MICROFILM DIVIDER

OMB/RECORDS MANAGEMENT DIVISION
SFN 2053 (2/85) 5M

ROLL NUMBER

DESCRIPTION

1247

2003 HOUSE HUMAN SERVICES

HB 1247

2003 HOUSE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. HB 1247

House Human Services Committee

☐ Conference Committee

Hearing Date January 21, 2003

Tape Number	Side A	Side B	Meter #
1	x		48.3 - 60.8
1		x	0.3 - 61.6
2	x		0.0 - 25.8
Committee Clerk Signature			

Rep. Niemeier appeared as prime sponsor in support with written testimony and proposed amendments.

Rep. Porter requested list of drugs and devices used by men that were not covered by insurance to make the claim of discrimination, Rep. Niemeier did not have.

Rep. Gulleson appeared in support with written testimony.

Rep. Porter stated that this bill is telling me I don't have a choice anymore and how she related contraceptives as health care.

John Lindgren, ACLU appeared in support and gave the organizations views on government and religion.

Rep.. Porter had concerns with mandating and small businesses and stated that this bill takes away the option of small businesses being able to choose between these types of coverage's and what they can afford as businesses.

Rep. Price stated this may cause employers to stop providing insurance altogether because of that reason.

Rep. Pollert noted concerns with the government dictating what he should have to do even if its against his religion.

Wanda Rose, ND Assoc. of University of Women (NDAUW) appeared in support with written testimony.

Rep. Price asked for a definition of emergency contraceptives. Answer: A contraception that would be provided within a short period of time (24 to 75 hrs) after sexual intercourse.

Rep. Porter commented that 75% of these pregnancies resulted in live birth and 9% of those pregnancies resulted in abortions, where are the other 16%? Answer: The other 16% would be where the child was not born alive or there was a spontaneous abortions.

Rep. Porter: So 16% is a statistical factor of miscarriages? Answer: yes

Janelle Moos, Bismarck citizen appeared in support with written testimony.

Bob Scarlet, OBGYN, appeared in support stating he's pro-choice, pro-life and pro-contraceptive and states the issue of fairness and feels this is prevention of diseases by using contraceptives.

Penni Weston appeared on her own behalf and in support of the bill.

Dr. Scarlet was asked to appear and define emergency contraceptives. Answer: something used to prevent conception (morning after pill) used in emergency only.

Sparb Collins, Public Employees Retirement System (PERS) appeared neutral on the bill with written testimony and proposed an amendment.

Tim Lindgren, ND Life League appeared in opposition of the bill with written testimony, stating employers are being or will be forced to pay for something that may be against their religion and that some contraception's may actually cause cancer.

Rod St. Aubyn of BCBS appeared in opposition with written testimony stating that premiums have now just gone up and this will up it again. He also noted that they would support an amendment on striking out the mandate.

Christina Kendall of ND Family Life appeared in opposition stating that many people are going to have a problem with being mandated to pay for something they either don't use or believe in.

Christopher Dodson, ND Catholic Conference appeared in opposition as the bill is written. Stated 3 things that haven't been pointed out: 1) No definition in this bill regarding emergency contraception; In ND group policies cannot cover abortions; 2) With regard to contraception, emergency contraception and fertility treatment, there needs to be true conscience protection for those employees that have morally subjection's; 3) HMO's

Closed the hearing.

2003 HOUSE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. HB 1349 & HB 1247

House Human Services Committee

☐ Conference Committee

Hearing Date January 28, 2003

Tape Number	Side A	Side B	Meter #
2		x	47.6 - 57.4
Committee Clerk Signature	Sharon Renfrow		

Minutes: Committee Work

Rep. Potter asked what determines a mandate? Answer: anything that adds a service to a service.

Rep. Devlin moves the mandate on those 2 bills (HB 1247 & HB 1349), secondd by Rep. Weisz.

Rep. Porter asked what this is going to cost us? Answer: essentially $5,000.00 per bill.

Vote on motion: 12 - 1 - 1

2003 HOUSE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. HB 1247
House Human Services Committee

☐ Conference Committee

Hearing Date February 5, 2003

Tape Number	Side A	Side B	Meter #
1	x		32.1 - 48.6
Committee Clerk Signature			

Minutes: Committee Work

Rep. Niemeier stated she feels its a big need in our state and had additional amendment she handed out.

Basically it puts waiver in for organizations with immoral and states if there are less unwanted babies, less maternity care, etc. and moves the amendment 0201, second by Rep. Potter which removes Section 3. 10 - 3 - 0 Passed

Rep. Niemeier moves the amendment 0202, second by Rep. Potter

Rep. Porter states its unfair to exclude religious organizations when you are jamming something down the throats of small businesses.

STATEMENT: Catholic conference employers/employees are exempt from this.

Rep. Weisz noted that we are exempting a religious organization but not a small business who would be forced paying and not given the choice.

Vote: 4 - 9 - 0 Failed

Rep. Devlin moved for a motion of DO NOT PASS as AMENDED, second by Rep. Weisz.

Rep. Amerman states he will support this as amended.

Rep. Porter stated he doesn't feel contraceptives are not medically necessary tools of health insurance, example given that viagra is covered for men as an actual medical condition that its treatable for the medication just like high blood pressure.

Rep. Niemeier: States she sees pregnancy as a health concern and feels contraception is a health need and should be paid for.

Rep. Uglem believes strongly that insurance is for the unexpected. Every body has to plan their family, something they should be thinking about all along. If we are going to be raising insurance rates, it should be for something like increasing the maximum spending cap from 1 million to 2 million for those people who get real disasters and have possibility of their total assets wiped out. Birth control is a personal responsibility and everybody pays for it, not something you need to insure against.

Rep. Devlin stated the choice is there, they have a right to do that now, this a mandate and shouldn't mandate it.

Vote: 10 - 3 - 0 Rep. Devlin will carry the bill.

FISCAL NOTE

Requested by Legislative Council
02/10/2003

Amendment to: HB 1247

1A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2001-2003 Biennium		2003-2005 Biennium		2005-2007 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues						
Expenditures			$364,000	$810,500	$364,000	$810,000
Appropriations			$364,000	$337,000	$364,000	$337,500

1B. **County, city, and school district fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

2001-2003 Biennium			2003-2005 Biennium			2005-2007 Biennium		
Counties	Cities	School Districts	Counties	Cities	School Districts	Counties	Cities	School Districts
			$149,000	$74,000	$93,000	$149,000	$74,000	$93,000

2. **Narrative:** *Identify the aspects of the measure which cause fiscal impact and include any comments relevant to your analysis.*

The outpatient prescription drugs for hormone replacement therapy and for osteoporosis treatment and management are already covered by the NDPERS benefit, so would not have an added cost to NDPERS. The additional cost to NDPERS to cover outpatient prescription drugs for contraceptives and for infertility therapy through their regular drug benefit is estimated at $3.60 per contract per month (spread over all contracts) for the 7-03/6-05 biennium. The infertility drugs are covered under the current benefit, but this assumes that the infertility drugs would be processed under the drug benefit rather than the infertility benefit and they would no longer accumulate toward the $20,000 lifetime infertility maximum.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*
   A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

   B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

Expenditures refect the additional premium of $3.60 that would be necessary for the 13,584 state contracts to pay the cost of this additional benefit.
The cost for political subdivisions is for those entities that participate in the PERS health plan. Shown above is the cost for counties, school districts and cities. Also thier are 385 additional governmental units in PERS and the additional cost to them for the upcoming biennium is $33,264. The above estimates are based upon 24 months of coverage.

   C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, of the effect on the biennial appropriation for each agency and fund affected and any amounts included in the executive budget. Indicate the relationship between the amounts shown for expenditures and appropriations.*

The appropriated amount reflects the actual additional appropriation that will be necessary for state contracts (8,107).

The 5,477 higher education contracts are covered as part of their continuing appropriation.

Name:	Sparb Collins	**Agency:**	Public Employees Retirement System
Phone Number:	328-3901	**Date Prepared:**	02/10/2003

FISCAL NOTE

Requested by Legislative Council
01/13/2003

Bill/Resolution No.: HB 1247

1A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2001-2003 Biennium		2003-2005 Biennium		2005-2007 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues						
Expenditures			$364,000	$810,500	$364,000	$810,000
Appropriations			$364,000	$337,000	$364,000	$337,500

1B. **County, city, and school district fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

2001-2003 Biennium			2003-2005 Biennium			2005-2007 Biennium		
Counties	Cities	School Districts	Counties	Cities	School Districts	Counties	Cities	School Districts
			$149,000	$74,000	$93,000	$149,000	$74,000	$93,000

2. **Narrative:** *Identify the aspects of the measure which cause fiscal impact and include any comments relevant to your analysis.*

The outpatient prescription drugs for hormone replacement therapy and for osteoporosis treatment and management are already covered by the NDPERS benefit, so would not have an added cost to NDPERS. The additional cost to NDPERS to cover outpatient prescription drugs for contraceptives and for infertility therapy through their regular drug benefit is estimated at $3.60 per contract per month (spread over all contracts) for the 7-03/6-05 biennium. The infertility drugs are covered under the current benefit, but this assumes that the infertility drugs would be processed under the drug benefit rather than the infertility benefit and they would no longer accumulate toward the $20,000 lifetime infertility maximum.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*
   A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

   B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

Expenditures refect the additional premium of $3.60 that would be necessary for the 13,584 state contracts to pay the cost of this additional benefit.

The cost for political subdivisions is for those entities that participate in the PERS health plan. Shown above is the cost for counties, school districts and cities. Also thier are 385 additional governmental units in PERS and the additional cost to them for the upcoming biennium is $33,264. The above estimates are based upon 24 months of coverage.

   C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, of the effect on the biennial appropriation for each agency and fund affected and any amounts included in the executive budget. Indicate the relationship between the amounts shown for expenditures and appropriations.*

The appropriated amount reflects the actual additional appropriation that will be necessary for state contracts (8,107). The 5,477 higher education contracts are covered as part of their continuing appropriation.

