Attachment C

American Cancer Society Guideline for Colorectal Cancer Screening: A Summary for Clinicians

THE AMERICAN CANCER SOCIETY RECOMMENDS:

- Adults ages 45 and older with an *average risk* of colorectal cancer (CRC) should undergo regular screening with either a high-sensitivity stool-based test or a structural (visual) exam, depending on patient preference and test availability. As a part of the screening process, all positive results on non-colonoscopy screening tests should be followed up with timely colonoscopy.

  The recommendation to begin screening at age 45 is a *qualified recommendation*. The recommendation for regular screening in adults ages 50 and older is a *strong recommendation.*

- Average-risk adults in good health with a life expectancy of more than 10 years continue colorectal cancer screening through the age of 75. (*Qualified recommendation*)
- Clinicians individualize colorectal cancer screening decisions for individuals ages 76 through 85, based on patient preferences, life expectancy, health status, and prior screening history. (*Qualified recommendation*)
- Clinicians discourage individuals older than 85 from continuing colorectal cancer screening. (*Qualified recommendation*)

DEFINITIONS

Average risk: No personal history of polyps, colorectal cancer, inflammatory bowel disease, or confirmed or suspected hereditary colorectal cancer syndrome (such as familial adenomatous polyposis or Lynch syndrome); no family history of colorectal cancer

Strong recommendation: Conveys the consensus that the benefits of adherence to that intervention outweigh the undesirable effects that may result from screening

Qualified recommendation: Indicates there is clear evidence of benefit of screening but less certainty about the balance of benefits and harms, or about patients' values and preferences, which could lead to different decisions about screening

RECOMMENDED TESTS AND SCREENING INTERVALS

Offer your patient the choice between a high-sensitivity stool-based test and a structural (visual) exam.

High-sensitivity Stool-based Tests

Screening Test	Considerations
Fecal Immunochemical Test (FIT) ***Interval:*** Every year	▸ Evidence of superior performance in cancer and adenoma detection compared to HSgFOBT ▸ High nonadherence (especially in the absence of annual reminder systems)
High-sensitivity Guaiac-based Fecal Occult Blood Test (HSgFOBT) ***Interval:*** Every year	▸ Higher false-positive rate than FIT (leads to more colonoscopies) ▸ High nonadherence (especially in the absence of annual reminder systems) ▸ Requires multiple samples, reducing adherence compared with FIT ▸ Requires avoidance of nonsteroidal anti-inflammatory drugs for 7 days; and avoidance of vitamin C, red meat, and cruciferous vegetables for 3 days prior
Multi-target Stool DNA Test (MT-sDNA) ***Interval:*** Every 3 years	▸ Evidence of superior performance in cancer and adenoma detection compared with HSgFOBT and FIT. ▸ Improved detection of advanced adenomas and sessile serrated polyps compared to other stool-based tests ▸ Higher false-positive rate than FIT (leads to more colonoscopies) ▸ Uncertainty in management of positive results followed by a negative colonoscopy ▸ New test, needs performance monitoring over time

Structural (Visual) Exams

Screening Test	Considerations
Colonoscopy ***Interval:*** Every 10 years	▸ Offers both early detection and prevention of CRC through polypectomy ▸ Risks: bowel perforation – 4 in 10,000; major bleeding – 8 in 10,000; cardiovascular event (due to sedation) – 2-4 in 10,000. These risks increase with age and comorbidity burden. ▸ Laxative preparation may not be done properly, leading to suboptimal visualization.
CT Colonography (CTC) ***Interval:*** Every 5 years	▸ Comparable performance to colonoscopy in identifying cancer and advanced adenomas without procedural risks of colonoscopy ▸ Exposure to low-dose radiation ▸ Incidental extracolonic findings may require workup. ▸ May not be covered by insurance (not covered by Medicare at this time)
Flexible Sigmoidoscopy (FS) ***Interval:*** Every 5 years	▸ Best evidence among structural exams for reducing CRC mortality and incidence ▸ Risks: bowel perforation – 1 in 10,000; major bleeding – 2 in 10,000 ▸ Self-administration of enemas may not be done properly, leading to suboptimal visualization. ▸ Misses cancers and polyps in the proximal colon

DISCUSSING COLORECTAL CANCER SCREENING WITH YOUR PATIENTS

Emphasize:

- All types of screening tests are effective at finding colorectal cancer.
- The best screening test is the one that gets done on time.
- Screening may lower the number of deaths due to colorectal cancer by as much as half.
- To be effective, screening must be completed on time.
- Screening is a long-term commitment.

