



Benefit Briefing

Insights on Employer Benefits

THE ALLIANCE

Employers moving health care forward



We asked our members and their brokers what topics they would like to learn more about to help create better health benefits for employees and their families.

This eBook was created using the advice of our Alliance Learning Circle speakers and other industry experts.

Join us in the conversation by learning more about our Alliance Learning Circle events. Many of them offer continuing education credit too.

We're here to create high-value care for your clients.

The Alliance provides a long-term solution that reduces health benefit costs for self-funded employers.

Our large network of doctors and hospitals means there is little disruption for your clients' workforce.

We help you satisfy the needs of employers who want more employee health for the money.

The Alliance was formed in 1990 and continues as a group of employers who work together as a cooperative to prove health care can cost less and deliver more.

www.the-alliance.org

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Insights on How to Help a Client Hold a Vendor Summit



Insights on How to Help a Client Hold a Vendor Summit

You can enhance the employee experience - and reduce waste and inefficiency for your clients - by helping your clients hold a vendor summit for their health benefit programs.

Employers often organize health-related benefit programs as independent “silos.” There might be one silo for wellness programs, one silo for pharmacy benefit management and another for third-party administration/health benefits, for example.

The result can be a patchwork of overlapping vendors, who often target the same group of employees and family members with chronic conditions.

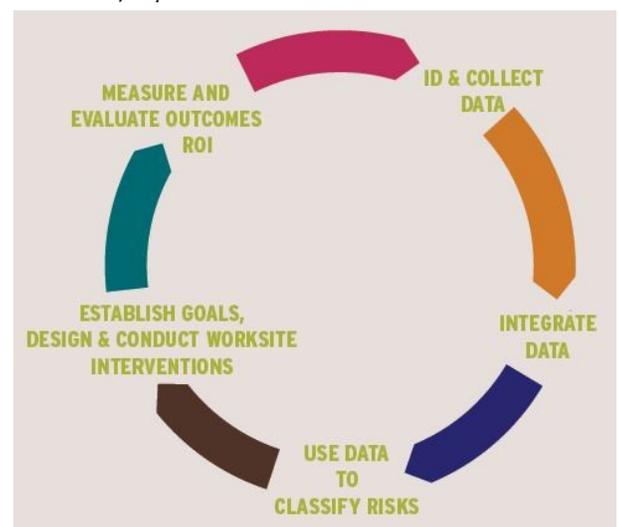
The following are recommendations for you to suggest to a client for a more effective vendor summit.

The Vendor Summit

A vendor summit brings together all your vendors to identify services and set goals as part of an integrated approach to health, disability and absenteeism. The Alliance helped employers who self-fund their health benefits hold a vendor summit as part of our Value-Based Benefit Design pilot.

If you decide to hold a vendor summit, plan to invite all the vendors who help you manage health-related services to a meeting held early in your plan year. Your invitation list should include:

- TPA for self-funded employers or your health insurer for fully-insured employers
- Primary network (The Alliance) for self-funded employers
- Pharmacy benefit manager
- Employee assistance program
- Wellness
- Disease management/care management
- Disability
- Workers’ compensation
- Broker/consultant
- Any internal resources that impact employee health benefits.



The Sustainable Change Cycle (shown above) should guide your vendor summit efforts.

Focus Your Efforts

Before you hold your summit, you should analyze your benefit data to identify the top three to five conditions driving health care costs. This information will be invaluable in working with vendors and setting goals.

The next step is to create a shared vision to present to vendors.

This vision typically has a dual focus:

1. Enhancing the employee experience.
2. Reducing waste and inefficiency in your benefit program.

You should also set goals for your vendor summit.

These goals might include:

- Establish a foundation for partnership
- Identify a condition or conditions to focus on for the coming year.
- Determine how vendors can help improve outcomes for those conditions.
- Create communication and action plans for the coming year.



Ask Vendors to Do Their Homework

Now you're ready to invite vendors to the half-day, face-to-face summit. As part of the invitation, ask the vendor to do "homework" in advance by identifying the top five conditions that impact your health benefit costs and employee productivity.

Ask the vendors to explain what information led them to identify these five conditions and share their ideas for obtaining additional information or data. In addition, ask vendors to explain who gets vendor reports and how often those reports are available.

Targeted Conditions

Based on the information provided by vendors and the goals set by the employer, the vendor summit group should reach a consensus on the conditions to target over the coming year.

