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2003 HOUSE HUMAN SERVICES

HB 1349

2003 HOUSE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. HB 1349

House Human Services Committee

☐ Conference Committee

Hearing Date January 21, 2003

Tape Number	Side A	Side B	Meter #
2	x		26.6 - 61.6
2		x	0.0 - 10.4
Committee Clerk Signature	Sharon Renfrew		

Rep. Sandvig appeared as prime sponsor and handed out a sheet on colorectal cancer.

Sparb Collins, (PERS) appeared in support with written testimony. and proposed an amendment.

Rep. Wentz appeared to share her own experience and not to speak either for or against the bill and gave a hand out on the comparative costs of cancer treatment.

Deborah Knuth, Dir. of American Cancer Society appeared in support with written testimony.

Dave Peske appeared for Douglas Bergland, MD in support with written testimony.

Rep. Porter had a question on sigmoidoscopy vs. colonscopy no options being written in the bill.

Penni Weston, ND Nurses Assoc. appeared in support with written testimony.

Rod St. Aubyn, BCBS appeared in opposition of the bill with written testimony also noting that if its medically indicated, these procedures are covered by insurance now.

Rep. Sandvig had questions on the statement that a colonscopy is the only test that will find colon cancer in certain areas and if the screening tests actually find the cancer or just indicate it was present. Also wondered why these 2 tests don't agree on time lines.

Dr. Paul Jondahl, Doctor of the day was asked to explain the test. The fecal occult screening just checks for blood, its a much cheaper test, but if you get a nose bleed and swallow a lot of blood, then it would turn positive. It does not tell you that there are cancerous cells there, just means you need to be evaluated.

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 Keogan		

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 1349

House Human Services Committee

☐ Conference Committee

Hearing Date February 5, 2003

Tape Number	Side A	Side B	Meter #
1		x	48.7 - 61.7
2	x		0.0 - 10.6
Committee Clerk Signature	Sharon Rayfield		

Minutes: Committee Work

Rep. Sandvig handed out amendments & moved them, second by Rep. Niemeier. Rep. Sandvig went through and explained what the amendments would do.

12 - 0 - 1 Amendment passed

Rep. Price noted that Section 54 is the PERS Plan.

Rep. Porter noted that #1 this still falls back to a mandate on a small business, #2 the best screening test available is already a covered service and if that screening test comes back positive then the physician can through medical necessity once again in assessment move up to the next levels of what they feel is necessary to treat the patient.

Rep. Sandvig noted that the fecal occult test doesn't detect cancer, but as Rep. Porter stated, it does indicate a warning for further testing which is covered.

Rep. Sandvig moved to add Sparb Collins amendment to appropriations second by Rep. Devlin.

Vote: 11 - 1 - 1 Amendment passed.

Rep. Niemeier moves a DO PASS as Double AMENDED & Refer to Appropriations, second by Rep. Amerman

3 - 9 - 1 Motion Failed

Rep. Devlin moved a DO NOT PASS as AMENDED, second by Rep. Pollert

Rep. Pollert stated that this in reference to Rep. Sandvig's statement about business, Thank God there are people in this room who want to take an entrepreneurial step and try to provide jobs for the State of North Dakota because if we actually would want to do it the way Sandvig would, we probably wouldn't have any economic development in the State.

Vote: 9 - 3 - 1 Rep. Porter to carry the bill.

FISCAL NOTE

Requested by Legislative Council
02/10/2003

Amendment to: HB 1349

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			$322,846	$720,410	$322,846	$720,410
Appropriations			$322,846	$299,800	$322,846	$299,800

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
			$132,400	$65,750	$82,100	$132,400	$65,750	$82,100

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

The PSA and fecal occult blood test screenings are already covered by the NDPERS benefit, so would not have an added cost to NDPERS.
The additional cost to NDPERS to cover the flexible sigmoidoscopy, colonoscopy, and double contrast barium enema as screenings is estimated at $3.20 per contract per month (spread over ALL contracts) for the 7-03/6-05 biennium. This assumes that the colonoscopy would be allowed once every 10 years, beginning at age 50, as recommended by the AMA. The flexible sigmoidoscopy and double contrast barium enema would be allowed once every 5 years, beginning at age 50, as recommended by the AMA.

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.*

The expenditures are the cost of the additional premium that will be necessary to pay for the new benefits proposed in this bill. The expenditures are for all state contracts.

   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 appropriation is the additional appropriation needed for the state agencies to pay the higher premium needed to support the proposed new benefits in this bill. The premium included in the Governors budget did not provide for this benefit. Higher Education is not included in the appropriation since they have a 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
01/16/2003

Bill/Resolution No.: HB 1349

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			$322,845	$720,410	$322,845	$720,410
Appropriations			$322,845	$299,800	$322,845	$299,800

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
			$132,400	$65,750	$82,100	$132,400	$65,750	$82,100

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

The PSA and fecal occult blood test screenings are already covered by the NDPERS benefit, so would not have an added cost to NDPERS.

The additional cost to NDPERS to cover the flexible sigmoidoscopy, colonoscopy, and double contrast barium enema as screenings is estimated at $3.20 per contract per month (spread over ALL contracts) for the 7-03/6-05 biennium. This assumes that the colonoscopy would be allowed once every 10 years, beginning at age 50, as recommended by the AMA. The flexible sigmoidoscopy and double contrast barium enema would be allowed once every 5 years, beginning at age 50, as recommended by the AMA.