Cost

- Cost without insurance varies from $20-30 for HSgFOBT and FIT, and from one to several thousand dollars for colonoscopy, with other testing methods falling between the two extremes.
- Medicare and most commercial insurance products cover CRC screening with no copay or deductible due to a provision of the Patient Protection and Affordable Care Act (ACA).
- Medicare does not cover CT colonography at this time.
- Follow-up colonoscopy for a positive test (other than colonoscopy) may be subject to out-of-pocket costs.
- Polypectomy and anesthesia for colonoscopy may be subject to out-of-pocket costs.

How to talk to your patients about logistical barriers to screening

Screening Test	Potential Patient Barriers	Discussion Points and Alternatives
Fecal Immunochemical Test (FIT)	▸ Inconvenience of collecting stool sample	▸ Inform patient that they do not directly handle specimen. ▸ Offer MT-sDNA instead.
High-sensitivity Guaiac-based FOBT (HSgFOBT)	▸ Inconvenience of collecting stool sample ▸ Inconvenience of dietary and medication restrictions ▸ Inconvenience of needing samples from 3 separate stools	▸ Inform patient that they do not directly handle specimen. ▸ Offer FIT or MT-sDNA instead.
Multi-target Stool DNA (MT-sDNA)	▸ Inconvenience of collecting stool sample ▸ Costly, depending on insurance coverage	▸ Inform patient that they do not directly handle specimen. ▸ Offer HSgFOBT or FIT instead.
Colonoscopy	▸ Inconvenience of laxative regimen ▸ Need for ride to colonoscopy site ▸ Inconvenience of time commitment ▸ Costly, depending on insurance coverage	▸ Consider reduced-volume laxative regimen. ▸ Offer stool-based testing instead.
CT Colonography (CTC)	▸ Inconvenience of laxative regimen ▸ May require second prep if same-day colonoscopy not available for positive test ▸ Costly, depending on insurance coverage (not covered by Medicare at this time)	▸ Consider reduced-volume laxative regimen. ▸ Consider alternative strategy if same-day colonoscopy not available for positive test. ▸ Offer stool-based testing instead.
Flexible Sigmoidoscopy (FS)	▸ Concern about discomfort with enema prep or FS itself	▸ Counsel to use enema with pre-lubricated tip (e.g., Fleet®) or consider alternative screening method.

ABOUT THE AMERICAN CANCER SOCIETY GUIDELINE DEVELOPMENT PROCESS

The American Cancer Society Guideline Development Group (GDG) is responsible for developing and updating our cancer screening guidelines, which are then approved and adopted by the American Cancer Society Board of Directors. The GDG is a multidisciplinary panel of clinicians, biostatisticians, epidemiologists, economists, and a patient representative. This group is responsible for interpretation of the evidence, judgments about the balance of benefits and harms, and the framing of the recommendations and writing of the guidelines. The GDG panel votes on each recommendation and the strength of that recommendation, on the basis of the balance between desirable and undesirable outcomes, the quality of evidence, and variability in values and preferences. Individuals with relevant clinical and research expertise in the areas of colorectal cancer natural history, detection, diagnosis, and decision-making also advise the GDG but do not participate in deliberations on recommendations or voting. The American Cancer Society protocol for developing and disseminating guidelines includes a transparent process for disclosing and managing financial, professional, and intellectual conflicts that minimizes bias. More information about the guideline development process can be found at *https://jamanetwork.com/journals/jama/fullarticle/1104727.*

Madame Chair:

I am Andrea Dwyer and am testifying today as the incoming Chair of the Colorado Cancer Coalition but sharing my experience as a public health practitioner from the University of Colorado Cancer Center and the Colorado School of Public Health. This bill will allow screening to begin for the average risk population at age 45, to address the increased incidence of colorectal cancer in those under age 50. The average risk, medical guidelines for colorectal cancer recommends a variety of high quality tests, beyond just colonoscopy. This is an important point, as not all patients can or will have a colonoscopy as their initial screening test. This is particularly true based on my experience in implementing colorectal cancer prevention programs for the medically underserved throughout Colorado. However, if a positive first line test, such as a stool based screening test indicates a possible abnormal finding, colonoscopy is required to complete the preventive screening cycle. There are barriers to receiving a follow-up colonoscopy and out of pockets costs for patients are amongst the most noted. This bill specifically addresses these issues.

The median age at diagnosis has dropped to an unprecedented shift in younger people, as half of patients are now 66 or younger. One of the biggest shifts is the increase is in those who are 45-50 years old and the reason for the guideline change.

Related to the barriers, we know that 50% of the time, patients who have a positive front line test-such as a stool based test for colorectal cancer, do not follow-up with a follow-up colonoscopy and out of pocket expenses are noted as one of the biggest barriers for this follow up colonoscopy.

Based on my work in cancer research and the science, I amongst an international study team who reviewed the data in 2018, with the support of American Cancer Society to identify 45 as the appropriate age to begin screening the average risk population.

In my own family in rural eastern Colorado-my mother and godfather used stool based tests, good test that identified a need for a colonoscopy but in both cases, a follow up colonoscopy was delayed. My mom was diagnosed with early stage colorectal cancer and godfather also delayed and ultimately died from the disease. This bill will address the barriers my family faced and has the potential to save lives and suffering within many Colorado families.

Please Support House Bill 1103 - Colorectal Cancer Screening by Representatives Buckner & Will, Senators Fields & Priola

Colorado law requires insurers to provide preventive colorectal cancer (CRC) screenings at age 50. Recent science backed by the American Cancer Society (ACS) recommends screening from 45, due to higher CRC incidence among under 50s. When screening results are positive, patients are often charged a diagnostic fee.

House Bill 1103 will:

- Lower the screening age from 50 to 45 (per ACS guidelines)
- Include the Medicaid population in the requirement
- Prohibit a diagnostic fee for a preventive colonoscopy following an abnormal non-invasive test (eg FIT)

Why 45?

- CRC has grown 51% among 20-49s since 1994. Incidence for a 45 year-old today is the same as a 50 year-old in the early 90s
- Absent screening, diagnoses among <50s are often 'late stage' when treatment is less effective and costs ~5x more than early stage (typical late stage treatment costs $618k per patient)
- Half of all CRC diagnoses in Colorado are late stage, rising to 65% for 45-49 year olds.

Why Screen for Colorectal Cancer?

- CRC is highly preventable and treatable when caught early. Increased screening has resulted in a 40% drop among the 50+ age group since 1987 (SEER 9 delay-adjusted rates, 1975-2012)
- ACS CAN believes screening from 45 may cut 45-49 year-old CRC deaths in half - without adding new screens into the system
- Adding 45-49 year-old Coloradans to the CRC screening mandate will save lives and cut late stage healthcare costs.

Did you know?

- Early stage 5-year survival rates are 90% vs 10% at Stage 4
- Catching just 10% of CRC diagnoses earlier could save at least $74m in Colorado-based treatment costs over 4 years and protect more Coloradans from cancer

COLORECTAL CANCER IN COLORADO:

- Cancer is Colorado's leading cause of death
- Colorectal Cancer (CRC) is the 2nd biggest cancer killer of women and men in the U.S. and Colorado
- Colorado had an estimated 1,940 new CRC cases and 660 deaths in 2019
- CRC incidence among <50s in Colorado is rising
    - +3.2% for men
    - +10.8% for women
- CRC is now the fastest growing young female cancer in Colorado and the single biggest cancer
- killer of young men in the USA
- Through screening, over a third of cancer deaths could be prevented or found earlier

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ACS CAN, the nonprofit, nonpartisan advocacy affiliate of the American Cancer Society, supports evidence-based policy and legislative solutions designed to eliminate cancer as a major health problem. ACS CAN works to encourage elected officials and candidates to make cancer a top national priority. ACS CAN gives ordinary people extraordinary power to fight cancer with the training and tools they need to make their voices heard. For more information, visit www.fightcancer.org.

