000 or more (ACS, 2005).

As a registered nurse, I know how important early diagnosis and treatment are to decrease mortality and morbidity in any population. I also know that ensuring access to care is critical to improving health outcomes.

When colorectal cancer is diagnosed in its earliest stages, the 5-year survival is 90%. However, only 39% of colorectal cancers are diagnosed at this stage. Screening for colorectal cancer would increase the number of cases diagnosed at its earliest stage.

I am
~~As~~ a 55-year-old retiree, I find myself in the unenviable position of not having coverage for colorectal cancer screening as part of my health care plan. And, while I know to look for classic colorectal cancer signs such as rectal bleeding, blood in the stool, and a change in bowel habits, I also know that these signs are more likely evidence of advanced colorectal cancer, not early colorectal cancer.

I look forward to the benefits that HB 393 will bring: early diagnosis and treatment, fewer deaths from colorectal cancer, and improved access to care.

Patricia Hong, RN
5654 Chilkoot Ct G201
Anchorage AK 99504

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 Couric 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. DiPalma

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

JAD:mhr

HOUSE BILL NO. 393

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FOURTH LEGISLATURE - SECOND SESSION

BY REPRESENTATIVES ANDERSON, Lynn, Gruenberg, LeDoux, Kapsner, Guttenberg, Crawford

Introduced: 1/25/06
Referred: Labor and Commerce, Health, Education and Social Services

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

(1) a fecal occult blood test or fecal immunochemical test conducted annually;

(2) a flexible sigmoidoscopy conducted every five years;

(3) a combination of a fecal occult blood test or fecal immunochemical test conducted annually along with a flexible sigmoidoscopy conducted every five years;

(4) a colonoscopy conducted every 10 years;

(5) a double-contrast barium enema every five years; or

(6) any additional medically recognized screening tests for colorectal cancer as required by the commissioner of health and social services.

DELETE

(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 to be 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 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.

(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.

ALASKA STATE HOUSE OF REPRESENTATIVES

Labor & Commerce Committee, Chair

Administrative Regulation Review, Chair

Judiciary Committee, Vice-Chair

Health, Education and Social Services

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Phone (907) 269-0265
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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.

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):1954-61.

[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

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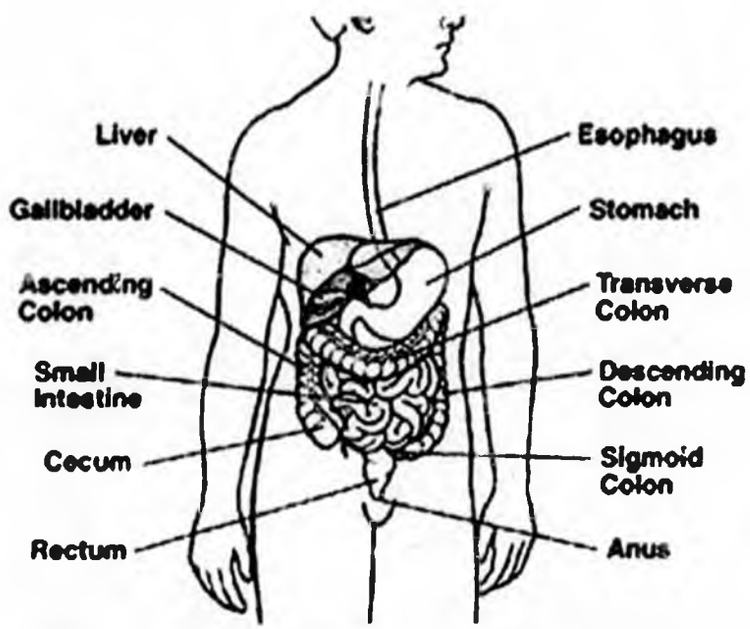
Colorectal Cancer: Early Detection

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 pernaps 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: Chron 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

followed 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 Immunochmeical 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

cancer screening law including coverage of colorectal cancer screening in May 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.