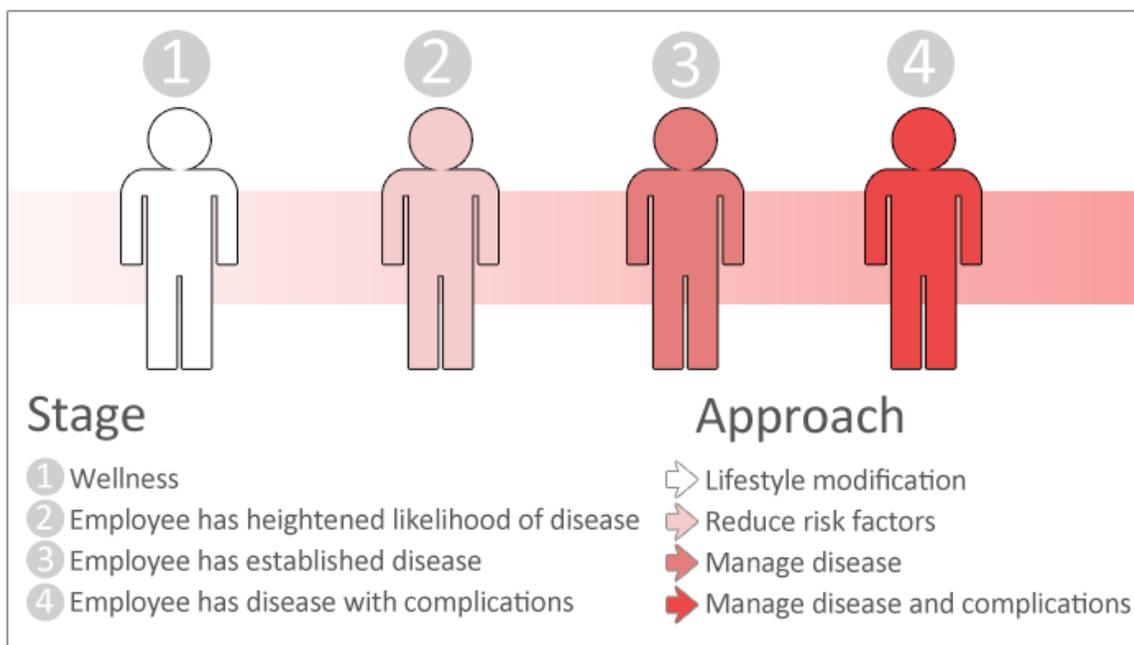
It's best to focus the rest of the summit on these two or three conditions. For example, XYZ Co. might decide to use an integrated health management approach to focus on diabetes, obesity and preventive screening.

Integrated Health Management

Each of XYZ Co.'s targeted conditions can be addressed along a progression that marks the four stages that an employee would experience as a chronic condition moves from wellness to disease.

For each of the four stages, the summit will aim to identify:

- Which vendors offer services and support?
- What are these services and support?
- How does the vendor engage employees? How often?
- What could make the vendor more successful in serving the employer and employees?
- How will the employer determine, measure and communicate success?



Vendor Accountability

Remember, your goal is to integrate data to maximize services and provide more value to employees and dependents. As part of that process, it's important to learn how services are coordinated by multiple vendors.

The plan that emerges from the vendor summit should include:

- Key initiatives and goals to support targeted conditions
- Prioritization of initiatives by: vendor, target audiences and due date
- Communication plan
- Follow-up plan
- Measurement

Plan to work with each vendor to describe services, set targets and define measurements for the conditions you plan to target. Ultimately, this could help you develop performance guarantees for vendor services.

The final step for each vendor is reviewing scenarios likely to impact employees seeking vendor services. For example, XYZ Co. might want to know how each vendor would handle a call from an employee who is having trouble with her vision and is actively engaged in a diabetes-focused disease management program. Completing this exercise will help the vendor and employer alike visualize how the process will work and how the employee will benefit.

Revisiting the Process



The beginning of this section provided an overview of the vendor summit process. To regroup, it included:

1. Employer sets goals based on needs of employee population.
2. Employer determines which vendors interact with these employees.
3. Vendors are invited to a summit to share information about their services.
4. Specific goals are set for each vendor for the targeted conditions.
5. Measurements for success are defined.

Ideally, you should regroup with vendors in six to 12 months, as appropriate, to evaluate progress and adjust accordingly. This will let you fine-tune your relationship with the vendors and your employees.

The Payoff



A vendor summit represents an investment of time and effort. The results make the investment worthwhile, according to employers who self-fund their health benefits through The Alliance.

After participating in a vendor summit, employers say vendors are more likely to share vital information, align activities with the employer's strategic goals, participate in an integrated health management approach and deliver measureable results.

"It was a real eye-opener to us when we brought our vendors together," an employer's representative said. "We found out about services that we weren't even aware of."

Insights on Annual Physicals and Preventive Screening



Insights on Annual Physicals and Preventive Screening

Having an annual exam and preventive screenings is the key to good health -- or is it?

The answer may depend on who you ask and what you're trying to achieve. Experts have become so divided on the annual exam that the New England Journal of Medicine's October 2015 issue addressed it with two articles written by physicians: one article supporting the annual physical and one advising against it.

Likewise, some preventive screenings have been hotly debated in recent years. While many preventive screenings can identify health problems early, when they can be treated most effectively, that's not always the case. Studies have shown that some screenings have doubtful value, while others can lead to unnecessary treatment and some may even cause harm to some patients. Consumer Reports notes that "Many Common Medical Tests and Treatments are Unnecessary" and offers examples such as giving EKGs to patients without risk factors during routine exams.

This "insights" publication aims to:

- ✔ Sort through conflicting opinions.
- ✔ Offer a list of screenings that experts agree are worthwhile and so may be worthy of incentives.
- ✔ Provide a form you can use if you decide to offer incentives for the annual physical or preventive screenings.

Why Some Employers Encourage Annual Physicals

Some employers want everyone covered by their health plans to get an annual physical. They want to meet these goals:

- Encourage employees and family members to have an ongoing relationship with a primary care doctor.
- Encourage employees and family members to get preventive screenings that are recommended for early detection of chronic or potentially life-threatening conditions.