ALBA WILSON-AXPE / H&HS HEARING (MAY 2020)

Madame Chair, committee members…. My name is Alba Wilson-Axpe and I live in Arapahoe County, Colorado.

I'm here on behalf of the Colorado Cancer Coalition in support of HB1103 and for my Dad, who was diagnosed at 48 with Stage 4 colorectal cancer, while **I was just ten years old**. I never met Dad's mom, my gran, because she passed from the disease at 59.

My Dad's battle with colorectal cancer has **dominated the last four years of our family's life** and **I'm now classed as 'high-risk'** which has really opened my eyes to how many young people are affected, like 11-year old Mia Batista, who last year lost her young life to the disease.

I will be screened well ahead of time, whether it's covered by insurers or not, because my Mom and Dad have made it their mission that my brother, Andrew and I will not go through the **agony of a young onset cancer diagnosis** and **the life-long impact that will have on our family** – physical, mental and financial.

The problem with colorectal cancer, though, is that it's **no respecter of risk.** The majority of young onset diagnoses have no family history, no warning, so the only way to get ahead of the disease is preventive screening which works, when it's available. When it isn't, however, **it's quite literally fatal**.

Colorectal Cancer is now the **fastest growing cancer among women under 50**, not just in Colorado, but across the USA, where it's fair to say **colorectal cancer blue is now the new pink**.

Despite being 14, I'm not naive enough to argue that we should start screening every average-risk adolescent in Colorado.

But, I do get basic math. When you have a 40% *drop* in disease among the screened population, compared with a 51% *increase* among the unscreened under 50s *and* you are charged by the State with saving lives and health care costs, **you simply have to move the line.**

Every Senator on this committee has a personal stake in lowering age and cost barriers to screening.

- **More than half** of all colorectal cancer diagnoses in Senator Ginal's Larimer County are late stage
- Vice Chair Winter's Adams County is **the #3 hotspot for late stage male diagnoses**
- And Senator Crowder's south east region has **the highest rates of late stage colorectal cancer in the whole of Colorado**

I could go on, but trust me, there's not one region in Colorado that comes out of this looking good.

HB1103 provides simple, compelling steps to protect Coloradans from a devastating cancer diagnosis and ensure that children like me get to see their Dad become a Grandad.

Thank you for the allowing me to testify.

Testimony of R.J. Ours, Colorado Government Relations Director
American Cancer Society Cancer Action Network
In Support of House Bill 20-1103 "Concerning Health Insurance Coverage for Colorectal Cancer Screening"
Colorado Senate Health and Human Services Committee
May 27, 2020

Good afternoon, Madam Chair, and members of the Health & Human Services Committee. I am R.J. Ours, the Colorado Government Relations Director for the American Cancer Society Cancer Action Network, or ACS CAN. ACS CAN is the advocacy affiliate of the American Cancer Society.

On behalf of ACS CAN, I would like to thank you for the opportunity to speak today in support of House Bill 1103. If enacted, this bill will save lives by finding colorectal cancer early, when treatment is more likely to be successful and by detecting and removing polyps, which actually contributes to the prevention of colorectal cancer.

HB 1103 is a simple and straightforward update to the existing law requiring insurance coverage for colorectal cancer screening in accordance with recent changes to the clinical guidelines of the American Cancer Society and grounded in new evidence-based science.