Name:	Sparb Collins	**Agency:**	Public Employees Retirement System
Phone Number:	328-3901	**Date Prepared:**	01/17/2003

30206.0201
Title.0300

Adopted by the House Human Services Committee
January 15, 2003

VR
2/6/03

HOUSE AMENDMENTS TO HOUSE BILL NO. 1247 **HS 2-6-03**

Page 1, line 4, remove "; and to provide for application"

HOUSE AMENDMENTS TO HOUSE BILL NO. 1247 HS 2-6-03

Page 2, remove lines 1 through 4

Renumber accordingly

Feb 5
Date: ~~January 21,~~ 2003
Roll Call Vote #: 1

2003 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. HB 1247

House HUMAN SERVICES Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken 1st Amendment .0201

Motion Made By Rep Niemeier Seconded By Rep Potter

Representatives	Yes	No	Representatives	Yes	No
Rep. Clara Sue Price - Chair	✓		Rep. Sally Sandvig	✓	
Rep. Bill Devlin, Vice-Chair	✓		Rep. Bill Amerman	✓	
Rep. Robin Weisz	✓		Rep. Carol Niemeier	✓	
Rep. Vonnie Pietsch	✓		Rep. Louise Potter	✓	
Rep. Gerald Uglem	✓				
Rep. Chet Pollert		✓			
Rep. Todd Porter		✓			
Rep. Gary Kreidt		✓			
Rep. Alon Wieland	✓				

Total (Yes) 10 No 3

Absent 0

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Feb 5

Date: ~~January 21~~, 2003
Roll Call Vote #: 2

2003 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. HB 1247

House HUMAN SERVICES Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken 0202 Amendment.

Motion Made By Rep Niemeier Seconded By Rep. Potter

Representatives	Yes	No	Representatives	Yes	No
Rep. Clara Sue Price - Chair		✓	Rep. Sally Sandvig	✓	
Rep. Bill Devlin, Vice-Chair		✓	Rep. Bill Amerman	✓	
Rep. Robin Weisz		✓	Rep. Carol Niemeier	✓	
Rep. Vonnie Pietsch		✓	Rep. Louise Potter	✓	
Rep. Gerald Uglem		✓			
Rep. Chet Pollert		✓			
Rep. Todd Porter		✓			
Rep. Gary Kreidt		✓			
Rep. Alon Wieland		✓			

Total (Yes) 4 No 9

Absent 0

Floor Assignment

If the vote is on an amendment, briefly indicate intent:

Date: ~~January 21~~ Feb 5, 2003
Roll Call Vote #: 3

2003 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. HB 1247

House HUMAN SERVICES Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken DNP as Amended

Motion Made By Rep Devlin Seconded By Rep. Weisz

Representatives	Yes	No	Representatives	Yes	No
Rep. Clara Sue Price - Chair	✓		Rep. Sally Sandvig	✓	
Rep. Bill Devlin, Vice-Chair	✓		Rep. Bill Amerman		✓
Rep. Robin Weisz	✓		Rep. Carol Niemeier		✓
Rep. Vonnie Pietsch	✓		Rep. Louise Potter		✓
Rep. Gerald Uglem	✓				
Rep. Chet Pollert	✓				
Rep. Todd Porter	✓				
Rep. Gary Kreidt	✓				
Rep. Alon Wieland	✓				

Total (Yes) 10 No 3

Absent 0

Floor Assignment Rep. Devlin

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE (410)
February 6, 2003 3:48 p.m.

Module No: HR-23-1911
Carrier: Devlin
Insert LC: 30206.0201 Title: .0300

REPORT OF STANDING COMMITTEE

HB 1247: Human Services Committee (Rep. Price, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO NOT PASS** (10 YEAS, 3 NAYS, 0 ABSENT AND NOT VOTING). HB 1247 was placed on the Sixth order on the calendar.

Page 1, line 4, remove "; and to provide for application"

Page 2, remove lines 1 through 4

Renumber accordingly

2003 TESTIMONY

HB 1247

HOUSE BILL 1247 REP. CAROL A. NIEMEIER, DIST. 20

Thank you, Madam Chairman, Members of the Committee;

I will introduce HB 1247 mandating coverage of prescription contraceptives and other women's health products. Some of the listed drugs and devices are covered by some insurance policies, but this bill seeks to make that uniform.

In June 2001, in a widely watched lawsuit in Seattle, US District Judge Robert S. Lasnik ruled in favor of an employee in her suit charging discrimination according to gender under Title VII. Judge Lasnik said "Although the plan covers almost all drugs and devices used by men, the exclusion of prescription contraceptives creates a gaping hole in the coverage offered to female employees."

The American College of Obstetrics and Gynecologists issued a statement praising the court ruling. They said in part: "Contraception brings great financial savings to the health care system, since the alternatives to birth control - maternity care and delivery, neonatal intensive care, or spontaneous or induced abortion - are so much more costly. Insurers and employers benefit from the significant savings that contraception brings to a health care plan. But they unfairly require women to subsidize those savings for them. That is discrimination."

"It is time to stop dismissing or trivializing women's reproductive health needs as less important than services unique to men, or less important than services in other areas of health care. Control of reproduction is a fundamental health need. The exclusion of prescription contraception from insurance coverage not only discriminates against women, it reflects a deeply flawed and costly health policy."

With women now making up 46% of the US workforce, many employers have added contraception coverage to their employee health plans. A new study by human resource consultant William M. Mercer, Inc. reports that coverage of the five major types - oral drugs, injectable drugs, implants, diaphragms, and IUD's - costs, on average, about $17 per employee per year. However, direct cost savings result from a decrease in maternity cases and fewer unhealthy newborns. Indirect savings result from decreased absenteeism, increased productivity, and improved employee morale.

Dr. Luella Klein, director of women's health issues for ACOG, remarked that

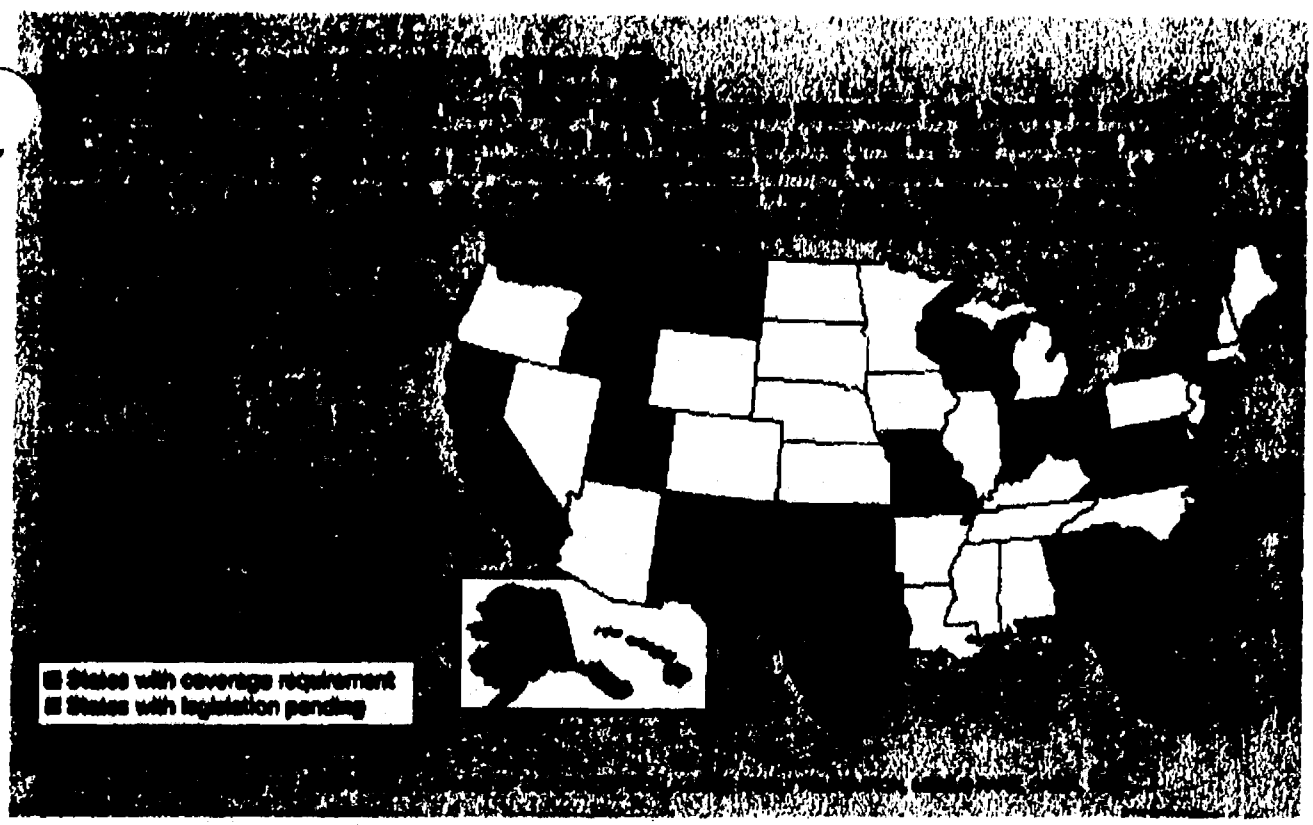
Excluding contraception "makes no economic or medical sense and raises gender discrimination issues." It costs about $6,000 currently to have a baby, "and you know that pregnancy prevention is much cheaper than that. The benefits of contraception provide great savings to the healthcare system, yet it is the individual woman who is shouldering the burden of cost savings to insurers." Studies show that women pay 68% more than men in out-of-pocket medical expenses.

In Jan. 1001, Sen. Olympia Snowe (R-ME) and Sen. Harry Reid (D-NV) introduced S. 104, Equity in Prescription Insurance and Contraception Coverage (EPICC) which is still in committee. A companion bill, H.R. 1111 was introduced by Rep. Greenwood (R.-PA). as an amendment to the drug bill. If the federal law doesn't pass, then each state will be a mechanism.

I believe that North Dakota should join the 20 states which have contraceptive coverage proving that we value and protect the health of our women. Consider these words:

Fairness - women deserve coverage equal to men of their health needs.
Choice - a woman will make the decision if contraception is right for her in regulating the size of her family.
Prescription - these drugs and devices are available only through a medical provider.
Premiums - the insured pay (self or employee benefit) for the assurance that their legitimate health care ~~needs~~ costs will be met.

I ask that the committee give careful consideration to this bill and vote a Do Pass recommendation.



LOCAL PRICES ON COMMON CONTRACEPTIVE PRODUCTS

ORAL - $31.95 to $34.50 (Month's supply)
Generic - $22.95 to $26.95

TRANSDERMAL SYSTEM - PATCH $37.05 (Month)

VAGINAL RING - $42.65 (Three month duration)

INJECTION - $58.35 (Three month duration)

DIAPHRAGM - $33.25 (Duration depends on use and care)

Ob/gyns Call For Contraception Coverage

WL LEANS (Reuters) -- Insurers who refuse to pay for contraception place "an unfair burden on women, a practice that amounts to gender bias," said officials from the American College of Obstetricians and Gynecologists (ACOG).