Unfortunately, employers cannot assume that every doctor's office already offers patients all their recommended preventive screenings. A study published in January 2012 in the American Journal of Preventive Medicine showed that patients were typically due for five to six preventive services when they visited the doctor, but received only three. The study examined care for patients ages 50 to 80 who made nearly 500 visits to Michigan family-practice and internal-medicine doctors.

Some employers may use incentives to encourage annual physicals, preventive screenings or both. Appendix A provides a form adapted from Monroe Truck and Equipment, Monroe, Wis., which offers a financial incentive to employees who get an annual physical plus recommended screenings. Employers can revise the form provided in Appendix A to require only the annual exams, only preventive screenings, or both the exam and screenings.

Where the Annual Exam Falls Short



When the annual exam identifies a significant health problem, there's no doubt it's a "win." But what if it leads to a "false positive" test result that requires more testing or treatments, even if there's nothing actually wrong with the patient? Or it identifies a problem that is sometimes linked to unnecessary treatment, such as thyroid nodules?

"There have been many studies of the effects of these annual checkups," states The Choosing Wisely publication on "Health Checkups: When You Need Them and When You Don't." "In general, they probably won't help you stay well and live longer. And usually they don't help you avoid hospital stays or keep you from dying of cancer or heart disease." Choosing Wisely is sponsored by

the American Board of Internal Medicine (ABIM) Foundation and works with specialty medical associations to help patients and doctors have conversations about unnecessary care.

One issue with the annual physical is that its components can differ significantly from one provider to another. In some cases, this means that having an annual physical results in unnecessary tests. The U.S. health system spends \$300 million a year on unnecessary tests ordered in annual physicals, according to Choosing Wisely.

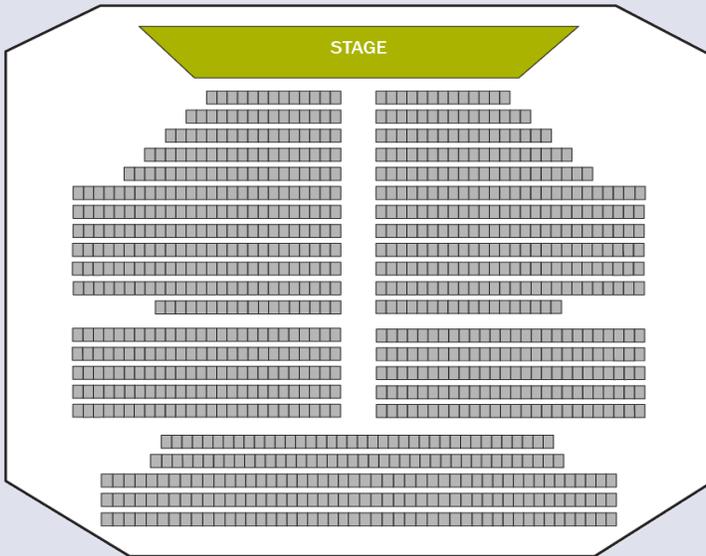
Another issue is the organization of modern physician offices, which may support a primary care doctor's practice with physician assistants or nurse practitioners. Patients who call for an appointment may not see "their" primary care doctor and will instead have an appointment with the physician assistant or nurse practitioner. So while an initial physician visit will create a relationship with a specific physician office, it can be argued that subsequent visits are unlikely to extend that relationship since the patient might see a different health professional at each visit.

The availability of medical staff could make scheduling routine physicals more difficult in the years ahead, when primary care physicians are expected to be in short supply. Approximately 10 percent of primary care visits are for annual physicals, according to "Improving Value in Health Care - Against the Annual Physical," published Oct. 15, 2015 in the New England Journal of Medicine. As fewer physician appointments are available, more appointments may be reserved for patients with urgent issues, making it more difficult to schedule an annual physical.

Benefit/Risk Characterization Theater Approach

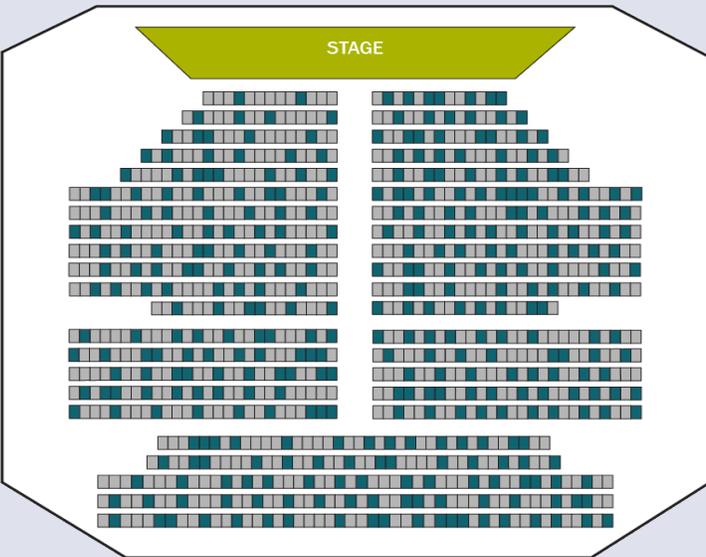
Dr. Andrew Lazris and Erik Rifkin, PhD, summed up the debate about the annual preventive exam in their book, *Interpreting Health Benefits and Risks*: "The annual exam is a forum to look for problems about which the patient may be unaware...But by fishing for problems, we may uncover false positives: abnormal results that are not reflective of real disease." They also noted that there is another danger: "false negatives, where tests or exams are normal in the face of real disease, a situation that sows a sense of false security."