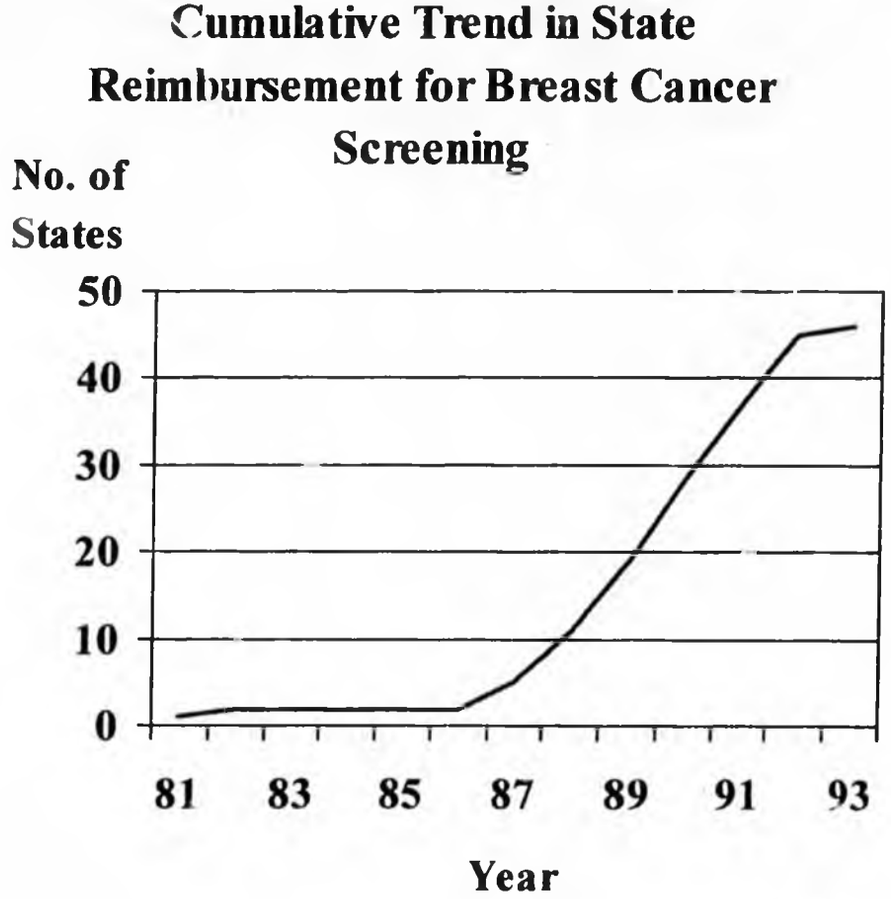
Colorectal Cancer Column Series: Impacting Action on Colorectal Cancer Legislation: What Can I Do? Available at www.preventcancer.org.