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.*

The expenditures are the cost of the additional premium that will be necessary to pay for the new benefits proposed in this bill. The expenditures are for all state contracts.

   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 appropriation is the additional appropriation needed for the state agencies to pay the higher premium needed to support the proposed new benefits in this bill. The premium included in the Governors budget did not provide for this benefit. Higher Education is not included in the appropriation since they have a continuing appropriation.

Name:	Sparb Collins	**Agency:**	Public Employees Retirement System
Phone Number:	328-3901	**Date Prepared:**	01/20/2003

30504.0101
Title.

Prepared by the Legislative Council staff for
Representative Sandvig
January 24, 2003

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1349

Page 1, line 3, after the semicolon insert "and"

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

Page 1, line 5, remove "application"

Page 1, line 22, after the second underscored comma, insert "or" and remove ", or other procedure"

Page 2, remove lines 8 through 11

Renumber accordingly

30504.0102
Title.0200

Prepared by the Legislative Council staff for
House Human Services
February 6, 2003

VR
2/6/03
1 of 2

HOUSE AMENDMENTS TO HOUSE BILL NO. 1349 **HS 2-6-03**

Page 1, line 5, replace "application" with "an appropriation"

Page 1, line 22, after the second underscored comma insert "or" and remove ", or other procedure"

HOUSE AMENDMENTS TO HOUSE BILL NO. 1349 HS 2-6-03

Page 2, line 8, replace "**APPLICATION.** Notwithstanding any legislative measure approved by the" with "**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 health insurance premiums necessary to pay the screenings provided by section 1, for the biennium beginning July 1, 2003, and ending June 30, 2005, as follows:

DEPARTMENT	GENERAL FUND	SPECIAL FUNDS	TOTAL
Governor	$1,306		$1,306
Secretary of state	1,843		1,843
Office of management and budget	6,368	$2,695	9,063
Information technology department	2,794	14,793	17,587
State auditor	2,498	1,189	3,687
State treasurer	461		461
Attorney general	7,981	2,618	10,599
State tax commissioner	9,446		9,446
Office of administrative hearings		384	384
Legislative assembly	9,523		9,523
Legislative council	2,765		2,765
Judicial branch	24,933	27	24,960
Retirement and investment office		1,152	1,152
Public employees retirement system		1,997	1,997
Department of public instruction	1,958	4,340	6,298
North Dakota university system	1,273	109	1,382
State land department		1,306	1,306
Forest service	1,382		1,382
State library	1,920		1,920
School for the deaf	3,075	95	4,070
North Dakota vision services - school for the blind		2,150	2,150
State board for vocational and technical education	1,156	611	1,767
State department of health	7,004	15,037	22,041
Veterans home	7,219		7,219
Indian affairs commission	230		230
Department of veterans affairs	433	28	461
Children's services coordinating committee		77	77
Department of human services	118,397	40,886	159,283
Protection and advocacy project	1,235	608	1,843
Job service North Dakota	0	27,412	27,418
Insurance commissioner		2,918	2,918
Industrial commission	3,916	384	4,300
Labor commissioner	532	159	691
Public service commission	2,775	297	3,072
Aeronautics commission		384	384
Department of financial institutions		1,613	1,613
Securities commissioner	614		614
Bank of North Dakota		12,749	12,749
Housing finance agency		2,381	2,381
Mill and elevator association		8,832	8,832
Workers compensation bureau		16,358	16,358
Highway patrol	5,454	8,985	14,439
State radio	1,996	154	2,150
Division of emergency management	622	838	1,460
Department of corrections and rehabilitation	38,163	3,309	41,472
Adjutant general	2,258	5,729	7,987
Department of commerce	3,626	137	3,763
Department of agriculture	2,321	1,596	3,917
State seed department		1,843	1,843
Upper great plains transportation institute	227	1,923	2,150
Branch research centers	5,026	811	5,837
North Dakota state university	12,911	8,286	21,197

2 of 2

extension service	350	264	614
Northern crops institute	18,860	8,020	26,880
North Dakota state university main research center		230	230
Agronomy seed farm	3,614	457	4,071
State historical society	384		384
Council on the arts		10,291	10,291
Game and fish department	3,090	136	3,226
Parks and recreation department		6,067	6,067
State water commission		77,107	77,107
Department of transportation			
Total	$322,845	$299,772	$622,617"

Page 2, remove lines 9 through 11

Renumber accordingly

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

2003 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. HB 1349

House HUMAN SERVICES Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken DP as Amended

Motion Made By Rep. Niemeier Seconded By Amerman

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 A		
Rep. Gerald Uglem		✓			
Rep. Chet Pollert		✓			
Rep. Todd Porter		✓			
Rep. Gary Kreidt		✓			
Rep. Alon Wieland		✓			

Total (Yes) 3 No 9

Absent 1

Floor Assignment

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

Date: ~~January 21,~~ Feb 5 2003
Roll Call Vote #: 2

2003 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. HB 1349

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 Pollert

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 A		
Rep. Gerald Uglem	✓				
Rep. Chet Pollert	✓				
Rep. Todd Porter	✓				
Rep. Gary Kreidt	✓				
Rep. Alon Wieland	✓				

Total (Yes) 9 No 3

Absent 1

Floor Assignment Rep. Porter

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

REPORT OF STANDING COMMITTEE

HB 1349: Human Services Committee (Rep. Price, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO NOT PASS** (9 YEAS, 3 NAYS, 1 ABSENT AND NOT VOTING). HB 1349 was placed on the Sixth order on the calendar.