"We don't believe there's anything optional about contraception, it's really necessary," said Dr. Luella Klein, director of women's health issues for ACOG, on Tuesday at the 46th annual ACOG meeting here. "Health insurers ought to cover reproductive health and pregnancy prevention," she said.

"To ignore the health benefits of contraception is to say that the alternative of 12 to 15 pregnancies during a woman's lifetime is medically acceptable," said Klein in an ACOG statement.

According to ACOG, 49% of traditional fee-for-service insurers and almost half of managed care plans, such as health maintenance organizations (HMOs) and preferred provider organizations (PPOs), do not routinely pay for birth control that requires a prescription. But 90% of these plans cover most other prescription drugs and devices.

The group wants equity in coverage, especially now that so[illegible]surers and some Medicaid programs are beginning o[illegible]r the impotence drug Viagra (sildenafil citrate). Klein believes that insurers are paying for that drug because impotence is considered a medical problem, "and that a medical problem should be covered."

Excluding contraception "makes no economic or medical sense and raises gender discrimination issues," Klein said. It costs about $6,000 currently to have a baby, "and you know that pregnancy prevention is much cheaper than that," she said. A 1995 American Journal of Public Health study found that a 15% increase in oral contraceptive users in a health plan would provide enough savings in pregnancy costs alone to provide oral contraceptive coverage for all plan members, ACOG officials pointed out.

The benefits of contraception provide great savings to the healthcare system, yet it is the individual woman who is shouldering the burden of this cost savings to insurers," Klein added. ACOG said studies showed that women pay 68% more than men in out-of-pocket medical expenses.

"The lack of access to affordable contraception contributes significantly to the high unintended pregnancy rates in this country," said Dr. Anita Nelson, a professor of obstetrics and gynecology at the University of California at Los Angeles.

According to Nelson, there were 2.7 million unintended pregnancies in the US in 1997, a rate double that in other industrialized nations. Almost half those pregnancies occurred in women who did not use contraception.

ACOG wants insurers to cover oral contraceptives, the IUD, Depo-Provera, Norplant, the diaphragm, and the cervical cap.

The group is also seeking coverage of emergency contraception, a birth control pill regimen given immediately after unprotected intercourse to prevent pregnancy. It has been approved by the Food and Drug Administration, but currently is not widely used. Anti-abortion groups have objected to the regimen, saying they consider it to be an abortifacient.

ACOG is backing a congressional proposal introduced by Sen. Olympia Snowe (R-ME) that would require insurers that cover prescription drugs to also cover all FDA-approved drugs and devices. If it became law, it would apply to self-insured companies as well, ACOG officials said.

Klein said she and her colleagues were hopeful that Congress would enact the federal law. "If the federal law doesn't pass, then each state will be a mechanism," she commented.

Bills have already been introduced in 20 states, and a Maryland law taking effect in October mandates coverage of oral contraceptives.

"This should help mobilize women," Nelson said, claiming that many have been unaware that they could demand coverage in the past.

But Kathy Bryant, associate director of government relations at ACOG, noted in an interview with Reuters Health that, "It is not clear if emergency contraception will be covered in that bill." She added, "There is enough controversy surrounding the issue (of contraception) in general that it is difficult to pass this type of legislation.... It is really a question of how vocal women are."

Contraception: A Choice for Women, Not Insurers

by Rep. Alice K. Wolf

January 29, 2002
Appeared in the Cambridge Chronicle
For more information: Dana Reichman 617-722-2070

Given the commonwealth's proud tradition of progressivism, many young women are surprised to learn that the state's record on reproductive choice is not so great. Massachusetts was the last state in the union to allow married women to use contraception. That's right - contraception was illegal here until 1966.

Likewise, it is hard to believe that in 2002, some health insurers in Massachusetts exclude birth control pills and hormone replacement therapy from their prescription benefit plans. Beyond the obvious benefits of these medications, studies show that the pill decreases the chances of ovarian cancer, cervical cancer, and osteoporosis. Yet, somehow, there are insurers who think the basic health care needs of women can be overlooked. And while 23 other states have legislated some kind of protection against this clear form of gender bias, Massachusetts has been mum. Until now, that is.

It now appears that the contraceptive equity bill, of which I am a leading sponsor, will come to vote in the House of Representatives as early as today and hopefully be passed into law. This bill tops the priority lists of members of many advocacy groups such as NARAL, Planned Parenthood, the ACLU and the Massachusetts Caucus of Women Legislators. Together, our fight has been slow and steady.

It took several attempts in recent years, but we did not falter in our quest for basic fairness in health care. This session, 92 legislators, an impressive number, signed a letter urging House leadership to bring this bill to the floor for a vote. With 92 signatories and close to unanimous support among women legislators, passage seems all but guaranteed.

This time, at least, Massachusetts will not be last across the finish line when it comes to the equitable treatment of women. And when our daughters and granddaughters realize, years from now, that there was once a time when basic women's health care was not provided by all insurance plans, I hope they'll find it as incredible as the fact that birth control was illegal for married women in Massachusetts as recently as 1966.

###

HB 1247
Health Insurance Coverage of prescription contraceptives and other women's health products.

Rep. Pam Gulleson

HB 1247 requires insurance to provide coverage for prescribed contaceptives and other womens health products. While insurance companies routinely cover other prescription drugs, including viagra, they often fail to cover prescription contraception. It is time to end this discriminatory practice and remedy years of longstanding inequity in insurance coverage in women's health care.

The lack of insurance coverage for contaception results in an increased financial burden for women's health care services. Women spend about 68 percent more in out-of-pocket expenses for health care than men. A significant portion of this difference is due to the expenses relating to birth control.

I see this bill as pro-family and pro-life. Contraception is basic health care for women. When women and families are assisted in accessing affordable, preventative options regarding reproduction, they can avoid other undesireable decisions that sometimes take place in the absense of preventation, such as abortion.

I would appreciate your support for HB 1247.

AMERICAN
ASSOCIATION OF
UNIVERSITY
WOMEN

WANDA ROSE
1429 POCATELLO DRIVE
BISMARCK, ND 58504

TEL 701-222-2327
FAX 701-323-6967
EML wandarose@msn.com

January 21, 2003
Testimony on HB 1247

Chairman Price and Members of the House Human Services Committee.

I am Wanda Rose representing ND Association of University Women (ND AAUW). I am testifying in support of HB 1247. ND AAUW supports access to safe and affordable family planning and reproductive health services for all women. Contraception and related outpatient services are basic health care for women and, like other basic health care needs, should be covered by health insurance policies. Access to the full range of contraceptive care ensures that women are able to choose methods most appropriate for their health and lifestyle to determine when to have children.

In North Dakota, 11,170 of the 137,840 women of childrebearing age become pregnant each year. 75% of these pregnancies result in live births and 9% in abortions. (AGI 2002). According to Alan Guttmacher Institute (2002) 71,230 women in North Dakota are in need of contraceptive services and supplies.

In any single year, 85 of 100 sexually active women of reproductive age not using a contraceptive method become pregnant compared to only 3 to 6 percent of sexually active women using oral contraceptives. (Trussell et al., 1998).

Contraceptives have a proven track record of enhancing the health of women and children, preventing unintended pregnancy, and reducing the need for abortion. However, although contraception is part of basic health care for women, far too many insurance policies exclude this vital coverage.

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lifelong education and positive societal change

surers have relied on women and their families paying out of pocket for contraceptive services and supplies, forcing financial decisions that may result in the use of less effective or less medically appropriate contraceptive methods.

Women of reproductive age currently spend 68 percent more in out-of-pocket health care costs than men (WREI, 1994). Much of the gender gap in expenses is due to reproductive health-related supplies and services.
The more effective forms of contraception are generally also the most expensive, often costing hundreds of dollars at the onset of patient use (AGI, 1994). Women and their families who must pay out of pocket may well opt for less expensive and sometimes less effective methods, increasing their risk for unintended pregnancies.

Cost analyses have shown that if health insurance policies were to include coverage for these contraceptive supplies, costs to employers would be minimal — as little as $1.43 per employee per month (Darroch, 1998).

The correlation is clear. Contraception prevents unintended pregnancy, helps women plan their pregnancies, and reduces the need for abortion.

D AAUW urges a DO PASS on HB 1247.

Cited References

AGI - Alan Guttmacher Institute. (1994). Uneven and Unequal: Insurance Coverage of Reproductive Health Services. New York: The Alan Guttmacher Institute.

AGI-Alan Guttmacher Institute. (2002) Contraception Counts: North Dakota : New York: The Allan Guttmacher Institute.

_____.

Darroch, Jacqueline. (1998). Cost to Employer Health Plans of Covering Contraceptives. New York: The Alan Guttmacher Instititue.

Trussell, James, et al. (1998). Contraceptive Technology, 17th ed. New York: Ardent Media.

WREI - Women's Research and Education Institute. (1994). Women's Health Care Costs and Experiences. Washington, D.C.: WREI.

Promotes equity for all women and girls,
lifelong education and positive societal change

Thank you Madam Chair and Members of the Committee for allowing me to testify in support of House Bill 1247 to provide insurance coverage for contraceptives.

I'm Janelle Moos and I live in Bismarck. I'm currently employed for a private non-profit agency through which I receive private health insurance coverage. My husband and I moved back to Bismarck last fall so that I could attend graduate school. Both of us presently work full time in our career field, while I am also completing my Master's thesis. We have chosen to put off starting a family until we can become more established in our careers and more prepared to purchase a home.

Currently, we spend $30 a month or $360.00 a year on contraceptives, non of which is covered by our private insurance providers. This money could be budgeted more effectively if the contraceptives were covered by our private insurance. The use of contraceptives is an important part of our planning and in making choices for the future.

Prior to returning to Bismarck, I was employed for a private non-profit agency in Minnesota, who provided private health insurance that covered contraceptives. In Minnesota, I was able to obtain 3 months prescription for contraceptives for the same price of one-month prescription in ND.

My husband and I are committed to staying in ND, but because we are young and have no children we are able to relocate without much hesitation. The choices we are making now will affect out future and our ability to remain in ND. If contraceptives were covered by private insurance providers it would allow for use to budget more effectively in preparation for having a family.

Thank you for allowing me this opportunity to speak in support of this issue affecting many women and families in ND. I'd be glad to answer any questions that you, Madam Chair or the Committee may have.