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

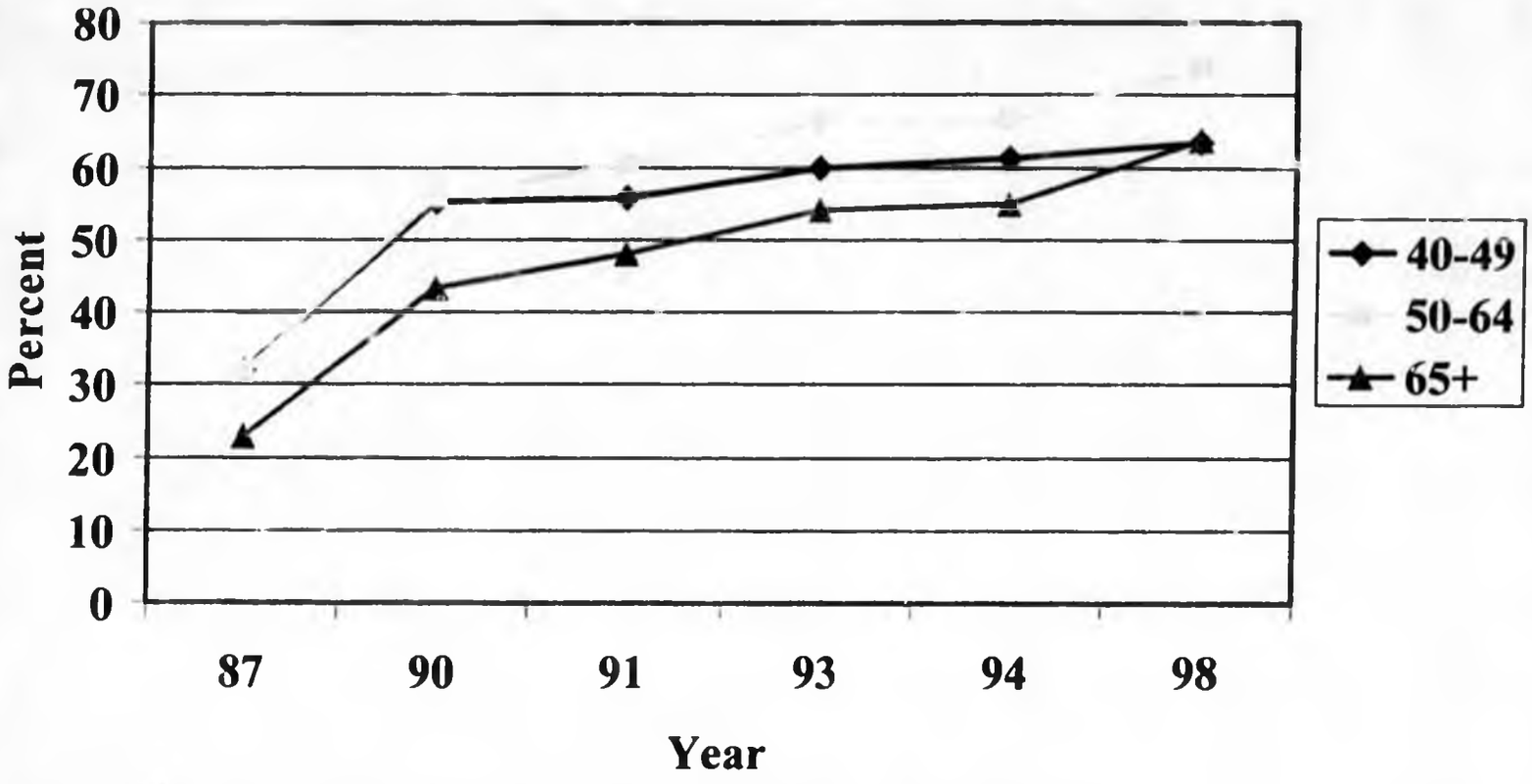
Revised: 1/6/05

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

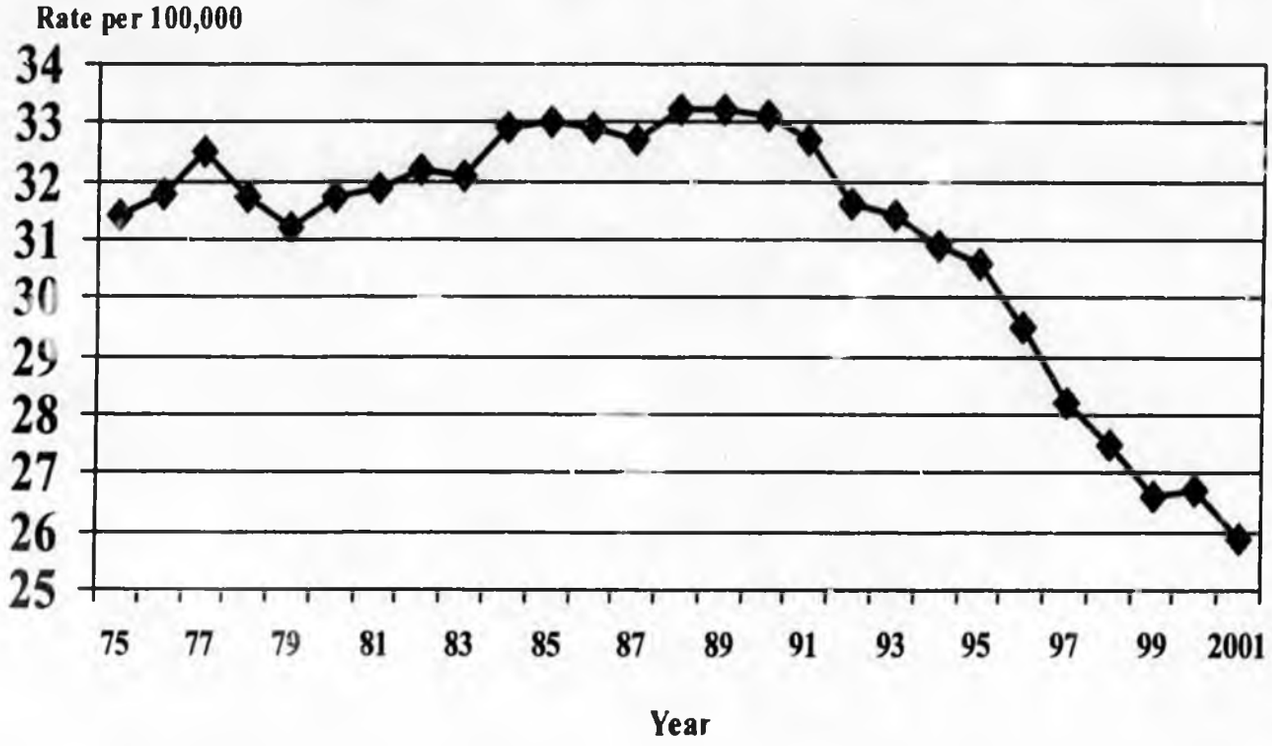


Rate of US Women Having Regular Mammograms By Age, 1987-1998



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.

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

HB

394

HOUSE COMMITTEE REPO

(7)
Date Referred to Committee: January 25, 2006

FURTHER REFERRALS: Finance

Date of Committee Action: February 22, 2006

The LABOR AND COMMERCE Committee considered: **HB 394**

HOUSE BILL NO. 394 **INSURANCE POLICIES IN FOREIGN LANGUAGES**

"An Act relating to allowing insurance policies to be filed, approved, and delivered in languages other than English if an official English language version is also provided."

Recommends it be replaced with [ ] HCS or [X] CS for HB 394 (L&C)
For Senate Bills with new title: [ ] Technical Title [ ] New Title: HCR________ [ ] Same Title [X] New Title

[ ] attach amendments
[ ] add new referral to ____________Committee
[ ] Letter of Intent____________Committee

List of Abbrev for Depts.:
ADM
CED
COR
CRT
EED
DE
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
CED				X

PREVIOUS FISCAL NOTES

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

Signing with recommendations	Printed Last Name	DP	DNP	NR	AM
[signature]	CRAWFORD	X			
[signature]	LYNN	X			
[signature]	LEDOUX	X			
[signature]	KOTTENBERG	X			
[signature]	Rokeberg			✓	
Chair: [signature]	ANDERSON	X			
Chair:					

24-LS1506\F
Bailey
2/22/06

CS FOR HOUSE BILL NO. 394( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FOURTH LEGISLATURE - SECOND SESSION

BY

Offered:
Referred:

Sponsor(s): REPRESENTATIVE MEYER

A BILL

FOR AN ACT ENTITLED