Page 1, line 5, replace "application" with "an appropriation"

Page 1, line 22, after the second underscored comma insert "or" and remove ", or other procedure"

Page 2, line 3, replace "**APPLICATION.** Notwithstanding any legislative measure approved by the" with "**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 health insurance premiums necessary to pay the screenings provided by section 1, for the biennium beginning July 1, 2003, and ending June 30, 2005, as follows:

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Mill and elevator association		8,832	8,832
Workers compensation bureau		16,358	16,358
Highway patrol	5,454	8,985	14,439
State radio	1,996	154	2,150
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research center			
Agronomy seed farm		230	230
State historical society	3,614	457	4,071
Council on the arts	384		384
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State water commission		6,067	6,067
Department of transportation		77,107	77,107
Total	$322,846	$299,772	$622,617"

Page 2, remove lines 9 through 11

Renumber accordingly

2003 TESTIMONY

HB 1349

COLORECTAL CANCER:

Colorectal cancer is the second leading cause of cancer related deaths in the United States.

In 1999, 380 North Dakota residents were diagnosed with colorectal cancer and 153 residents died of this disease.

Colorectal cancer is the THIRD most frequently diagnosed cancer in North Dakota.

In 1999 only 30 percent of North Dakota residents, age 50 and older had had either a flexible sigmoidoscopy or a colonoscopy in the past five years.

In 1999 only 17 percent of North Dakota residents, age 50 and older had had an occult blood test in the past year.

It is estimated that 148,300 new cases of colorectal cancer will be diagnosed and that 56,600 deaths will occur from this disease in the United States in 2002.

In the United States an individuals risk of developing colorectal cancer is nearly 6 percent, with 90 percent of the cases occurring after the age of 50.

The colorectal death rate decreased by 1.8 percent per year from 1992 t0 1998.

If colorectal cancer is detected early, the five year survival rate is nearly 90 percent. However, only 37 percent of the cancers are found at this stage.

The survival rate after colorectal cancer has metastasized is 8 percent.

Most colorectal cancers begin as polyps, however, over time, some polyps grow larger and become malignant.

As polyps grow they can bleed or obstruct the intestines.

ACS recommended screening:

Annual fecal occult blood test, plus
Flexible Sigmoidoscopy every five years.
A colonoscopy every ten years.
A digital rectal exam (DRE) can detect cancer of the rectum but not the colon.

Risk Factors include: (Approximately 15 to 20 % of colorectal cancers occur among people at increased risk.)

A strong family history of colorectal cancer or polyps.
Families with hereditary colorectal cancer syndromes.
A personal history of colorectal cancer or adenomatous polyps.
A personal history of chronic inflammatory bowel disease.

See your doctor if you have any of these warning signs:

Bleeding from the rectum,
Blood in your stool or in the toilet after you have a bowel movement,
A change in the shape of your stool,
Cramping pain in your lower stomach,
A feeling of discomfort or an urge to have a bowel movement when there is no need to have one.

TREATMENT:

SURGERY: If colon cancer is detected at an early stage, the patient can undergo a polypectomy (removal of the polyps containing cancer) or a local excision (removal of the cancer and small margin of tissue).

If the cancer is large or invades surrounding tissue or lymph nodes, the individual will most likely have a segmented resection (removal of the cancer, some colon tissue, and lymph nodes). A **colostomy** (an opening in the abdomen to allow the elimination of body wastes) is performed if the physician is unable to reconnect the parts of the colon after surgery.

Rectal cancers that have not reached advanced stages and are located near the anus can be treated with polypectomy or local excision. Local excision is used to remove invasive cancers, as well as some surrounding tissue by cutting through all the layers of the rectum.

RADIATION: Radiation therapy is used primarily to treat rectal rather than colon cancer. The goal of this treatment is to prevent metastatic disease caused by the rapid spread of cancer cells that are often missed during surgery.

CHEMOTHERAPY: Chemotherapy is administered to eradicate any remaining cancer cells and to prevent recurrent disease. Flurorouracil (5-FU) is the most common drug used to treat colorectal cancers, and is used in conjunction with medicines such as levamisole and leucovorin.

TESTIMONY OF SPARB COLLINS
ON HB 1349

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 1349, 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. Since this bill 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 $3.20 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 about $50.

HB 1349 requires that certain benefits be added to the PERS health plan. Specifically the benefits proposed relate to colorectal cancer screening. The PSA and fecal occult blood test screenings are already covered by the NDPERS benefit so would not have an added cost to NDPERS. The additional cost to NDPERS to cover the flexible sigmoidoscopy, colonoscopy, and double contrast barium enema as screenings is estimated at $3.20 per contract per month (spread over ALL contracts) for the 7-03/6-05 biennium. This assumes that the colonoscopy would be allowed once every 10 years, beginning at age 50, as recommended by the AMA. The flexible sigmoidoscopy and double contrast barium enema would be allowed once every 5 years, beginning at age 50, as recommended by the AMA. This also assumes that these screenings would be subject to copays and coinsurance.

We also are concerned about the open-ended statement at the end of section 2 (lines 22 and 23) of the bill, where it states "or other procedure as determined appropriate by a medical provider." It would be helpful for administration of the plan if this statement was more specific or deleted. If it was made more specific it could have an effect on the cost estimates.