TESTIMONY OF SPARB COLLINS
ON HB 1247

Madame Chair, members of the committee good morning, my name is Sparb Collins and I am with the Public Employees Retirement System (PERS). I appear before you today neither in favor nor opposed to HB 1247, but rather to discuss with you the effect the provisions of this bill will have on the PERS health plan and to request an amendment.

HB 1247 requires that certain benefits be added to the PERS health plan. Of the provisions required PERS already covers outpatient prescription drugs for hormone replacement therapy and for osteoporosis treatment. Infertility drugs are also covered under the current plan as well. However the requirement relating to covering contraceptives and for infertility therapy are not presently covered and would have a cost to the PERS plan. Since this would require that we renegotiate our plan design with BCBS we asked them to provide us with the additional cost of adding these provisions. They have indicated that our premium would need to go up $3.60 to pay for these benefit enhancements. Since this is not anticipated in the proposed premium recommended by the Governor and presently being considered by the legislature I have attached a proposed amendment to this bill to pay the cost of the enhancements. If this bill was to pass and the premium would not be increased then the PERS Board would have to increase member's deductibles and co insurance to offset the cost of the enhancement. Under the alternate plan design that is presently being considered where the deductible for state employees in the PPO plan may already be increasing to a $250 across the board deductible if we had to add to that the cost of this bill it could increase that amount by approximately $50.

Madame Chair, members of the committee I would request that the attached amendment be added to the bill and be a part of its consideration. Thank you for providing me this opportunity.

PROPOSED AMENDMENT TO HOUSE BILL 1247

Page 1, line 4, remove "and"

Page 1, line 4, after "application" add "; and to provide an appropriation"

Page 2, after line 4, insert the following:

SECTION 4. APPROPRIATION. The funds provided in this section, or so much of the funds as may be necessary, are appropriated out of any moneys in the general fund in the state treasury, not otherwise appropriated, and from other funds derived from federal funds and other income, to the following departments for the purpose of defraying the cost of the additional health insurance premiums necessary to pay the cost of the provisions of this bill, for the biennium beginning July 1, 2003, and ending June 30, 2005, as follows:

	General	Other
Office of the Governor	$1,468.80	$0.00
Office of the Secretary of State	$2,073.60	$0.00
Office of Management and Budget	$7,163.52	$3,031.68
Information Technology Department	$3,143.03	$16,642.57
Office of the State Auditor	$2,809.83	$1,337.37
Office of the State Treasurer	$518.40	$0.00
Office of the Attorney General	$8,978.41	$2,944.79
Office of the Sate Tax Commissioner	$10,627.20	$0.00
Office of Administrative Hearings	$0.00	$432.00
Legislative Assembly	$10,713.60	$0.00
Legislative Council	$3,110.40	$0.00
Judicial Branch	$28,049.47	$30.53
Retirement and Investment Office	$0.00	$1,296.00
Public Employees Retirement System	$0.00	$2,246.40
Department of Public Instruction	$2,202.54	$4,882.26
North Dakota University System	$1,432.45	$122.75
State Land Department	$0.00	$1,468.80
Forest Service	$1,555.20	$0.00
State Library	$2,160.00	$0.00
School for the Deaf	$4,472.15	$107.05
School for the Blind	$0.00	$2,419.20
State Board for Vocational and Technical Ed	$1,300.19	$687.01
North Dakota Department of Health	$7,879.88	$16,916.92
Veterans Home	$8,121.60	$0.00
Indian Affairs Commission	$259.20	$0.00
Department of Veterans Affairs	$486.83	$31.57
Childrens Services Coordinating Committee	$0.00	$86.40
Department of Human Services	$133,196.31	$45,997.29
Protection and Advocacy Project	$1,389.31	$684.29
Job Service North Dakota	$6.38	$30,838.42
Office of the Insurance Commissioner	$0.00	$3,283.20
Industrial Commission	$4,406.01	$432.39
Office of the Labor Commissioner	$599.04	$178.56
Public Service Commission	$3,122.06	$333.94
Aeronautics Commission	$0.00	$432.00
Department of Financial Institutions	$0.00	$1,814.40
Office of the Securities Commissioner	$691.20	$0.00

Bank of North Dakota	$0.00	$14,342.40
North Dakota Housing Finance Agency	$0.00	$2,678.40
North Dakota Mill & Elevator Association	$0.00	$9,936.00
Workers Compensation Bureau	$0.00	$18,403.20
Highway Patrol	$6,135.49	$10,107.71
State Radio	$2,245.57	$173.63
Division of Emergency Management	$699.42	$942.18
Department of Corrections and Rehabilitation	$42,933.42	$3,722.58
Adjutant General	$2,540.17	$6,445.43
Department of Commerce	$4,079.47	$154.13
Department of Agriculture	$2,611.21	$1,795.19
State Seed Department	$0.00	$2,073.60
Upper Great Plains Transportation Institute	$255.38	$2,163.82
Branch Research Centers	$5,654.32	$912.08
NDSU Extension Service	$14,524.60	$9,321.80
Northern Crops Institute	$393.88	$297.32
NDSU Main Research Center	$21,217.82	$9,022.18
Agronomy Seed Farm	$0.00	$259.20
State Historical Society	$4,065.26	$513.94
Council on the Arts	$432.00	$0.00
Game & Fish Department	$0.00	$11,577.60
Department of Parks & Recreation	$3,476.22	$152.58
State Water Commission	$0.00	$6,825.60
Department Of Transportation	$0.00	$86,745.60
Total	$363,200.82	$337,243.98

North Dakota Life League
1336 25 Ave S Ste 207
Fargo ND 58103
(701) 293-6221

Testimony of Tim Lindgren

Chairman Clara Sue Price and other Representatives of the Human Services Committee:

North Dakota Life League represents over 1500 families throughout North Dakota and is a non-profit educational organization working to educate people on issues related to respect for human life and the right to life.

North Dakota Life League is opposed to requiring health insurance coverage and public employee health insurance coverage of contraceptives including emergency contraceptives.

Our reasons for opposing this legislation is that: 1) It requires many people to pay and or contribute funds toward something they consider immoral; 2) Many of the contraceptives themselves may act to prevent implantation of an already conceived human being, something many consider chemical abortion; 3) Emergency Contraception itself is intended to act almost exclusively to prevent implantation of a newly conceived human being if conception has occurred, an act that we believe is more accurately termed emergency abortion and 4) There is some evidence to suggest that oral contraceptives may be linked to various cancers of the reproductive organs.

North Dakota Life League urges a DO NOT PASS on HB 1247.

Thank you for your consideration of this testimony.

Testimony on HB 1247
House Human Services Committee
January 21, 2003

Madam Chair and committee members, for the record I am Rod St. Aubyn, representing Blue Cross Blue Shield of North Dakota (BCBSND). I appear before you today in opposition to HB 1247, another insurance mandate that will undoubtedly raise health insurance premiums and force many employers to either consider raising their employees contributions or worse yet, discontinuing providing health insurance as an employee benefit. I do not need to tell you that health care costs have risen significantly in the last several years. As an insurer, we have no choice, but to pass these increases to our members in the form of higher insurance premiums. According to a recent national survey completed by PricewaterhouseCoopers, medical cost trends increased by 13.7% in 2001. Over 15% of that increase have been attributed to insurance mandates and government regulations.

BCBSND has seen comparable increases in our market as well. Unfortunately, our marketing people have faced many unhappy employers when they have recently met with them to inform the employers what their new rates will be for 2003. The next two bills you are hearing today will further expand health costs and consequently health insurance premiums. I think it is important to emphasize to this committee that over $.89 of every dollar goes toward direct medical care and prescription drugs. Less than $.11 of every dollar is used for administrative costs and to maintain an insurance reserve to protect our members from a "higher than normal claims" year.

One factor to consider that anything you mandate, will only apply to the fully insure products. All self-insured plans are exempt from state mandates. For the plans that we offer and those that we administer, self-funded plans make up over a third of our contracts.

Another key point that needs to be said about insurance mandates is that they take away choice. We offer several insurance products to give our members choices. We currently offer a product with contraceptive coverage. We also currently provide HRT, infertility therapy, and osteoporosis treatment. However, all of these are managed based on medical policies. If this bill is to pass, it further limits our ability to offer products many of our employer groups want.

This bill raises many questions. Among those questions are the following:

- We currently maintain a drug formulary. Will this bill prevent any of the drugs for these specified mandates being off our formulary?
- Will this require an insurer to pay for off the counter items such as calcium, health food items, food supplements, vitamins, condoms, spermicidal foam, etc.?
- Will this require the payment for drugs that are investigational or experimental and not approved by the FDA for use.

- Can an insurer establish medical policies concerning these mandated benefits or limitations?
- What is to be covered in the infe' 'lity therapy, i.e. all ultrasounds, surgical procedures associated with harvesting and implantation of eggs, and associated costs?
- We currently have a $20,000 lifetime limit for infertility procedures and prior approval is required. Would limits and prior approval to assure that an approved procedure is being performed be eliminated?

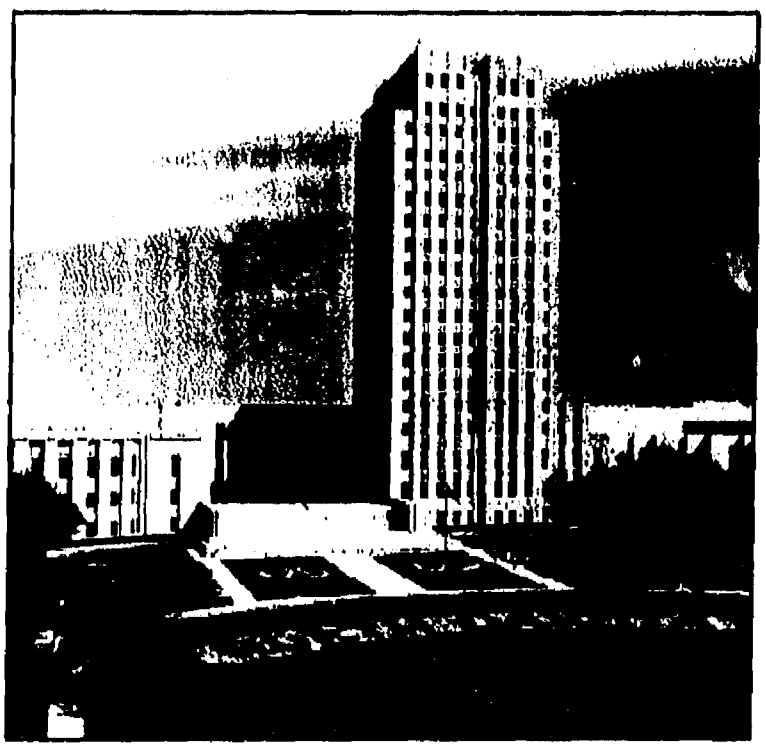
There are many more questions that could be posed. The interim Budget Committee on Health Care approved a bill draft this fall that would test any new mandates on the PERS plan first for a period of 2 years, to determine a more accurate cost. Several members on this committee, including the prime bill sponsor voted for that proposed bill in the interim committee. I won't read the minutes, but I have included them for your information.