Lazris and Rifkin developed the Benefit/Risk Characterization Theater (BRCT) approach to help engage patients in shared decision making about tests and treatments. As part of this process, they use an illustration of a theater with 1,000 seats to illustrate the benefits and risks. Lazris and Rifkin shared the BRCTs for the annual exam and annual blood tests at The Alliance Annual Seminar on May 16, 2017.



The Benefits of an Annual Exam.

If 1,000 people sitting in a theater have an annual exam, none, represented by no blackened seats, will have any statistically significant improvement in health outcome or mortality.



Accuracy of Annual Blood Tests in Finding Disease.

Out of 1,000 screening blood tests performed as part of an annual exam, approximately 360 will show false positive abnormalities, represented by blackened seats that are not indicative of any disease process. Routine urine testing yields a false positive rate of 900/1,000 tests, which is higher than the number of seats blocked. Approximately 7-30 out of 1,000 routine labs add some clinical information that may be of value.

From "Interpreting Health Benefits and Risks," by Erik Rifkin and Andrew Lazris. ©2015. Reprinted with permission.

Finding Middle Ground



There may be middle ground in this debate. It starts with an evidence-based approach, which means decisions are based on the best evidence currently available from research. An employer who wants to use an evidence-based approach to encourage employees to seek appropriate preventive care can create a program with three components:

1. Encourage employees to have an initial visit with a primary care physician so they have a relationship in place when problems arise.
2. Help employees understand when health checkups are useful. Choosing Wisely's "Health Checkups" guide notes eight times when a checkup may be needed:
 - When you are sick
 - When you have a symptom that could mean illness

- To manage chronic or ongoing conditions
 - To check on the effects of a new medicine
 - To help with risk factors like smoking or obesity
 - For prenatal care, if you are pregnant
 - For lifestyle issues like family planning, sexually transmitted disease (STD) prevention and healthy eating, especially if you are a young adult.
 - For other reasons based on your individual needs.
3. Base rewards for preventive screenings on evidence-based information. The U.S. Preventive Services Task Force (USPSTF) provides guidelines on preventive screenings. Choosing Wisely and Consumer Health Choices from Consumer Reports, which works closely with Choosing Wisely, are also reliable sources for evidence-based information about preventive screenings.

Preventive Screening: Eight Tests You Need

Consumer Reports' recommendation of "Eight Cancer and Heart Tests You Need" can be a good starting point for a preventive screening program that is linked to a monetary or time-off incentive. But even for these eight tests, there are exceptions based on age, gender and health history. Only the first item on the list - blood pressure - applies to everyone. And two items on the list - screenings for osteoporosis and abdominal aortic aneurysm - are recommended only for people above age 65, which means they may not be useful for the general population at many workplaces.

Here's the full list:



1. **Blood pressure.** Good for everyone, this test gives you a reading of your systolic (upper) and diastolic (lower) number. It should be done at least every two years and annually if your readings are at or above 120 over 80.
2. **Cervical cancer.** This consists of two tests recommended for women ages 21 to 65.
 - A pap smear, which analyzes cervical cell samples. Women should have a pap smear every three years, but can go five years between tests if they have an HPV test at the same time they have the pap smear.
 - A human papillomavirus (HPV) test to detect the HPV virus, which can cause cervical cancer.
3. **Cholesterol.** This test is recommended at least every five years for men ages 35 and older and women age 45 and older when they have other risk factors. Examples of risk factors are high blood pressure or smoking. The test measures levels of three types of cholesterol: LDL (the "bad" kind), HDL (the "good" kind) and triglycerides, which can clog arteries with fat.
4. **Diabetes.** A diabetes test measures your blood glucose level. The test is needed every three to five years for anyone with one or more of these three risk factors:
 - Systolic blood pressure over 135 or diastolic pressure over 80.
 - Obesity, indicated by a body mass index of 30 or higher.
 - LDL cholesterol over 130.

5. **Breast cancer.** Women ages 50 to 74 should have a mammogram every two years. Women who are in their 40s or age 75 or older should talk to a doctor to see whether a mammogram is recommended based on their individual risk factors.
6. **Colon cancer.** Tests for colon cancer are recommended for people ages 50 to 75 (see The Alliance’s “Insights on Colorectal Cancer Screening” for more information). When you should have the test differs based on which of these three types of tests you choose.
 - A colonoscopy every 10 years.
 - A sigmoidoscopy every five years, when combined with a stool test every three years.
 - A stool test every year.
7. **Osteoporosis.** Women age 65 and older should have the dual-energy X-ray absorptiometry (DXA) scan to measure bone density once, with additional tests based on the results of the initial test. Men age 70 and older should check with the doctor to see if the test is recommended.
8. **Abdominal aortic aneurysm.** An abdominal ultrasound is used to look for a ballooning of the main artery that carries blood from the heart to the rest of the body, which can be a fatal condition. This test is for men ages 65 to 75 who smoked at some point in their lives. Unless the first test reveals an abnormality, the test is only conducted once.

Consumer Reports also offers a guide on “Cancer Tests and Treatments” that addresses which tests are worthwhile and which are “oversold.”