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 1349

Page 1, line 4, remove "and"

Page 1, line 5, after "application" add "; and to provide an appropriation"

Page 2, after line 11, 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:

Department	General	Other
Office of the Governor	$1,305.60	$0.00
Office of the Secretary of State	$1,843.20	$0.00
Office of Management and Budget	$6,367.57	$2,694.83
Information Technology Department	$2,793.81	$14,793.39
Office of the State Auditor	$2,497.62	$1,188.78
Office of the State Treasurer	$460.80	$0.00
Office of the Attorney General	$7,980.81	$2,617.59
Office of the Sate Tax Commissioner	$9,446.40	$0.00
Office of Administrative Hearings	$0.00	$384.00
Legislative Assembly	$9,523.20	$0.00
Legislative Council	$2,764.80	$0.00
Judicial Branch	$24,932.86	$27.14
Retirement and Investment Office	$0.00	$1,152.00
Public Employees Retirement System	$0.00	$1,996.80
Department of Public Instruction	$1,957.81	$4,339.79
North Dakota University System	$1,273.29	$109.11
State Land Department	$0.00	$1,305.60
Forest Service	$1,382.40	$0.00
State Library	$1,920.00	$0.00
School for the Deaf	$3,975.25	$95.15
School for the Blind	$0.00	$2,150.40
State Board for Vocational and Technical Ed	$1,155.73	$610.67
North Dakota Department of Health	$7,004.33	$15,037.27
Veterans Home	$7,219.20	$0.00
Indian Affairs Commission	$230.40	$0.00
Department of Veterans Affairs	$432.73	$28.07
Childrens Services Coordinating Committee	$0.00	$76.80
Department of Human Services	$118,396.72	$40,886.48
Protection and Advocacy Project	$1,234.95	$608.25
Job Service North Dakota	$5.67	$27,411.93
Office of the Insurance Commissioner	$0.00	$2,918.40
Industrial Commission	$3,916.45	$384.35

Office of the Labor Commissioner	$532.48	$158.72
Public Service Commission	$2,775.16	$296.84
Aeronautics Commission	$0.00	$384.00
Department of Financial Institutions	$0.00	$1,612.80
Office of the Securities Commissioner	$614.40	$0.00
Bank of North Dakota	$0.00	$12,748.80
North Dakota Housing Finance Agency	$0.00	$2,380.80
North Dakota Mill & Elevator Association	$0.00	$8,832.00
Workers Compensation Bureau	$0.00	$16,358.40
Highway Patrol	$5,453.77	$8,984.63
State Radio	$1,996.06	$154.34
Division of Emergency Management	$621.70	$837.50
Department of Corrections and Rehabilitation	$38,163.04	$3,308.96
Adjutant General	$2,257.93	$5,729.27
Department of Commerce	$3,626.19	$137.01
Department of Agriculture	$2,321.08	$1,595.72
State Seed Department	$0.00	$1,843.20
Upper Great Plains Transportation Institute	$227.00	$1,923.40
Branch Research Centers	$5,026.06	$810.74
NDSU Extension Service	$12,910.75	$8,286.05
Northern Crops Institute	$350.12	$264.28
NDSU Main Research Center	$18,860.29	$8,019.71
Agronomy Seed Farm	$0.00	$230.40
State Historical Society	$3,613.57	$456.83
Council on the Arts	$384.00	$0.00
Game & Fish Department	$0.00	$10,291.20
Department of Parks & Recreation	$3,089.97	$135.63
State Water Commission	$0.00	$6,067.20
Department Of Transportation	$0.00	$77,107.20
Total	$322,845.17	$299,772.43

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NORTH DAKOTA HOUSE

STATE CAPITOL
600 EAST BOULEVARD
BISMARCK, ND 58505-0360

Speaker of the House

H.B. - 1349

HOUSE HUMAN SERVICES COMMITTEE

Testimony by **Representative Janet Wentz, House Speaker**

Fort Union Room, State Capitol
21 January, 2003

Comparative Costs of Cancer Treatment

Colonoscopy	$1,633.00
Surgery	$19,504.00
Chemo Treatment:	$7, 858.00
*At three week intervals consisting of 8-12 treatments.	($5,854.00-Oxaliplatin) ($1,166.00--Capecitabine)

Representative Janet Wentz

Testimony on HB 1349
House Human Services Committee
January 21, 2003

(Chairperson Price and members of the House Human Services Committee)

My name is Deborah Knuth, and I am the Area Director for the American Cancer Society. Traditionally the American Cancer Society supports cancer screening and we have been educating the public about the need for colorectal cancer screening. Therefore, I am asking for a do pass on House Bill 1349. At the very least I encourage a cost analysis study on the issue. I have distributed my testimony. If you have any questions, I would be happy to answer them. Thank you.

Colon Cancer Incidence

As of 1999 (the most recent year for which data is available), 153 North Dakotans out of 380 diagnosed died of colon cancer. This type of cancer is unfortunately not a rare one and in fact is the third most frequent type of cancer occurring in North Dakotans. What is most disturbing about these deaths is that they are, in many instances, preventable. Colon cancer patients enjoy a **90 percent five-year survival rate if detected early.** In fact, colon cancer can be prevented entirely if pre-cancerous polyps are detected early through screening. If the cancer has metastasized, the survival rate plummets to a grim **8 percent survival rate.** Our survival rate, while greater than 8 percent is still unacceptable at 40 percent.