"An Act relating to allowing insurance policy forms to be filed and approved in languages other than English if an official English language version is also filed, and authorizing use of insurance policy forms and associated materials in languages other than English."

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

*** Section 1.** AS 21.42 is amended by adding a new section to read:

Sec. 21.42.175. Non-English translations. (a) The director may approve an insurance policy form in a language other than English if the insurance policy form

(1) is filed with a copy of the same material in English; and

(2) discloses, in both English and the language other than English, that the English language version is the official version and the non-English language version is for informational purposes only.

(b) The English language version of the insurance policy form or associated material shall be the official version for purposes of application and interpretation if

the non-English insurance policy form or associated material

(1) is provided with a copy of the same material in English; and

(2) discloses, in both English and the language other than English, that the English language version is the official version and the non-English language version is for informational purposes only.

(c) An insurer may not knowingly misrepresent information in an insurance policy form or associated material translated into a language other than English.

(d) For purposes of this subsection, "associated material" means advertising and marketing information including brochures, pamphlets, or electronic media used to describe or promote the insurance policy form.

ALASKA STATE LEGISLATURE
Representative Kevin Meyer

Sponsor:	Representative Meyer
Current Version:	Blank CS HB 394 24-LS1506\A
Contact:	Mike Pawlowski 465-2812
Date:	February 21, 2006

Committee Substitute Comparison Sheet for House Bill 394

Short Title:

"Insurance Policies in Foreign Languages."