> ***It was moved by Representative Berg, seconded by Representative Keiser, and carried on a roll call vote that the bill draft providing that any health insurance coverage mandate approved by the Legislative Assembly apply only to the state public employees group health insurance program for a period of two years be approved and recommended to the Legislative Council with the following changes:***
>
> 1. ***Continue current statutory provisions requiring a cost-benefit analysis to be prepared.***
> 2. ***Provide that the mandate expires at the end of the following biennium unless a bill is introduced to continue the mandate for all insurers.***
> 3. ***Provide that PERS report to the Legislative Assembly rather than the Legislative Council and provide that the evaluation period may be for more than one year.***
> 4. ***Require an appropriation for PERS to be attached to the bill providing for the mandate, if needed.***
> 5. ***Add an emergency clause to the bill draft.***
>
> *Senators J. Lee, Bercler, and G. Lee and Representatives Berg, Devlin, Drovdal, Kasper, Keiser, Niemeier, Pollert, Porter, and Price voted "aye." Representative Cleary voted "nay."*

That bill passed unanimously by the Senate Human Services Committee and was approved by the full Senate on Friday. Section 3 of this bill flagrantly tries to avoid any review process. We simply do not understand the logic of avoiding the true impact of a new insurance mandate before applying it to all insurers.

In closing, if you support this bill and vote to approve it, you are essentially telling policy holders and employers across the state that you have made an informed decision to raise the cost of their insurance even more than current trends and limit their choices. We urge you to consid'r the consequences of this bill and give HB 1247 a Do Not Pass.

The Cost of Health Insurance Mandates



This won't cost much.
Alcohol/Drug Treatment
$6,174,592

This won't cost much.
Breast Reconstruction
$314,789

This won't cost much.
Dental Anesthesia
$68,244

This won't cost much.
Minimum Maternity Stay
$10,970,781

This won't cost much.
Emergency Services
$48,097,757

This won't cost much.
Mammography Screening
$2,135,269

This won't cost much.
TMJ Disorders
$527,995

This won't cost much.
Prostate Cancer Screening
$55,150

This won't cost much.
Lic. Addiction Counselors
$1,029,712

This won't cost much.
Mental Health
$22,928,041

This won't cost much.
Chiropractors
$6,766,233

This won't cost much.
Nurse Practitioners
$3,677,698

This won't cost much.
Psychiatric Nurses
$405,751

This won't cost much.
Psychologists
$4,657,986

This won't cost much.
Social Workers
$1,156,633

This won't cost much.
Nurse Anesthetists
$4,480,820

This won't cost much.
Nurse Midwives
$280,833

This won't cost much.
Professional Counselors
$722,496

The Cost of Health Insurance Mandates

While BCBSND does not necessarily oppose many of these mandated benefits and providers, it is important to note the true costs of establishing mandates.

Benefits	Professional	Institutional
Alcohol/Drug Abuse Treatment	$ 1,410,515	$ 4,764,077
Breast Reconstruction	$ 152,425	$ 162,364
Dental Anesthesia	$ 44,357	$ 23,887
Emergency Services	$ 2,956,144	$ 45,141,613
Mammography Screening	$ 1,587,347	$ 547,922
Mental Health (General)	$ 12,178,197	$ 10,749,844
Minimum Maternity Stays	$ n/a	$ 10,970,781
Prostate Cancer Screening	$ 45,087	$ 10,063
TMJ Disorders	$ 66,780	$ 461,215
	$ 18,440,852	$ 72,831,766

Providers	Professional
Chiropractors	$ 6,766,233
Nurse Midwives	$ 280,833
Nurse Anesthetists	$ 4,480,820
Nurse Practitioners	$ 3,677,698
Nurse, Psychiatric	$ 405,751
Professional Counselors	$ 722,496
Psychologists	$ 4,657,986
Licensed Addiction Counselors	$ 1,029,712
Social Workers	$ 1,156,633
	$ 23,178,162

TOTAL $114,450,780

(*Dollar amounts are based on claims incurred 8/1/2001 – 7/31/2002 and paid through 10/31/2002)

Insurance corner: taking the mystery out of health insurance

Insurance is only one part of the health care delivery system, yet it is often perceived as the most mysterious piece of the puzzle. The middleman between patient and provider, the payer must determine the appropriate amount of premium dollars needed as well as proper distribution of those dollars.

The payer's role—taking risk

Blue Cross Blue Shield of North Dakota (BCBSND) acts as a representative of its members. In fact, its mission is to provide members with the best value in health insurance for all members—regardless of health status, age or other factors. In doing so, BCBSND takes the legal and financial risk in ensuring that members' claims are paid. "We are regulated by insurance laws as well as the Blue Cross and Blue Shield Association," said Janine Weideman, vice president, Actuarial and Membership, BCBSND. "We have a fiduciary responsibility to remain financially strong and to fulfill our obligation to pay claims."

BCBSND must determine rates and decide how much money in premiums it needs to collect to pay for its members' covered services for the upcoming year. The company sets rates using a blend of rating techniques to make sure it meets standards and provides long-term rate stability.

Pooling and rating

When BCBSND collects premium payments from policyholders, it groups the money into various pools. The money in each pool must be enough to pay for all the claims for members—policyholders and their covered family members—in that pool. By examining members' past claims experience and evaluating the economic factors expected to influence future costs, BCBSND projects the amount of services members in the pool will use in the future year. "Due to the uncertainty of future events, these estimates are never exact," noted Weideman.

Based on these estimates, BCBSND establishes a rate that is spread among all participants in the pool. This way, members share the risk that they'll need to use a large amount of health care—a concept referred to as social equity. For example, to pay for the average cost of one BCBSND member's care for a stroke with hemorrhage, another policyholder, who has family coverage, would need to pay premiums for 15 years without using any benefits.

If an insurance company used purely financial equity when determining rates, a healthy couple would likely pay considerably lower premiums than a sicker couple. However, if the healthy couple experienced a catastrophic illness or injury, their insurance premiums would skyrocket to cover the high costs. Using an element of social equity, BCBSND can better manage rate stability over the long term. Rates still go up, but they rise by more moderate increments.

Pure community rating is the concept in which all members or those in a particular class of members pay the same rate for the same level of benefits. BCBSND uses a modified form of community rating to determine the premium rates it charges members. Those with coverage through an employer-sponsored plan are pooled into their employer group, and all employer groups are combined into one large pool. BCBSND then calculates the rates based on variables such as the group's demographics and claims experience, as well as the total group pool's experience.

Members who lack access to an employer-sponsored plan purchase their insurance as individuals. These members are grouped into one large pool, and costs are spread over all members. Their premium rates vary by factors such as age, level of benefits and class of coverage—single, single plus dependent or family.

Why are health care costs increasing?

During the 1990s, health care costs increased more gradually than they had in previous years. Now, costs are again skyrocketing. During 2002, Americans are expected to spend $1.3 trillion for health care, more than they will spend on food, housing and automobiles combined.[1]

Several factors contribute to the rising cost of health care. PricewaterhouseCoopers estimated that the average increase in health insurance premiums between 2001 and 2002 was 13.7 percent. Drugs, medical devices and medical advances make up the largest portion of this increase, followed by rising provider expenses, general inflation and increased consumer demand (see Table 1).[2] Medical technology is improving, and people are visiting more specialists, more often. In addition, as people age, they generally need more health care services, evident in North Dakota, with its large percentage of older adults. As the nation's 77 million baby boomers age, this increased demand for health care will only continue.

Table 1
The factors driving rising costs in health care premiums, 2001-2002[2]

Trend Factors	Percentage Points	Percent of Total Increase
Medical Trend	**13.7%**	**100%**
General inflation (CPI)	**2.5%**	**18%**
Drugs, medical devices and medical advances*	**3.0%**	**22%**
Prescription drugs		
Other advances in diagnostics and treatment		
Rising provider expenses	**2.5%**	**18%**
Hospitals (consolidated, in particular) negotiating higher payments		
Government mandates and regulation	**2.0%**	**15%**
Over 1,500 existing mandates at state and federal level		
New mandated benefits		
Elimination of cost-control tools or limiting flexibility to use them		
Regulatory requirements (red tape, duplication of federal and state requirements)		
Increased consumer demand	**2.0%**	**15%**
Aging population		
"Front page" treatments (i.e., media coverage drives demand for expensive treatment)		
Increased preventive and diagnostic activity		
Consumers moving away from less expensive managed care products		
Litigation and risk management	**1.0%**	**7%**
Class action lawsuits		
Outsized awards and legal costs		
Defensive medicine		
Malpractice premiums		
Reinsurance/risk management		
Other categories	**0.7%**	**5%**
Fraud and abuse		
Miscellaneous		

Source: PricewaterhouseCoopers analysis, April 2002.
* This percentage does not reflect potential savings from drugs, medical devices and other medical advances. For example, savings in future years may include reduced hospitalizations and consumption of other health care services.

Insurance corner: taking the mystery out of health insurance continued

Did You Know

Of each premium dollar BCBSND received in 2001, 89.3 cents was paid to hospitals, medical professionals and for pharmaceuticals.