Preventative Measures

- Only 30 percent of North Dakotans age fifty and older have had either a flexible sigmoidoscopy or a colonoscopy within the past five years. These are two widely accepted screening tools available to detect colon cancer and pre-cancerous polyps. While insurance coverage of these screening tools will not result in 100 percent of adults age fifty and above in getting these screenings, it would certainly increase the small percentage that currently get screened.

Financial and Human Cost of Colon Cancer Screening

The American Cancer Society has participated in a study, known as the Lewin Study, that seeks to establish costs and results if health insurance companies provide screening coverage for colon cancer. As an organization that prides itself on establishing policy positions based on factual evidence and careful

research, we believe this study accurately reflects the cost and benefits of providing screening coverage.

The study applies the following assumptions:

- Screening for colon cancer begins at age fifty.
- Within a health plan, 20 percent of members are receiving a flexible sigmoidoscopy and 10 percent are receiving a colonoscopy. This is in line with ACS screening guidelines that a flex sig is necessary once every five years and a colonoscopy is necessary once every ten years.
- Cost estimates are derived from current national private insurance costs and Medicare fee schedule. These cost estimates included physician visits.
- At age sixty-five, Medicare assumes 80 percent of these costs.
- All screening methods are included as if they are new benefits in health plans.
- The study reflects annual membership changes.

Short-term screening costs

Screening Tool	*Cost per member per year*	*Cost per month*
Fecal Occult Blood Test (FOBT)	$5.70	$.47
Flexible Sigmoidoscopy	$7.92	$.66
Colonoscopy	$6.64	$.55

If a plan already covers FOBT and adds colonoscopy the cost is only $.08 more per member per month.

Colonoscopy cost $.11 less than the combined screenings of FOBT and flexible sigmoidoscopy. The reasons for this are many:

1. Colonoscopy only needs to be completed once every ten years
2. Polyps or cancer can be removed during screening
3. Colonoscopies prevent more cancers and save more lives, providing savings in treatment and costs.

* The cost of colonoscopy is significantly lower than mammography, yet we have recognized the importance and necessity of requiring insurance coverage of mammography. The cost of mammography is $8.99 per member, per year or $.75 per member per month.

The financial cost of colon cancer

Initial Cancer Treatment Costs	Continuous Cancer Treatment Costs
Stage 1 - $15,200	Stage 1 - $1,200
Stage 2 - $19,800	Stage 2 - $1,200

Stage 3 - $22,200 Stage 3 - $2,200

Terminal Cancer Treatment Costs

Stage 1 - $11,200
Stage 2 - $13,200
Stage 3 - $17,900

The life cost of colon cancer

According to the study, without any type of screening 2,605 lives would be lost. If FOBT is utilized, this number decreases to 2,179. With flexible sigmoidoscopy, it further decreases to 1,999. Clearly colonoscopy saves the most lives by reducing the mortality rate to 1,803 for a difference of 802 lives saved.

By providing this coverage, insurance companies will save many lives at a minimal cost. A side benefit to this result is that requiring this type of coverage ensures a healthier pool of members, ultimately driving down costs.

We strongly urge that insurance companies provide testing and colorectal cancer screening benefits.

House Human Services Committee
January 21, 2003

The ND Chapter of the American College of Surgeons wishes to indicate support for House Bill 1349, screening for colorectal cancer.

Douglas Berglund, MD, Governor of the ND Chapter, American College of Surgeons.

Medical Content Reviewed by the Faculty of the Harvard Medical School

Colorectal Cancer

- What Is It?
- Symptoms
- Diagnosis
- Expected Duration
- Prevention
- Treatment
- When To Call A Professional
- Prognosis
- Additional Info

What Is It?

Colorectal cancer is a malignant tumor of the colon, rectum or both. Together the colon and rectum make up the large intestine (large bowel). It carries the remnants of digested food from the small intestine and eliminates them as waste through the anus. When cells lining the colon and rectum begin to grow abnormally and out of control, a tumor develops. Colorectal tumors begin as polyps (small growths) on the inside of the large bowel. Polyps that aren't removed eventually can become cancerous, penetrate through the wall of the colon or rectum and spread to other areas.

Colorectal cancer is a common type of cancer in the United States. The American Cancer Society estimates that 148,300 new cases of colorectal cancer will be diagnosed in 2002, and about 56,600 people in the United States will die of this disease. It is the second most common cause of cancer-related deaths in the country. Rates of colorectal cancer increase with increasing age.

Risk Factors

Factors that increase the risk of developing colorectal cancer include:

- **Family history** — Heredity may play a role in up to 10 percent of all cases of colorectal cancer. Genetic defects have been linked to a number of cancer syndromes that run in families and make family members more likely to develop polyps and colorectal cancer.
- **A personal history of the disease** increases the risk of colorectal cancer.
- **A personal history of adenomatous polyps** also increases the risk.
- **Inflammatory bowel disease (chronic ulcerative colitis, Crohn's disease)** — The longer and more severely the colon is inflamed, the greater the risk of cancer.
- **Poor diet** — Diets low in fiber and high in fat, especially saturated fat, increase the risk of colorectal cancer.
- **A sedentary lifestyle** — Among people who exercise regularly, the risk of colon cancer is reduced by half. Even regular brisk walking may reduce a person's risk of developing colon cancer.
- **Race and ethnicity** — Different racial and ethnic groups in the United States have very different rates of colorectal cancer. Incidence is highest among Alaska natives and lowest among Hispanics and Filipinos. Whites and African-Americans fall mid-range.