Source: Eight Heart Tests and Cancer Tests You Need, Consumer Reports

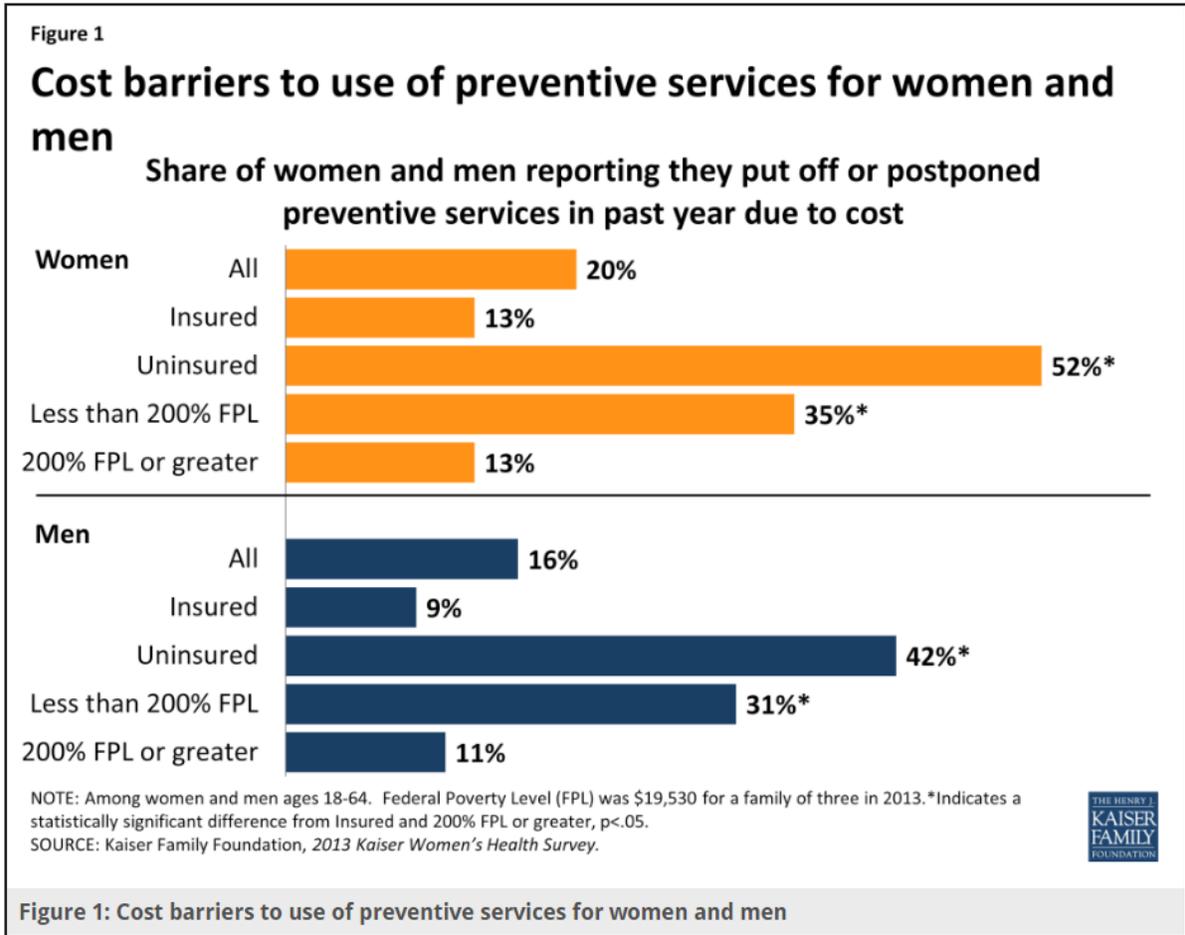
The Role of Plan Design, Location and Time-Off Policies

Cost can be a barrier to preventive screening, as shown by the Kaiser Family Foundation chart. Employers who self-fund their health benefits often have the flexibility to use plan design and incentives to encourage preventive screening by reducing out-of-pocket costs for enrollees.

The Affordable Care Act (ACA) requires 100 percent coverage for immunizations and evidence-based screenings for adults that currently have an “A” or “B” rating from the United States Preventive Services Task Force (USPSTF). The USPSTF is an independent panel of clinicians and scientists that works under the Agency for Healthcare Research and Quality. It is unknown whether this requirement will be removed or revised as part of health reform. If the ACA requirement is revised or removed, employers may choose to continue to offer 100 percent coverage as an incentive for employees and dependents to pursue evidence-based screenings.

Under a value-based benefit design approach, an employer may also choose to cover other high-value services and screenings at 100 percent.





Preventive Services Covered by Private Health Plans under the Affordable Care Act, The Henry J. Kaiser Family Foundation, Aug. 4, 2015 (<http://kff.org/health-reform/fact-sheet/preventive-services-covered-by-private-health-plans/>, accessed on March 20, 2017).

Research shows that making screening more convenient can help increase employee participation. A study of rural patients' compliance with screening colonoscopy published in the American Journal of Clinic Medicine in summer 2014 showed that roughly two-thirds of patients were willing to drive 30 minutes to get a colonoscopy, but only 18 percent were willing to drive an hour or more. When distance is a barrier, employers may want to explore other options. Examples of this approach include:

- Helping employees access other types of colorectal cancer screening when distance or other barriers are likely to reduce colonoscopy participation. Options are outlined in The Alliance Insights on Colorectal Cancer Screening.
- Bringing mobile mammography to the workplace. Some providers within The Alliance network offer mobile mammography services.
- Working with a wellness vendor to provide education about the role of cancer screening to increase awareness.