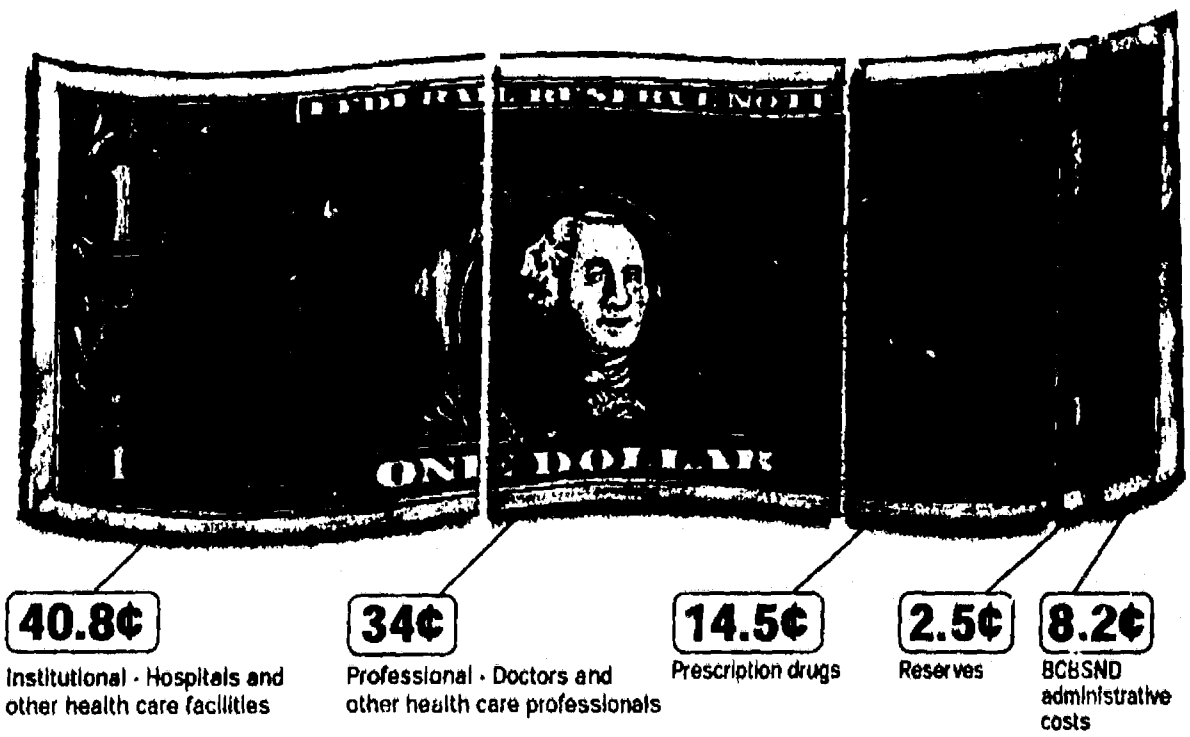


Figure 1. Where does the BCBSND premium dollar go?[4]

Discussion Point

To pay for one BCBSND member's care for a stroke with hemorrhage, another policyholder, who has family coverage would need to pay premiums for 15 years without using any benefits.

In 1995, BCBSND paid more than $404 million to cover claims. In 2001, the company paid $600 million. Both the number of claims and the cost per claim are climbing.

To help rein in the cost of health care, BCBSND has implemented several ideas, such as the use of cost sharing and the concepts of managed care. Unfortunately, these techniques have had little lasting impact on rate increases.

Of each premium dollar BCBSND received in 2001, 89.3 cents was paid to hospitals, medical professionals and for pharmaceuticals. Broken down further, 40.8 cents of every dollar went to cover institutional claims. These include services such as inpatient and outpatient hospital visits or the use of immediate care facilities.

Another 34 cents paid professional claims, including services and supplies provided by physicians, chiropractors and other health care professionals. In addition, 14.5 cents was used to pay for prescription drugs covered under members' health plans.

BCBSND used 8.2 cents of each dollar last year to cover its administrative expenses—among the lowest in the nation. Despite steadily increasing costs in recent years, BCBSND has worked to be as efficient as possible to keep its costs low.

The balance of the premium dollar, 2.5 cents, along with other income, was contributed to a policyholder reserve fund. In the next issue of *Health Care Discussions*, read about the policyholder reserve fund and why every insurance company has one.

References

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3. Miller JE. Washington, D.C.: National Coalition on Health Care. *A Perfect Storm: The Confluence of Forces Affecting Health Care Coverage.* November 2001.
4. Blue Cross Blue Shield of North Dakota data.

Written by Lori Dittmer, assistant editor, Health Care Discussions.

39286

Prepared by the North Dakota Legislative Council staff for Senator J. Lee
April 2002

LEGISLATIVE PROCEDURAL REQUIREMENTS FOR ANALYZING MANDATED HEALTH INSURANCE COVERAGE

INTRODUCTION

North Dakota Century Code Section 54-03-28, enacted during the 2001 legislative session:

1. Prohibits any committee of the Legislative Assembly from acting on any legislative measure mandating health insurance coverage of services or payment for specified providers of services unless the measure is accompanied by a cost-benefit analysis provided by the Legislative Council;
2. Prohibits any amendment that mandates health insurance coverage of services from being acted on by a committee of the Legislative Assembly unless the amendment is accompanied by a cost-benefit analysis provided by the Legislative Council;
3. Requires the Legislative Council to contract with a private entity, after receiving recommendations from the Insurance Commissioner, to provide the cost-benefit analysis required by the section;
4. Requires the Insurance Commissioner to pay the costs of the contracted services; and
5. Provides that a majority of the members of the committee, acting through the chairman, has sole authority to determine whether a legislative measure mandates coverage of services under this section.

SIMILAR PROVISIONS RESTRICTING LEGISLATIVE ACTION

The Legislative Assembly has enacted three other self-imposed restrictions on legislative action until certain requirements are met.

Section 54-03-25 relates to a legislative measure or amendment affecting workers' compensation benefits or premium rates. The Workers Compensation Bureau must review every measure affecting workers' compensation benefits or premium rates. If the bureau determines that the measure or amendment will have an actuarial impact on the workers' compensation fund, the bureau is required to submit, before the measure or amendment is acted upon, an actuarial impact statement prepared, at the expense of the bureau, by the actuary employed by the bureau.

Section 54-35-02.4(5) and (6) provide a legislative measure or amendment to a measure during a legislative session which affects a public employees retirement program, public employees health insurance program, or public employee retiree health insurance program may not be introduced or considered in either house unless it is accompanied by a report from the Employee Benefits Programs Committee. A majority of the members of the committee, acting through the chairman, has sole authority to determine whether any legislative measure affects a program.

Section 54-01-05.5 requires a written report and an opinion with regard to any bill introduced to authorize the sale or exchange of state land. The agency owning or controlling the land must prepare the report, and the Commissioner of University and School Lands must review the report and then issue an opinion to the standing committee to which the bill was initially referred concerning the proposed sale or exchange and the highest and best use of the land.

Workers' Compensation Bill Procedure

Section 54-03-25 was originally enacted in 1991. As enacted, the section provided a legislative measure affecting workers' compensation benefits or premium rates "may not be prefiled for introduction or introduced" in either house of the Legislative Assembly unless the measure had been reviewed by the Workers Compensation Bureau and the bureau had determined whether the measure would have an actuarial impact on the workers' compensation fund. If the bureau determined that the measure would have an actuarial impact on the fund, the measure could not be prefiled or introduced unless accompanied by an actuarial impact statement prepared by the actuary employed by the bureau. The section also provided that no amendment affecting workers' compensation benefits or premium rates "may be attached to any legislative measure" unless the amendment is accompanied by either a statement prepared by the bureau stating the amendment is not expected to have any actuarial impact on the fund or an actuarial impact statement prepared by the actuary employed by the bureau.

This prohibition against legislators prefiling or introducing bills or attaching amendments unless they were first reviewed by the Workers Compensation Bureau was replaced in 1995. Rather than prohibit the introduction of bills, the current procedure allows legislators to introduce bills and the bureau must review any legislative measure affecting workers' compensation benefits or premium rates to determine whether the measure would have an actuarial impact on the workers' compensation fund. If the bureau determines that a measure will have an actuarial

impact on the fund, the bureau is to submit, before the measure is acted upon, an actuarial impact statement prepared by the actuary employed by the bureau. The bureau is also to review any amendment affecting workers' compensation benefits or premium rates and is to submit, before the amendment is acted upon, either a statement stating the amendment is not expected to have any actuarial impact on the fund or an actuarial impact statement prepared by the actuary employed by the bureau. Thus, under the current section, a measure may be introduced and an amendment may be considered, but neither may be acted upon until the bureau has reviewed the measure or amendment and has determined whether an actuarial impact is present.

Employee Benefits Programs Committee Procedure

Section 54-35-02.4 requires the Employee Benefits Programs Committee to consider and report on legislative measures and proposals over which it takes jurisdiction and which affect, actuarially or otherwise, retirement programs of state employees or employees of any political subdivision and health and retiree health plans of state employees or employees of any political subdivision. The committee is also to take jurisdiction over any measure or proposal that authorizes an automatic increase or other change in benefits beyond the ensuing biennium which would not require legislative approval. The committee is authorized to contract with an actuarial firm and provides that the retirement, insurance, or retiree insurance program is to pay from its funds the cost of any actuarial report required by the committee which relates to that program. The committee is authorized to solicit draft measures and proposals from interested persons during the interim between legislative sessions and may study measures and proposals referred to it by the Legislative Assembly or the Legislative Council.

A copy of the committee's report concerning any legislative measure, if that measure is to be introduced for consideration by the Legislative Assembly, must be appended to the copy of the measure which is referred to a standing committee. A measure affecting a public employees retirement program, public employees health insurance program, or public employee retiree health insurance program may not be introduced in either house unless accompanied by a report from the committee. A majority of the members of the committee, acting through the chairman, has sole authority to determine whether any legislative measure affects a program. These procedures also apply to any amendment made during a legislative session to a legislative measure affecting a public employees retirement program, health insurance program, or retiree health insurance program.

The committee has established a procedure whereby legislators and agencies with the bill introduction privilege are requested to submit their proposals to the committee before April 1 of the year preceding the legislative session, e.g., April 1, 2002. The committee determines whether to take jurisdiction over the proposals. With respect to these proposals, the committee directs the affected retirement, health insurance, or retiree health insurance program to have an actuarial review conducted. The committee reviews the reports during the interim and gives its recommendations. The reports and the committee's recommendations are then attached to those bills which are introduced. Even though measures are submitted by April 1, the committee usually does not receive reports from the actuary until the July 1 actuarial review of the program is completed, usually early November.

LEGISLATIVE PROCEDURE CONSIDERATIONS

Section 54-03-28 prohibits a legislative committee from acting on any measure or amendment mandating health insurance coverage without a cost-benefit analysis. The section also provides that the sole authority to determine whether a legislative measure mandates coverage of services is a majority of the members of the legislative committee, acting through the chairman. The section implies that the request for a cost-benefit analysis is by motion approved by a majority of the committee. Thus, the committee must take action before a report is requested. If the committee does not request a cost-benefit analysis on every bill that appears to have an impact on any of the factors that a cost-benefit analysis must address, an issue could be raised that, as a result of the committee determining the bill does not mandate coverage of services, the bill does not have an impact on the total cost of health care (one of the factors a cost-benefit analysis must address).