ymptoms

Precancerous polyps and early colorectal cancer generally don't cause symptoms. In part, this is why regular screening tests are important for detecting precancerous polyps and colon cancer at an early stage. More advanced cancer can cause any of the following symptoms:

- A change in bowel habits
- Diarrhea or constipation
- Blood in the stool (bright red, black or very dark)
- Narrowed stools (about the thickness of a pencil)
- Bloating, fullness or stomach cramps
- Frequent gas pains
- A feeling that the bowel does not empty completely
- Weight loss without dieting
- Continuing fatigue

Diagnosis

Colorectal cancer usually is diagnosed by a sigmoidoscopy or colonoscopy. These tests may find a malignant polyp or mass in the colon or rectum. Along with a barium enema, these tests provide information about the size and location of the cancer. Sometimes, if the cancer has spread outside the colon or rectum, a biopsy from that area confirms the diagnosis of colorectal cancer.

Other tests also may be needed:

- An abdominal computed tomography (CT) scan can provide further information.
- An endorectal ultrasound scan can be useful with cancer of the rectum.
- A complete physical examination and a chest X-ray will be performed after the cancer is diagnosed to see if it has spread.
- Blood tests will evaluate liver function and measure levels of carcinoembryonic antigen. This substance is sometimes higher than normal in people with colorectal cancer.

Expected Duration

Without treatment, colon cancer will continue to grow.

Prevention

The best defense against colorectal cancer is regular screening. Screening tests are designed to find benign polyps (precancerous growths) that can be removed before they become malignant and catch cancer at an early stage when it is easier to cure. The American Cancer Society recommends that all adults begin screening for colorectal cancer at age 50. People at higher risk (see Risk Factors) should begin screening earlier. Recommended screening methods include:

- **Digital rectal examination** — Beginning at age 40, then yearly after 50. Should not be used as the sole screening method.
- **Fecal occult blood test** — Annually beginning at age 50
- **Sigmoidoscopy** — Every five years beginning at age 50, unless you have a colonoscopy
- **Colonoscopy** — As a routine screening test every 10 years, beginning at age 50, unless you have a screening sigmoidoscopy every five years
- **Double-contrast barium enema** — Not the preferred method of routine screening, but can be performed instead of colonoscopy or in addition to sigmoidoscopy every five years

In addition to these screening tests, other methods can reduce a person's risk of developing colon cancer. Daily exercise and a diet low in fats, especially saturated fats, and high in fruits, vegetables and whole-grain foods can lower your risk of colorectal cancer. Also, some scientific studies have suggested that

aspirin along with some vitamins and minerals may reduce a person's risk of colon cancer. These should be discussed with your doctor to see if they are appropriate for you.

Treatment

Surgery is the primary method of treatment for colorectal cancer. The extent of surgery and the need for follow-up treatment (with chemotherapy or radiation) depends on the stage of the disease and whether it is in the colon or rectum.

There are three slightly different systems for staging colon cancer: Dukes, Astler-Coller and AJC/TNM. Following are the stages in the AJC/TNM system and recommendations for treatment in addition to surgery.

- **Stage 0** — Cancer is confined to the inner layer of the colon or the rectal lining. No treatment is recommended after surgery or polypectomy.
- **Stage I** — Cancer has grown through the inner rectal wall or the inner lining of the colon and underlying layers, but has not penetrated the colon wall. Usually no treatment is recommended after surgery.
- **Stage II** — Cancer has grown entirely through the colon or rectal wall, but hasn't spread to nearby lymph nodes. Chemotherapy may be done after surgery in some cases of colon cancer. For rectal cancer, chemotherapy and radiation can be done before or after surgery.
- **Stage III** — Cancer has spread to nearby lymph nodes but not to other parts of the body. For colon cancer, chemotherapy typically is recommended after surgery. For rectal cancer, chemotherapy and radiation usually are given either before or after surgery.
- **Stage IV** — Cancer has spread to distant organs, most commonly the liver or lungs. Treatment after surgery consists of chemotherapy, radiation therapy or both to relieve symptoms of advanced cancer and, in rectal cancer, to prevent blockage of the rectum. Occasionally, the metastasis can be removed surgically.

For colon cancer, surgery removes the malignant area of the colon with some surrounding normal tissue and nearby lymph nodes. The severed ends of the colon are reconnected so that the colon can function normally. Occasionally, very early cancers can be removed through colonoscopy. Colon cancer surgery usually does not require a colostomy or bag, unless performed temporarily in emergency surgery. Recuperation time varies depending on several factors, including the person's age and general health, and the extent of the surgery.

For rectal cancer, treatment often combines surgery with chemoradiation (chemotherapy and radiation), depending on the stage of the disease. Chemoradiation can be given before or after surgery.

Surgical procedures used for rectal cancer, depending on the location and stage of the cancer, include:

- **Polypectomy** — This procedure removes polyps containing stage 0 tumors.
- **Local excision** — This procedure removes superficial cancers and some nearby tissue from the rectum's inner layer, often working through the anal canal.
- **Low anterior resection** — This procedure is used for most rectal cancers, except when the tumor is very close of the anal sphincter. The colon and rectum are reconnected so that the anus is spared.
- **Abdominoperineal resection** — This surgery treats cancer in the lowest part of the rectum. Once the malignant area is removed, a colostomy is performed to allow for drainage of wastes through an opening in the abdominal wall.