Time-off policies can also play a role in determining whether employees get preventive screening. One study showed that employees with paid sick-leave had "significantly higher" rates of participation in mammography or colorectal cancer screening, which typically require several hours or even a full day off work to complete. Some sources suggest that employees may be more likely to have tests if they receive an additional time-off benefit - that is not charged against accrued sick time or other paid time off - to use for specific cancer screenings.

AN EMPLOYER CHECKLIST

These seven steps can help you create a preventive care strategy that suits the goals of your company.



Decide what will goals and information will guide your decisions.

Relying on evidence-based guidelines is always the “gold standard.”



Choose the behavior you want to reinforce.

Do you want employees to get an initial visit or an annual visit? Or do you want to emphasize preventive screenings? Be specific as you develop your program.



Determine whether plan design plays a role.

Under the ACA, employers were guided by the ACA’s requirement to cover screenings at 100 percent. Health reform could change that requirement. If it does, will your company change its benefit plan?



Consider other factors that might encourage or discourage employees from getting preventive screening, such as time off policies.



If you decide to offer a financial reward, figure out how to make the reward pay off for your company.

Issues to consider include:

- Deciding how to notify employees that a reward is available.
- Creating a method to verify that employees received the targeted care, which will trigger payment of the reward. Appendix A offers one option, but your TPA or broker may have additional ideas.
- Telling employees how often the reward has been used. While you must never share personal health information, you can tell employees that 12 employees have already received a check for getting preventive screening, for example. People hate to “lose out” on a financial reward that others are getting.



If you decide to encourage or reward the annual physical, help patients prepare to use the time with the doctor wisely.

The Better Health Care Consumer booklet and presentation from The Alliance provide information that “coaches” employees about questions to ask and how to talk with doctors and other health professionals.



Stay current.

Guidelines for preventive screenings evolve over time, so periodically check to make sure your program is still in line with the evidence that supports preventive screenings.

APPENDIX A

**Annual Wellness Statement for (INSERT COMPANY) Health & Wellness Discount
Complete and return this form by (INSERT DATE) to get your discount.**

We hope this discount will help you work with your primary care provider to learn healthy habits and catch early warning signs for health issues. To get your discount, you should:

- Complete section 1.
- Ask your primary health care provider’s office to complete section 2.

Section 1: You (the employee) should complete this three-step section.

Step 1. Participant Name: _____
(Please print)

Step 2. Participant Authorization

I hereby authorize my primary health care provider’s office to complete this document on my behalf as part of (INSERT COMPANY NAME)’s Health & Wellness Discount. I understand that my participation in the Wellness Discount program and the providing of this authorization is completely voluntary.

_____ **Yes** _____ **No**

Step 3. Forward or bring this form to your Primary Health Care Provider for completion and then follow-up with them to make sure it was sent to (INSERT COMPANY NAME & DEPT).

Section 2: Ask your health care provider to complete this four-step section.

Step 1. Please check Yes or No based on: a) whether the participant’s labs have been received; and b) whether the participant is up-to-date on necessary exams and screenings based on age, gender and/or medical guidelines. This includes the physical exam and immunizations as well as these screenings: blood pressure, cholesterol, diabetes, colon cancer (ages 50 to 75), mammogram (women), and cervical cancer (women ages 21-65).

_____ **Yes** _____ **No**

Step 2. Please complete the Provider Verification below.

Signature of Provider’s designee:

Name (please print) _____ (Signature) _____ (Date)

Step 3. Provider’s Office – Please keep a copy of this document.

Step 4. Send completed Wellness Statement to:

THE PARTICIPANT NAMED ABOVE **OR**
(INSERT COMPANY NAME & DEPARTMENT)

Via Confidential Fax to (INSERT CONFIDENTIAL FAX NUMBER FOR PROVIDER’S USE)

Insights on Colorectal Cancer Screening



Insights on Colorectal Cancer Screening

Recommendations for covering colorectal cancer screening changed significantly in 2016. What are your options? What issues should you consider?

A Good Starting Point: the USPSTF

This document relies on information provided by the United States Preventive Services Task Force (USPSTF) as part of its June 2016 recommendation statement on colorectal cancer screening.

The USPSTF is made up of experts in prevention and evidence-based medicine who volunteer their time to serve on the task force. USPSTF recommendations are used nationwide to guide discussions of the value of preventive screening.



A Quick Review of Recommended Methods for Colorectal Cancer Screening

In June 2016, the USPSTF gave its highest “A” rating to screening for all adults ages 50 to 75 at average risk of colorectal disease. **Rather than rating a specific type of screening, as it had in the past, the USPSTF indicated that the best form of screening is the one that patients will use.** This will help meet USPSTF’s goal, which is “to maximize the total number of persons who are screened because that will have the largest effect on reducing colorectal cancer deaths.”

The USPSTF’s 2016 recommendation applies to a total of five types of colorectal cancer screening, including two that are on the recommended list for the first time: “virtual colonoscopy,” which is also known as computed tomography (CT) colonography, and Cologuard®, which is a fecal DNA test.