Summary:

- CSHB 394 allows the Director of the Division of Insurance to approve a policy form filed in another language if an English version is provided and made the official version, allows an insurance company to provide policy forms and associated materials in another language if an English version is provided and made the official version, prohibits an insurance company from misrepresenting information in another language and defines "associated material."

Changes in blank CSHB 394:

1.) General changes.
   a. Changed "insurance policy or form" to "insurance policy form" which is a term of art.
   b. Changed "foreign language" to "non-English" for clarity.
2.) To section 1 (a):
   a. Deleted "associated materials" from (a) because the Division of Insurance does not need to review "associated materials."
   b. Deleted "An insurer may file and" to remove the reference to an insurance company because they are already allowed to file.
3.) To section 1 (b).
   a. Added disclosures (1) & (2) from (a) since "associated materials" is included in (b) and not in (a).
4.) To section 1 (c):
   a. Removed the reference to AS 21.90.020 and made misrepresentation a blanket prohibition so that it falls under the general provisions of AS 21.90.020 and other relevant statutes.
5.) New section 1 (d):
   a. Added a definition of "associated material."

FISCAL NOTE

STATE OF ALASKA
2006 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: HB 394
() Publish Date:

Revision Date/Time (Note if correction):
Dept. Affected: Commerce
Title: Insurance Policies in Foreign Languages
RDU: Insurance (116)
Component: Insurance Operations
Sponsor: Meyer
Requester: 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 allows insurance policies to be filed, approved and delivered in languages other than English if an official English language version is also provided. It does not impact the operations of the division.

Prepared by: Linda S. Hall, Director
Phone 907.269.7900
Division: Insurance
Date/Time 2/21/06 5:58 PM
Approved by: William C. Noll, Commissioner
Date 2/21/2006
Agency: Commerce, Community, and Economic Development

(Revised 9/7/2005 OMB)

REPRESENTATIVE KEVIN MEYER

HOUSE DISTRICT 30

SPONSOR STATEMENT

HB 394

"An Act relating to allowing insurance policies to be filed, approved, and delivered in languages other than English if an official English language version is also provided."

Under current law, an insurance company cannot realistically publish a policy in a language other than English because there isn't a provision in statute making the English version the official version. Any dispute arising over a claim couldn't be resolved without an agreement first on which version is the official version. House Bill 394 explicitly makes the English version filed with the Division of Insurance the official version and enables versions in a foreign language to be published for informational purposes only.

According to the last census, more than 80,000 Alaskans speak a language other than English at home. An insurance policy is difficult enough to read in a native tongue and HB 394 will ensure that Alaskans, for whom English is a second language, have equal access to the insurance market.

Email: Representative_Kevin_Meyer@legis.state.ak.us • **Toll Free:** (866) 465-4945
Session: State Capitol, Juneau, Alaska 99801-1182 • Phone: (907) 465-4945 Fax: (907) 465-3476
Interim: 716 W. 4th Ave., Anchorage, Alaska 99501-2133 • Phone: (907) 269-0199 Fax: (907) 269-0197

January 9, 2006

REPRESENTATIVE KEVIN MEYER

HOUSE DISTRICT 30

MEMORANDUM

DATE: **February 15, 2006**

TO: **Representative Kevin Meyer**

FROM: **Mike Pawlowski**

RE: **Sectional Analysis for HB 394**
(Version No. 24 – LS1506\A)

As a preliminary matter, note that a sectional summary of a bill should not be considered an authoritative interpretation of the bill and the bill itself is the best statement of its contents. If you would like an interpretation of the bill as it may apply to a particular set of circumstances, please advise.

Section 1. Adds a new section to AS 21.42 allowing an insurer to file and the director to approve an insurance policy in a language other than English with certain conditions and specifies penalties for knowingly misrepresenting information in a translation.