The statutorily outlined procedure may not allow sufficient time for preparation of an accurate cost-benefit analysis on every measure or amendment that mandates health insurance coverage of services or payment for specified providers of services. The 2003 legislative session deadlines could result in the following scenario:

1. On Monday, January 27 (the 15th legislative day) a bill is introduced in the Senate; the bill is referred to the Industry, Business and Labor Committee.
2. On Wednesday, January 29, the chairman reviews all bills referred to the committee for purposes of scheduling hearings the following week (as provided by Senate Rule 506) and determining whether a bill might be within the

purview of Section 54-03-28; the chairman sets aside the bill for committee discussion when the committee meets on the following Monday.

3. On Monday, February 3, the committee discusses the bill and votes to request a cost-benefit analysis; this request is immediately taken to the Legislative Council office.
4. By Tuesday, February 4, the Legislative Council staff refers the request for a cost-benefit analysis to the entity under contract to provide the cost-benefit analysis.
5. On Thursday, February 6, Senate Rule 329 would need to be suspended if the bill would otherwise be rereferred to the Senate Appropriations Committee, because the committee cannot take "action" on the bill and rerefer it to the Appropriations Committee (the deadline for rereferral of bills to the Appropriations Committee is the 23rd legislative day--February 6).
6. By Wednesday, February 12, the chairman must schedule the bill for hearing.
7. By Tuesday, February 18 (the 31st legislative day), the bill must be reported out of committee.

Under this scenario, the actuary has 12 calendar days to prepare and deliver the cost-benefit analysis to the committee--assuming the actuary receives the request on midday on Tuesday, February 4, and returns the cost-benefit analysis midday on Monday, February 17, for a hearing on the 18th, on which day the bill must be reported out of committee.

Possible Legislative Rule

The timeframe described in the preceding section illustrates the limited time available for requesting, preparing, and receiving a cost-benefit analysis, as well as for scheduling a hearing on the measure, if the analysis is not requested until the committee has reviewed the bill. Presumably, a hearing would not be held until after the cost-benefit analysis is received. This time factor may be addressed during the 2003 session through a joint legislative rule to establish a procedure similar to that for measures requiring fiscal notes. The rule could provide that every measure mandating health insurance coverage of services or payment for specified providers of services must have a cost-benefit analysis attached. Every committee to which such a measure would be referred would be deemed to have requested a cost-benefit analysis on the measures that the Legislative Council staff determine should have cost-benefit analyses. If the cost-benefit analysis has not been provided by the Legislative Council, the committee, acting through the chairman, could determine whether a legislative measure mandates coverage and then request a cost-benefit analysis. This would at least allow additional time for preparation of the cost-benefit analysis because the initial request to the entity preparing the analysis would be when the measure is prefiled or is introduced. This procedure would require the Legislative Council staff to review all measures introduced to determine which ones would appear to mandate health insurance benefits, and this procedure would require expertise in an area in which the staff has not previously had experience. The proposed joint rule could read:

> **HEALTH COVERAGE MANDATE ANALYSIS.** The committee to which a measure mandating health insurance coverage of services or payment for specified providers of services will be referred upon introduction is deemed to have requested preparation of a cost-benefit analysis as determined by the Legislative Council. The committee, through the chairman, to which a bill has been referred shall determine whether a cost-benefit analysis is to be prepared for a bill not having a cost-benefit analysis provided by the Legislative Council. The committee, through the chairman, shall determine whether a cost-benefit analysis must be prepared for an amendment mandating health insurance coverage of services. The committee shall determine whether the cost-benefit analysis must be prepared before final action on the amendment by the committee, before consideration of the amendment on sixth order, or before second reading of the amended bill. If the cost-benefit analysis is not prepared before final action on the amendment by the committee, the Secretary of the Senate or the Chief Clerk of the House, whichever the case may be, shall read the analysis at the time of consideration of the amendment or the reading of the title of the bill to be voted on.

Possible Statutory Change

The procedure for determining actuarial impact on the workers' compensation fund appears to have worked well since 1995. The Workers Compensation Bureau has the expertise to know which measures affect workers' compensation, to determine which measures could have an actuarial impact on the workers' compensation fund, to contract with its actuary to provide actuarial services, and to provide the actuarial report on measures that would have an actuarial impact on the workers' compensation fund.

Section 54-03-28 could be amended to provide a similar procedure, except that the Insurance

Commissioner would appear to be the appropriate official with expertise over health insurance issues. A proposed amendment is:

54-03-28. Health insurance mandated coverage of services - Cost-benefit analysis requirement.

1. ~~A~~ The insurance commissioner shall review any legislative measure mandating health insurance coverage of services or payment for specified providers of services ~~may not be acted on by any committee of the legislative assembly unless the measure is~~ to determine whether the measure should be accompanied by a cost-benefit analysis ~~provided by the legislative council~~. Factors to consider in this analysis include:

a. The extent to which the proposed mandate would increase or decrease the cost of the service.

b. The extent to which the proposed mandate would increase the appropriate use of the service.

c. The extent to which the proposed mandate would increase or decrease the administrative expenses of insurers and the premium and administrative expenses of insureds.

d. The impact of the proposed mandate on the total cost of health care.

2. ~~A majority of the members of the committee, acting through the chairman, has sole authority to determine whether a legislative measure mandates coverage of services under this section.~~

3. ~~Any~~ The commissioner shall review any amendment made during a legislative session ~~to a measure~~ which mandates health insurance coverage of services ~~may not be acted on by a committee of the legislative assembly unless the amendment is~~ to determine whether the amendment should be accompanied by a cost-benefit analysis ~~provided by the legislative council~~ that includes the considerations listed in subsection 1.

3. If the commissioner determines that a measure or an amendment should be accompanied by a cost-benefit analysis, the commissioner shall submit, before the measure or amendment is acted upon, the cost-benefit analysis to the appropriate legislative committee.

4. The ~~legislative council~~ commissioner shall contract with a private entity, ~~after receiving one or more recommendations from the insurance commissioner,~~ to provide the cost-benefit analysis required by this section. The insurance commissioner shall pay the cost of the contracted services to the entity providing the services.

SUMMARY AND CONCLUSION

Section 54-03-28 places the burden of determining which bills mandate health insurance coverage on standing committees and chairmen of those committees. Under current rules and deadlines during legislative sessions, there may not be sufficient time for preparation of appropriate cost-benefit analyses.

A legislative rule could be adopted creating a procedure similar to the current joint rule requiring fiscal notes. A disadvantage to that procedure is that it would require the Legislative Council staff to review all measures to identify which ones appear to mandate health insurance coverage, and that procedure would require expertise in an area in which the staff has not previously had experience.

Another option would be to enact legislation amending Section 54-03-28 to establish a procedure similar to that followed under current law on bills affecting workers' compensation legislation. Under this option, the Insurance Commissioner would be required to determine which measures mandate health insurance coverage. However, if the option of changing the law is selected, procedures will be required during the 2003 legislative session to handle this subject until the bill amending Section 54-03-28 is enacted.

NDRL

North Dakota Right to Life Association

Testimony before the HOUSE HUMAN SERVICES COMMITTEE

Regarding HOUSE BILL 1247

January 22, 2003

Chairman Price, Vice Chairman Devlin, and members of the committee, I am Stacey Pfliiger, Executive Director of the North Dakota Right to Life Association. Yesterday, you heard testimony on House Bill 1247. Since the hearing ran late and I would have reiterated much of what had already been said, I opted to sign in opposed to House Bill 1247. After visiting with Vice Chairman Devlin, I concluded it was also important to submit written testimony to the members committee.

The North Dakota Right to Life Association is opposed to any drug or medicine, which is capable of, and used with the intent of producing abortion (this includes RU-486 and methotrexate). The Association is also opposed to "contraceptives" that are in fact abortifacients.

Thank you for the opportunity to present you with this written testimony.

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Representing the Diocese of Fargo and the Diocese of Bismarck

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To: House Human Services Committee
From: Christopher Dodson, Executive Director
Subject: HB 1247 -- Mandatory Insurance Coverage
Date: January 22, 2003

Pursuant to Vice Chairman Devlin's request, I have prepared this written summary of the North Dakota Catholic Conference's concerns regarding House Bill 1247.

The North Dakota Catholic Conference opposes House Bill 1247 for three reasons.

(1) The bill does not contain a definition of "contraceptives" and "emergency contraceptives." As such, the bill could mandate coverage for abortifacients and chemical abortions, both of which are sometimes characterized as "contraceptives" and "emergency contraceptives." The North Dakota Catholic Conference opposes any policy mandating insurance coverage for what could be an abortifacient or a chemical abortion.

Moreover, mandating such coverage would be a radical departure from North Dakota law. North Dakota Century Code section 14-02.3-03 prohibits insurance policies from covering abortions except by an optional rider for which the covered person must pay an additional premium. In short, HB 1247, to the extent it mandates abortion coverage, would move the state from *prohibiting* to *mandating* abortion coverage.

(2) The North Dakota Catholic Conference believes that any law mandating coverage for such controversial services should include a meaningful conscience exception for employers, payers, enrollees, and religious affiliated entities. The conscience exemption must be meaningful. It cannot exclude any person or entity with a religious or moral objection to the coverage. It must also protect the enrollee's privacy if they opt not to participate in a plan that includes the objectionable services and an alternative plan must be made available.

(3) Unless a meaningful conscience exemption exists, the mandates in House bill 1247 threaten the ability of health care providers with religious or moral objections, such as Catholic health care providers, to survive in today's difficult health care market. If health care providers are to adapt to changing demographics and markets they must have the ability to form new partnerships, alliances, and products, including those arrangements that would be characterized as "insurance" under the law. If HB 1247 were to pass in its current form it would place barriers to adaption and possibly eliminate Catholic health care in North Dakota's future. Since the state has thirty-two Catholic health care facilities serving North Dakotans throughout the state -- perhaps the highest number per capita in the nation, HB 1247 could pose significant and serious problems for health care delivery in North Dakota.

A MILLIMAN GLOBAL FIRM

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February 4, 2003

Mr. John D. Olsrud
Director
North Dakota Legislative Council
600 E Boulevard
Bismarck, ND 58505-0360

Re: Analysis of House Bills 1247 and 1349

Dear Mr. Olsrud:

Thank you for your letter of January 29 requesting a cost-benefit analysis of the mandates included in House Bill Nos. 1247 and 1349. In accordance with NDCC 54-03-28, you asked that we provide information to help determine the following:

a. the extent to which the proposed mandate would increase or decrease the cost of the service;
b. the extent to which the proposed mandate would increase the appropriate use of the service;
c. the extent to which the proposed mandate would increase or decrease the administrative expenses of insurers and the premium and administrative expenses of insureds; and
d. the impact of the proposed mandate on the total cost of health care.