The Affordable Care Act (ACA) requires 100 percent coverage of all forms of colorectal cancer screening recommended by the USPSTF. Health benefit plans have one year to alter plan designs to offer A-rated screening methods without a co-payment.

The Five Colorectal Screenings Covered by the USPSTF

All five methods of colorectal screenings included in the USPSTF recommendation have advantages and disadvantages. The USPSTF noted that head-to-head studies are lacking to indicate that one method is more effective than another, although there are “varying levels of evidence” to support each test.

The five methods are:

1. **Fecal occult blood testing (FOBT) and fecal immunochemical testing (FIT).** Both FOBT and FIT are laboratory tests of your stool, also known as your feces or “poop.” These tests are done to see whether your stool contains blood. Blood in your stool can mean you have a problem with your digestive system, including the possibility of cancer in your colon or rectum. If you opt for FOBT or FIT, you receive a kit that is used to gather stool samples at home. Preparation for the test is simple. If you opt for FOBT, you will typically be asked to avoid certain foods for a set time period before taking the test. If blood is found in the stool, you will be asked to have a colonoscopy or other tests to determine whether you have cancer or another issue. The USPSTF recommends using a high-sensitivity version of the FOBT and having the test every year.
2. **Cologuard, or fecal DNA testing.** Like fecal occult blood testing, fecal DNA testing is used to look for blood in your stool. In addition, the test looks for DNA cell changes that have been linked to cancer. If you opt for fecal DNA testing, a kit is mailed to your home. No special diet, laxatives or enemas are required; you continue to follow your normal diet. You use the kit to collect a stool sample and mail it to a laboratory. If blood or cell changes are found, you will be asked to have a colonoscopy or other tests to determine whether you have cancer or another issue. Early studies showed that fecal DNA testing found more cases of colon cancer and precancerous growths than FOBT; however, tests are ongoing. When compared to FIT or FOBT, fecal DNA testing has more “false positive” results, which means the test result is “positive” but the person does not have cancer. Using fecal DNA testing will result in more colonoscopies than FIT or FOBT. The American Cancer Society recommends having fecal DNA testing every three years.
3. **Sigmoidoscopy plus FIT testing.** This test requires the insertion of a lighted tube into your anus or rectum so the doctor can examine the rectum as well as a portion of the colon. This method makes it possible for the doctor to remove small growths or collect a tissue sample that can be used to test for cancer. You may be asked to prepare by following a liquid diet for one to two days, having two enemas and not eating for 12 hours before the test. Patients typically receive a sedative during the test. If the test reveals a potential issue, you may be asked to have a colonoscopy or other tests. The USPSTF recommends having a sigmoidoscopy every 10 years plus a FIT test every year.
4. **Colonoscopy.** This test requires the insertion of a lighted tube into your anus so the doctor can examine the rectum and the entire colon. This method makes it possible for the doctor to remove small growths or collect a tissue sample that can be used to test for cancer. To prepare, you’ll be asked to modify your diet, take laxatives and have only clear liquids for one day before the colonoscopy. Patients typically have a sedative during the test. If no growths or issues are found, colonoscopies are recommended every 10 years.
5. **CT colonography or “virtual colonoscopy.”** CT colonography uses CT or MRI scans to create a three-dimensional image of the interior of your colon and rectum. Preparation typically involves the same steps as a colonoscopy: modify your diet, take laxatives and have only clear liquids for one day before the colonoscopy. If a CT scan is used, you may be asked to drink a special liquid just before the test to improve the view of the colon in the image. During the test, a thin tube is inserted through your anus. This tube is used to insert gas for a CT scan or a liquid for the MRI scan, again to improve the quality of the images. If the test reveals a potential issue, you may be asked to have a colonoscopy or other tests. Patients who rely on CT colonography for colorectal cancer screening should have the test every five years. While an MRI scan does not expose you to radiation, a CT scan does. The American College of Gastroenterology says that the radiation dose from a CT colonography is “equivalent to several hundred chest X-rays.” The more radiation you are exposed to over time, the more your lifetime risk of cancer increases.

Benefit Strategy Considerations

As the USPSTF noted, “The best screening test is the one that gets done.”

A study in the April 2012 issue of the Archives of Internal Medicine found that people were more likely to be screened for colorectal cancer if their doctor recommended a stool test as a first step, when compared to recommending a colonoscopy. This was reinforced at the 2015 Alliance Annual Seminar by Dr. Otis Webb Brawley, chief medical and scientific officer of the American Cancer Society, who said “The best science ever done on any cancer until 2012 and still on colon cancer for screening, shows that stool blood tests at a cost of about \$30 a year saves lives.”

Test	CPT Codes Used for Screening
Colonoscopy	45378
FIT	82274
FOBT	82770
Sigmoidoscopy	45330
CT Colonography	74261-74263
Fecal DNA Test	81528

It is worth noting that costs for colorectal screening can vary considerably by provider within The Alliance network. For example, the cost of a colonoscopy without biopsy varied from \$1,720 to \$8,550 as of July 2017. This variation provides an opportunity for employers to guide employees and family members to specific colonoscopy providers on the basis of cost, or to encourage the use of Find a Doctor to check the cost before scheduling a colonoscopy or another form of colorectal screening. Costs for other colorectal screening methods are compared in the chart below.