Early colorectal cancer usually has no symptoms, with warning signs typically only appearing with advanced stages of disease. Early detection tests for colorectal cancer can help find polyps, which can easily be removed, thereby lowering the individual's risk of developing cancer. Colorectal cancer has a 90 percent five-year survival rate if it is detected at the local stage, yet only 39 percent are diagnosed at an early stage. This is

why ensuring access to colorectal cancer screening is so important, as the test can prevent cancer altogether by removing polyps or detecting it during an earlier, more treatable stage.

Ensuring individuals have access to colorectal cancer screenings without cost sharing is also critical to preventing colorectal cancer and reducing the burden of cancer for Coloradans.

As research and evidence grow, clinical guidelines also change. In 2018, the American Cancer Society updated its screening guidelines for colorectal cancer. The guideline was changed, based in part, on new data showing rates of colorectal cancer are increasing in younger populations. The current guideline differs from the previous guideline in the starting age, an emphasis on choice of tests for screening, and age-specific recommendations about when to stop screening. The updated guideline recommends screening for average risk patients start at age 45, instead of 50. In addition, the previous guideline expressed a preference for colonoscopy, whereas the updated guideline does not prioritize among screening test options, instead emphasizing patient preferences and choice in consultation with their doctor. We believe in the notion that “the best test is the one that gets done -- and done well.” The updated guideline also stresses that when a screening test (other than colonoscopy) comes back positive, that test must be followed with a timely colonoscopy in order to complete the screening process.

More specifically, in addition to colonoscopy, there are high-sensitivity stool-based tests, like the Fecal Immunochemical Test (FIT) or the Fecal

Occult Blood Test (FOBTC), that can be used to detect colorectal cancer early. Promotion of these tests has been linked to increased screening rates in many parts of the US, especially in rural areas where a patient may have to travel great distances to get a colonoscopy, or for patients who struggle to take time off from work for the prep and procedure required for colonoscopy. Some patients prefer a stool-based test because it is less expensive, can be offered by any member of a health care team, requires no bowel preparation, can be done in privacy at home, does not require time off from work or assistance getting home after the procedure and is non-invasive.

HB 1103 also clarifies coverage for follow-up colonoscopies if one of the other screening tests comes back positive.

The decision to lower the average risk age to 45 in ACS' updated guidelines is largely based on an ACS-commissioned modeling study that extended a previous analysis conducted for the 2016 USPSTF screening recommendations. While the USPSTF began its process to review their guidelines in January of 2019, this review could take months, if not years. In the meantime, there are lives on the line that could benefit from screening average risk individuals starting at age 45.

For these reasons, we believe it is the right time for Colorado law to ensure individuals can begin screening at age 45, if they so choose, without cost sharing. It is the hope of ACS CAN that widespread adoption of the age per ACS guideline will have a major impact on the incidence, suffering, and mortality caused by colorectal cancer. Passing HB 1103 gives Coloradans

a fighting chance by finding colorectal cancer early, when treatment is more likely to be successful, and by detecting and removing polyps, which contributes to the prevention of colorectal cancer.

Thank you so very much Madam Chair and members of the committee. I would be happy to answer any questions you may have.

SUBMITTED WRITTEN TESTIMONY

Committee Senate Health & Human Services
Meeting Date 05/27/2020 Upon Adjournment

Registered	Bill Number	First Name	Last Name	Position on Bill
5/27/2020 9:55	HB20-1103	Martha	Cox	For

Witness Signup List

Representing	Status	Testifying
American Cancer Society Cancer Action Network	Open	Submitted text

Text of Testimony

I am a long time volunteer for the American Cancer Society Cancer Action Network and a colorectal cancer survivor. I adamantly support HB20-1103, whi

ch would lower the recommended age for screening colonoscopies to 45 (from the presently recommended age of 50). I was diagnosed with stag

Witness Signup List

ge three colorectal cancer at age 51 and underwent treatment for a year. I'm a lucky survivor, but if I had been urged by my doctor to get a screer

Witness Signup List

ıing colonoscopy around age 45, my life (and my finances) would have been much improved. Please support HB20-1103 -- many lives will be char

ıged for the better, and others will be saved! Thank you, Martha E. Cox