Given the short turn around time you requested, we are providing this letter which summarizes the information we have gathered to date. If you have questions regarding this information or would like additional detail on any point, we would be happy to continue our review on a more comprehensive basis.

This letter is intended for use by North Dakota legislators and officials for the purpose of considering this proposed legislation. It should not be used for other purposes and was not prepared for the benefit of any third party. In doing our work, we have relied on the data and information cited in this letter. This information includes the House Bills attached to your letter. If there are changes to these bills, the comments here may no longer be appropriate.

We discuss each of the bills separately below. In general, these mandates will introduce some added administrative costs. These include updating contracts and other policyholder communications, changes in claims processing systems to allow payment of these claims, and additional agent or broker commissions where they apply. However, we would not expect any extraordinary administrative expenses due to these mandates.

Bill No. 1247 – Outpatient Prescription Drugs and Devices

This bill would provide coverage for certain outpatient prescription drugs and devices, including osteoporosis treatment and therapy (including hormone replacement therapy), contraceptives, and infertility therapy. We will address each of these coverages individually.

In general, we do not believe that mandating coverage for these particular drugs will materially impact the unit price that carriers pay for them. (However, there may be some impact on the rebates that drug companies sometimes pay, depending on the change in volume.)

Osteoporosis Treatment and Therapy (Including Hormone Replacement Therapy)

We researched the drugs used to treat this condition, primarily using the *Milliman Care Guidelines 8th Edition (CGs)*. The *CGs* describe the best practices for treating common conditions in a variety of care settings. The *CGs* are designed to assist physicians and other healthcare professionals in providing optimal care. They show what is currently being done by providers and hospitals across the United States, as supported by the latest research in risk and medical management.

According to the *CGs*, the following are the drugs most commonly used to treat osteoporosis:

- Calcium and Vitamin D: These drugs are generally available over the counter, and so may not be covered by the mandate. The typical price of these drugs ranges from $0.63 to $6.44 per month.

- Estrogens: The typical price of these drugs ranges from $7 to $33 per month, depending on the drug. Insurance carriers often pay something less than these prices for drugs—discounts in the range of 10 – 20% are common.

  According to the *CGs:* "Hormone replacement therapy (HRT) has been recommended for most postmenopausal women not only for its ability to preserve BMD but also for help with menopausal symptoms and for a presumed cardio-protective effect."(1) In a report on a related mandate, the Pennsylvania Health Care Cost Containment Council cites research by Katalinic showing that when estrogen is used for at least 10 years, the risk of heart attack is significantly reduced. (2)

  However, thinking about the appropriate use of these treatments has been changing in recent years. According to the *CGs:* "Recent studies have shown less encouraging data regarding advantages of hormone replacement therapy."(3) The *CGs* also indicate that: "Recent randomized controlled trials indicate that the cardio-protective effect of hormone replacement therapy is now a point of controversy. Data from some of the same trials also revealed no fracture protection with estrogens."(4)

  From the *CGs:* "A well-designed, recent study has supported prior work on the association of hormone replacement therapy (HRT) with an increased risk of breast

cancer. While estrogen alone increases risk, the combination of estrogen and progesterone appears to increase the risk even further." (5)

- Anti-Resorptive Drugs: These drugs serve as a protective coating for the bones and prevent disintegration. The typical price of these drugs ranges from $10 to $500 per month.

- Selective Estrogen Receptor Modulators: These are used as an alternative to estrogen replacement. The typical price ranges from $73 to $214 for a one month supply.

The impact of this mandate on the total cost of care is unknown because of the uncertainty regarding the appropriate use and the side effects of the treatment. If the medication truly increases the risk of cancer, both economic and social costs could increase. Whether or not these costs would be financially offset by the benefits of the treatment is currently unclear.

The extent to which mandating coverage for these drugs would impact their appropriate use in aggregate is highly dependent on the degree to which the benefits are already covered. Generally, insurance plans do provide coverage for these drugs, except where they are available on an "over the counter" basis. A survey of the top carriers in the state would help to ascertain the extent of existing coverage in North Dakota. Also, since most of these drugs are relatively inexpensive, insureds are more likely to be paying for them out-of-pocket than they might be for a more expensive drug. In that case, insuring them may not significantly increase their use.

We expect that even if this benefit was not previously covered, the mandate would have a relatively small impact on premium. This is due to the low cost and the low utilization of the drugs by the insured population. We prefer not to quantify this impact without additional research, which we would probably be able to complete within another week if you would like us to.

Contraceptives

According to the Milliman *Health Cost Guidelines (HCGs)*, oral contraceptives (the most common type of prescription contraceptives) make up about 4% of prescription drug costs, when covered. This is about 0.5% of total claim costs for a comprehensive major medical plan before cost sharing. The HCGs also indicate that, in a typical commercially insured population with coverage for contraceptives, there are 459 prescriptions filled for oral contraceptives per year per 1,000 insureds.

According to the *CGs*, the price for prescription oral contraceptives ranges from $33 to $45 per month. The typical price of Norplant, a single dose alternative which protects against pregnancy for up to five years, is slightly over $500 per dose.

The impact the mandate would have on appropriate use is a point of debate. Some sources say that because of the cost of contraceptives, some people either go without contraception or use less effective (but also less expensive) forms of contraception. Others contend that

the majority of those who would use contraceptives currently have access to them, and they would use them regardless of whether or not they are covered. In a report prepared by Milliman for the State of Texas, we estimated that 25% to 75% of gross healthcare costs for oral contraceptives will be recovered through reduced pregnancy and delivery costs. (6) These estimates may be somewhat different if adjusted to reflect the North Dakota population, although we did not have time to do this for this analysis.

Infertility

According to the CDC, 3% of women have ever used ovulation drugs, the most common form of treatment for infertility. Based on research we performed in developing our Milliman *Health Cost Guidelines*, the per member per month cost of infertility drugs and supplies ranges from $0.22 to $0.45. This would equate to less than 0.25% of premium for a comprehensive major medical plan covering a typical commercial population.

Of course, fertility treatment would presumably lead to an increase in other costs related to pregnancy and childbirth. We could probably quantify this increase given additional time.

Bill No. 1349 – Colorectal Cancer Screening

This bill mandates coverage for prostate-specific antigen (PSA) testing and for colorectal cancer screening. PSA testing is currently a mandate in North Dakota, and our analysis of this benefit appears in our report dated September 18, 2002.

This bill adds coverage for colorectal cancer screening and requires carriers to cover the cost of screenings for individuals who are fifty years of age or more who do not have personal or family history risk factors, and for individuals who are less than fifty years of age if they have personal or family history risk factors. This screening may include a fecal occult blood test, flexible sigmoidoscopy, double contrast barium enema, colonoscopy, or other procedure as determined appropriate by a medical provider.

The American Cancer Society estimates that in North Dakota there will be 300 new cases of colon and rectal cancer and 100 deaths due to these cancers in 2003. (7) The Agency for Healthcare Research and Quality of the US Department of Health and Human Services reports that colorectal cancer is the 4th most common cancer in the US and the 2nd leading cause of cancer death.

The American Cancer Society recommends the following screening schedule for men and women beginning at age 50:

- Annual fecal occult blood test and flexible sigmoidoscopy every five years, or
- A double-contrast barium enema every five years, or
- A colonoscopy every 10 years.

Therefore, we expect that this benefit would be used by a significant portion of the population.

According to information from the Centers for Disease Control and Prevention (CDC), the following costs are a typical range of rates for colorectal cancer screening tests.

- Flexible occult blood test (FOBT) - $10-$25
- Flexible Sigmoidoscopy - $150-$300
- Double contrast barium enema - $250-$500
- Colonoscopy - $800-$1,600 (8)

You should also be aware that there are potentially more expensive procedures that may be used for these screenings, such as nuclear magnetic resonance, although this is uncommon and not currently recommended by the CDC.

We estimated that this mandate might increase insurance premiums in the range of 0.1% to 0.3%, where coverage is not currently provided. In calculating this estimate, we used the mandate pricing model we developed last year for North Dakota, along with some relatively conservative assumptions regarding the compliance with the recommendations outlined above. In particular, we assumed that each year: (1) 25 percent of adults between the ages of 50 – 65 received a FOBT and (2) either 10% received a sigmoidoscopy or 5% received a colonoscopy. We have not included the cost of any office visits or other services that may be incurred along with the actual colorectal screening test. This compares to our estimates of 0.1% for PSA testing (including an office visit) and 0.5% for mammography testing in our September 2002 report.

The actual increase will depend on a number of factors, including the demographics of the covered population, out of pocket costs (such as deductibles, coinsurance, and copays), and the degree of compliance with screening recommendations. Also, costs may be higher the first year the mandate is in place, since many insureds may be behind schedule and may be incented to undergo screening after it becomes an insured benefit.

There could also be offsetting benefits related to the early detection and treatment of colorectal cancer. The state of Pennsylvania recently considered a similar mandate and issued a report in which the American Cancer Society is cited as reporting offsetting benefits. In particular, they report that a precancerous polyp can be removed during screening for about $1,100. They go on to say that if that polyp goes undetected and develops into stage four colorectal cancer, treatment costs can reach up to $58,000. They also stated that "the initial cost of treating rectal cancer that is detected early is about $5,700. This is approximately 75% less than the estimated $30,000 - $40,000 that it costs to initially treat rectal cancer that is detected further in its development." (9)

On the other hand, the FOBT is reported to have a significant rate of false positives, which would introduce added follow up costs. The follow up test is typically a colonoscopy. We are not able to quantify this cost without additional research.

Additional expenses to insureds may include health insurance cost sharing and time taken off work to go to the exam. On the other hand, insureds may realize some savings in disability and life insurance costs over the long run, if morbidity and mortality costs decline due to these screenings.

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This letter contains estimates of future experience, based on the assumptions described here. It is certain that actual experience will not conform exactly to the assumptions used in this analysis. If actual experience is different from the assumptions used in the calculations, the actual amounts will also deviate from the projected amounts.

John, I hope this letter is helpful to you as you consider these bills. If you have questions regarding this letter, or would like us to do additional analysis, please feel free to contact me at (952) 820-2481 or leigh.wachenheim@milliman.com.

Sincerely,

Leigh M. Wachenheim

Leigh M. Wachenheim, FSA, MAAA
Principal

cc: Jim Poolman, Insurance Commissioner

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