- **Pelvic exenteration** — This surgery removes the rectum, bladder, prostate, uterus and other nearby organs if cancer has spread to them. A colostomy and drainage for urine are needed. This type of aggressive surgery is rarely needed.

When To Call A Professional

Visit a doctor for regular screenings according to the guidelines. Also, see your doctor if you have any of the signs or symptoms of colorectal cancer.

Prognosis

The prognosis depends on the stage of the disease. The five-year survival rates range from near 100 percent for stage 0 disease to about 5 percent for stage IV disease.

Additional Info

American Cancer Society (ACS)
1599 Clifton Rd., NE
Atlanta, GA 30329-4251
Toll-Free: (800) 227-2345
http://www.cancer.org/

Cancer Research Institute
681 Fifth Ave.
New York, NY 10022-4209
Phone: (212) 688-7515
Fax: (212) 832-9376
http://www.cancerresearch.org/

Centers for Disease Control and Prevention (CDC)
1600 Clifton Rd., NE
Atlanta, GA 30333
Phone: (404) 639-3534
Toll-Free: (800) 311-3435
http://www.cdc.gov/

National Cancer Institute (NCI)
Building 31
Room 10A03
31 Center Dr., MSC 2580
Bethesda, MD 20892-2580
Phone: (301) 435-3848
Toll-Free: (800) 422-6237
http://www.nci.nih.gov/

National Comprehensive Cancer Network
50 Huntingdon Pike
Suite 200
Rockledge PA 19046
Phone: (215) 728-4788

HB 1349

39266

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.

HB 1349
NORTH DAKOTA NURSES ASSOCIATION TESTIMONY

Chairman Price and members of the House Human Services Committee. My name is Penni Weston and I am a Registered Nurse and the Vice President of the North Dakota Nurses Association. I appear before you today on their behalf to offer testimony in support of HB 1349.

While I know there is concern about the cost of mandated health benefits, this benefit offers a means to try and control costs by using early detection and prevention as a means to prevent costly treatment for advanced disease.

According to the American Cancer Society 2002 facts and figures, colorectal cancer strikes men and women with almost equal frequency and surpasses both breast and prostate cancer in mortality. Colorectal cancer is second only to lung cancer in number of cancer-related deaths in the United States. More than 90 percent of cases of the disease occur in people over the age of 50.

During previous legislative sessions, you have supported mandatory coverage for breast and prostate cancer screening tests and I hope you will give favorable consideration to this benefit as well. The screening methods are relatively simple and can be completed in the physician office. Sadly enough, even if the benefit is covered by insurance, there will be a considerable number of individuals who will choose not to have this screening exam done. This is a sad statement when we know that colorectal cancer can be prevented by early detection.

Thank you for the opportunity to testify and I hope you will recommend a DO PASS on HB 1349.

Testimony on HB 1349
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 asked for one of our Medical Directors, Dr. Jon Rice to attend today, but because of other conflicts, he was unable to attend. He has provided me with information to present to your committee. I appear before you today in opposition to HB 1349, 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. Much of my testimony on HB 1247 could apply here, so I will avoid repeating myself.

I recently spoke to a legislator who expressed a concern about a constituent who had reached his "Lifetime Maximum" for his policy. This legislator expressed concern that insurance coverage should be for catastrophic events and now when his constituent has a serious ailment, he has already reached that "Lifetime Maximum". This bill, if passed, is just one of many examples which could contribute to that constituent's problem. Every new mandate simply increases costs and the "Lifetime Maximum" meter continues to tick away.

While no one will argue that Colorectal Cancer Screening is beneficial, once again this mandate will take away choices for our members and employer groups. We currently offer plans with a Preventive Screening Service. However, the screening is limited based on medical policies. For example, the US Preventative Services Task Force can't at this time justify the general use of colonoscopy for screening purposes. In fact in their report, they state that "*It is unclear whether the potential benefits of colonoscopy compared with other screening appproaches are large enough to justify the added risks and incconvenience of colonoscopy for all patients.*" Screening using the Fecal Occult Blood Test has been approved. The USPSTF supports this in the statement that "*The USPSTF found good evidence that periodic fecal occult blood testing (FOBT) reduces mortality from colorectal cancer and fair evidence that sigmoidoscopy alone or in combination with FOBT reduces mortality.*" If the FOBT or other medical conditions show some indications, sigmoidoscopy or colonoscopy procedures may be called for and are paid by the benefit plan. However, this bill appears to preclude any medical policies and leave open the possibility of mandating payment for any new procedure, which could be considered investigational or experimental and is unlikely to have cost benefit analysis available. On lines 21-23, it clearly states that any screening procedure must be paid "as determined appropriate by a medical provider." The USPSTF has indicated that screening strategy should be based on patient preferences, medical contraindications, patient adherence, and resources for testing and follow-up. We feel that this is better accomplished through medical policies based on current medical research and effectiveness than a legislative mandate that is unable to address evolving public health information.

For the education of the committee we looked at current reimbursement for these procedures in the hospital outpatient setting and office:

	OP	Office
FOB testing	$ 7.20	$ 5.90
Barium Enema	$ 232.30	$ 177.50
Sigmoidoscopy	$ 256.30	$ 144.10
Colonoscopy	$ 714.40	$ 624.00

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

- Exactly who is a "medical provider"? Is that limited based on their scope of practice?
- Could a provider determine an annual colonoscopy is appropriate even though the USPSTF recommends the procedure once every 10 years?
- Can a provider require payment for DNA testing of the stools or Capsule Endoscopy even though there are no studies showing their value?
- Can any limits be placed within a policy, i.e. Colonoscopies no more that once every 10 years for screening?
- Is it good public policy for the legislature to mandate testing and procedures about, which there is confusion in the medical community about how best to proceed?