Email: Representative_Kevin_Meyer@legis.state.ak.us • **Toll Free:** (866) 465-4945
Session: State Capitol, Juneau, Alaska 99801-1182 • Phone: (907) 465-4945 Fax: (907) 465-3476
Interim: 716 W. 4th Ave., Anchorage, Alaska 99501-2133 • Phone: (907) 269-0199 Fax: (907) 269-0197

Table 3a. Alaska – Ability to Speak English by Language Spoken at Home for the Population 5 Years and Over: 2000

[Data based on a sample. For information on confidentiality protection, sampling error, nonsampling error, and definitions, see http://www.census.gov/prod/cen2000/doc/sf3.pdf]

Language spoken at home	Total	Speak English "very well"		Speak English "well"		Speak English "not well"		Speak English "not at all"	
	Number	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Population 5 years and over	579,740	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)
Speak only English	496,980	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)
Speak language other than English	82,755	51,915	62.7	19,975	24.1	9,325	11.3	1,540	1.9
Spanish or Spanish Creole	16,670	10,875	65.2	3,245	19.5	2,090	12.5	460	2.8
Other Indo-European languages	12,809	9,170	71.6	2,212	17.3	1,236	9.6	191	1.5
French (incl. Patois, Cajun)	2,195	1,640	74.7	280	12.8	275	12.5	0	0.0
French Creole	64	50	78.1	4	6.3	10	15.6	0	0.0
Italian	515	385	74.8	115	22.3	15	2.9	0	0.0
Portuguese or Portuguese Creole	185	160	86.5	25	13.5	0	0.0	0	0.0
German	3,575	2,915	81.5	420	11.8	230	6.4	10	0.3
Yiddish	45	30	66.7	0	0.0	15	33.3	0	0.0
Other West Germanic languages	273	265	97.1	4	1.5	4	1.5	0	0.0
Scandinavian languages	699	570	81.6	75	10.7	50	7.2	4	0.6
Greek	124	105	84.7	4	3.2	15	12.1	0	0.0
Russian	2,950	1,750	59.3	705	23.9	360	12.2	135	4.6
Polish	495	270	54.6	200	40.4	15	3.0	10	2.0
Serbo-Croatian	260	170	65.4	50	19.2	40	15.4	0	0.0
Other Slavic languages	500	215	43.0	115	23.0	150	30.0	20	4.0
Armenian	30	20	66.7	10	33.3	0	0.0	0	0.0
Persian	90	80	88.9	10	11.1	0	0.0	0	0.0
Gujarathi	0	0	0.0	0	0.0	0	0.0	0	0.0
Hindi	78	60	76.9	10	12.8	4	5.1	4	5.1
Urdu	104	90	86.5	10	9.6	4	3.9	0	0.0
Other Indic languages	153	60	39.2	85	55.6	4	2.6	4	2.6
Other Indo-European languages	474	335	70.7	90	19.0	45	9.5	4	0.8
Asian and Pacific Island languages	22,185	10,525	47.4	7,310	33.0	3,740	16.6	610	2.7
Chinese	1,290	630	48.8	470	36.4	165	12.8	25	1.9
Japanese	1,390	905	65.1	375	27.0	110	7.9	0	0.0
Korean	4,370	1,575	36.0	1,375	31.5	1,110	25.4	310	7.1
Mon-Khmer, Cambodian	125	50	40.0	30	24.0	45	36.0	0	0.0
Miao, Hmong	455	100	22.0	180	39.6	150	33.0	25	5.5
Thai	745	365	49.0	185	24.8	180	24.2	15	2.0
Laotian	1,135	450	39.7	305	26.9	290	25.6	90	7.9
Vietnamese	755	295	39.1	280	37.1	180	23.8	0	0.0
Other Asian languages	395	210	53.2	90	22.8	65	16.5	30	7.6
Tagalog	8,935	4,325	48.4	3,355	37.6	1,165	13.0	90	1.0
Other Pacific Island languages	2,590	1,620	62.6	665	25.7	280	10.8	25	1.0
Other languages	31,058	21,340	68.7	7,195	23.2	2,233	7.2	290	0.9
Navajo	45	45	100.0	0	0.0	0	0.0	0	0.0
Other Native North American languages	30,120	20,615	68.4	7,040	23.4	2,175	7.2	290	1.0
Hungarian	80	55	68.8	15	18.8	10	12.5	0	0.0
Arabic	190	140	73.7	25	13.2	25	13.2	0	0.0
Hebrew	220	160	72.7	45	20.5	15	6.8	0	0.0
African languages	224	175	78.1	45	20.1	4	1.8	0	0.0
Other and unspecified languages	179	150	83.8	25	14.0	4	2.2	0	0.0

(X) Not applicable

Source: U.S. Census Bureau, Census 2000
Internet Release Date: October 29, 2004