Plans that encourage patients to use stool tests first, before having a colonoscopy, will typically save money. Estimates of cost savings from stool tests should be tempered by the added cost of colonoscopies required to confirm test results indicating the possible presence of cancer. Finally, estimates should also include the cost of potential side effects from invasive forms of screening, such as colonoscopy.

Comparing Colorectal Cancer Screening Options in The Alliance Network

Test	Interval	Per Screening Procedure Cost to Employer**	Total Estimated Screening Cost, Age 50 - 75
Colonoscopy	Every 10 years	\$2,300 - \$5,100	Medium Anticipated Cost
FIT	Every year	\$130 - \$530 [†]	Low Anticipated Cost
FOBT	Every year	\$40 - \$410 [†]	Low Anticipated Cost
Sigmoidoscopy	Every 10 years plus FIT every year	\$1580 - \$1620	High Anticipated Cost
CT Colonography	Every 5 years	\$1,330	Low Anticipated Cost
Fecal DNA Testing	Every 3 years	\$550	Low Anticipated Cost

* Screening should require \$0 patient out-of-pocket costs but the amount your employer is charged by the hospital will vary based on type of test and location of service. Your employer pays for your health care benefits directly rather than paying for insurance.

+ Cost Per Screening encompasses a median of all typical charges rendered the same day as the screening.

! The costs of the individual services for FIT and FOBT tests are typically very small (\$15 - \$50); however, it is typical this test is done in conjunction with other services done the same day. We show the estimated cost range based on provider billing and service practices for the entire day of service.

Worthwhile Screening



Colorectal cancer ranks second among cancer deaths for men and women, following only lung cancer. The USPSTF estimates that 134,000 people will be diagnosed with colorectal cancer in 2016, with approximately 49,000 people dying from it.

Yet almost one-third of adults have never had any form of screening, according to the Centers for Disease Control and Prevention (CDC). This means that employers have a significant opportunity to save lives by encouraging appropriate colorectal cancer screening as part of their benefit plan design.

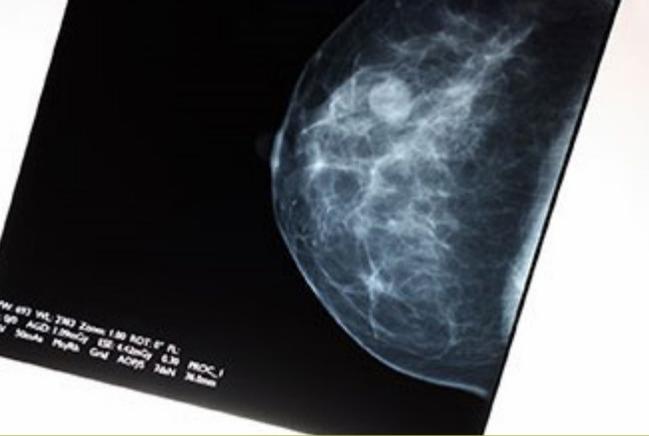
Helpful Resources for Benefit Plans



The National Colorectal Cancer Roundtable offers an employer brochure that discusses the value of colorectal screening and offers strategies to improve screening rates.

The American Cancer Society provides an online fact sheet about rules for benefit coverage of colorectal cancer screening.

Insights on 3-D Mammography



Insights on 3-D Mammography

Are There Advantages to 3-D Mammography? Is It Cost Effective?

A Quick Review of 3-D Mammography

Tomosynthesis, also known as 3-D mammography, is a more advanced form of mammography than the digital mammography that is currently available to most patients. Experts say 3-D mammography has these advantages:

- It is better at detecting cancer earlier in the process.
- It does a better job detecting cancer in patients with dense breast tissue.
- It is less likely to require that patients return to the doctor's office for follow-up screening.

On the negative side, 3-D mammography delivers a higher dose of radiation to the patient when compared to traditional mammography alone. The more radiation you are exposed to over time, the more your lifetime risk of cancer increases.

Cost-Effectiveness of 3-D Mammography

Studies are now exploring whether 3-D Mammography is cost-effective. One of the early studies on this topic was covered in the Modern Healthcare blog in January 2015. The blog article refers to a study that appeared in the Journal of ClinicoEconomics and Outcomes Research. The article noted that while 3-D mammography costs more than standard mammography alone, it may prove cost-effective over time because fewer callbacks for repeat mammograms or additional testing are required. Based on a comparison of 3-D mammography with standard mammography alone, the study estimated savings at \$28 per patient.

While 3-D Mammography identifies more cancers earlier in the process, it is impossible to know at this time whether 3-D Mammography is finding the kinds of cancers that require treatment. Some slow-growing cancers do not require treatment, and treating them can sometimes cause more harm than good. However, when doctors cannot identify whether a cancer requires treatment or not, they typically opt to provide treatment to protect the patient. We may not know whether 3-D mammograms are improving long-term outcomes for patients until we know more about the kinds of cancers that are detected and treated.

At this time, data is unavailable to show the long-term impact of 3-D mammography on treatment costs.

Consumer Demand

More consumers may request 3-D mammography as articles about its benefits appear in the media and hospital advertisements. The *Modern Healthcare* article notes that from the perspective of a consumer with a high-deductible health plan, having fewer callbacks can be desirable because the screening mammogram must be fully covered by the health plan, while any additional, diagnostic mammography is covered under the standard health plan, including requirements for deductibles and co-payments that are likely to increase the patient's out-of-pocket costs. This could also help fuel consumer demand for 3-D mammography.

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