There are many more questions that could be posed. There are current limited screening services available for the PERS plan. This bill greatly broadens that benefit and will definitely increase the cost of the PERS Plan. I'm sure you have already heard that due to increased utilization and other cost factors, the PERS plan will increase about 26% over the next two-year period. There is still about a $10 difference between the Governors Budget and what the bid for the product is at this time. If this bill passes, that bid price will definitely increase.

In closing, like I said in my testimony against HB 1247, 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 also limit their choices for insurance products. We urge you to consider the consequences of this bill and give HB 1349 a Do Not Pass.

"Gary or Earleen Friez" <bigwhite@pop.ototel.com>

To: "Rep. Sally Sandvig" <ssandvig@state.nd.us>
cc:
Subject: HB1349

01/22/2003 10:08 AM

Rep. Sandvig,

Read in the Bismarck Tribune this morning of HB1349. Thank you for sponsoring such legislation.

In previous sessions, I have contacted you in regard to child care legislation. After doing child care for 26 1/2 years, I had to give up that profession in the spring of 2001 because of colon cancer surgery and follow up radiation and chemo. The prognosis now is good, but I do not have the stamina to put in the long hours required of a licensed home based child care provider. I work part time as the sec/treas of the Community Promotions Office in Hettinger which serves the Hettinger Area Chamber of Commerce, Adams County Economic Development Corporation, and Dakota Buttes Visitor's Council.

I routinely had fecal occult blood tests during clinic visits which showed nothing. To be more effective, this test should be taken for 3 days one day apart because colon cancers may bleed from time to time rather than consistently. However that is not how the test is done in clinic situations rather is just done the one time rather than three. It was bleeding daily which got me to the clinic. I had surgery within 10 days and by that time the cancerous polyp has healed over and was no longer bleeding.

Other tests for detecting colon cancer include: proctoscopy which checks only the rectum which is the lower 8 inches of the intestinal tract, flexible sigmoidoscopy which checks the lower large intestine, air contrast barium enema which can miss smaller polyps, and colonscopy which checks the entire large bowel and can also allow surgical removal of detected polyps at the same time.

Because colonscopy is the only procedure which checks the entire colon, since it is a proven fact that the failure rate of the standard fecal occult blood test is high, and since discovery of polyps often leads to a colonscopy being done in additional to the origional test, I strongly support HB1349 which would require insurance companies to cover the cost of a colonscopy.

I am giving Rep. Sandvig permission to use this as testimony in support of HB1349.

Earleen Friez
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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.

❖❖❖

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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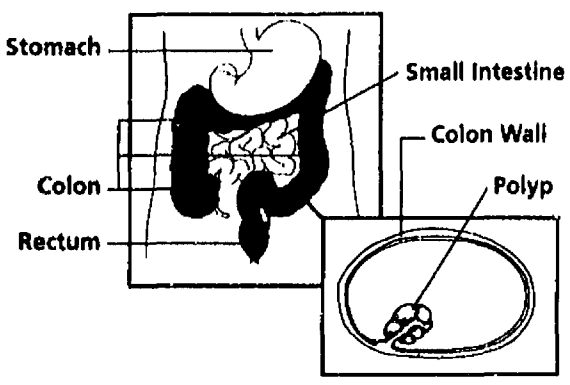
(9) *Mandated Benefits Review by the Pennsylvania Health Care Cost Containment Council: Senate Bill 636: Colorectal Cancer Screening Mandate*, The Pennsylvania Health Care Cost Containment Council, 2002

Get the polyp early and stop colon cancer before it starts!

Colon cancer almost always starts with a polyp. Get the polyp early and stop colon cancer before it starts. That's for both men and women.

What's a polyp?

Colon polyps are small growths on the lining of the colon or rectum, parts of the digestive tract.



How important is testing?

Testing can save lives by finding polyps before they become cancerous. If pre-cancerous polyps are removed, colon cancer can be prevented. And if this disease is found and treated at an early stage, the five-year survival rate is 90 percent.

How to Stop Polyps - Before They Go Bad

1 Know your risk

Personal risk for colon cancer varies. Can you answer yes to any of the following questions?

- Are you 50 or older?
- Are you of African American or Ashkenazi Jewish heritage?
- Has a doctor ever told you that you have inflammatory bowel disease, ulcerative colitis, or Crohn's disease?
- Has one of your parents or your brother, sister, or child had colon cancer or colon polyps?
- Do you smoke or use other tobacco products?
- Are you physically inactive - not getting regular exercise?
- Do you often eat red meat?

If you answered yes to any of these questions, you are at increased risk for colon cancer.

(over)

2 Talk with your doctor

Your physician can help you make an informed decision about the best testing method for you.

3 Get tested

The American Cancer Society recommends one of these five testing options for all people beginning at age 50.

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

For more information about colon cancer and how you can prevent it or stop it early, contact your American Cancer Society. If you or someone you love has been touched by this disease, we can help.

1.800.ACS.2345
www.cancer.org

Hope.Progress.Answers.

American Cancer Society

colon cancer.
get the test.
get the polyp.
get the cure.

American Cancer Society