MICROFILM DIVIDER

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

ROLL NUMBER

DESCRIPTION

2233

2005 SENATE HUMAN SERVICES

SB 2233

2005 SENATE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. SB 2233

Senate Human Services Committee

❑ Conference Committee

Hearing Date February 1, 2005

Tape Number	Side A	Side B	Meter #
1	x		2110-end
1		x	00-0870
3	x		1640-1750
Committee Clerk Signature	Cathy Minard		

Minutes:

Chairman Lee opened the hearing on SB 2233. All members were present.

Senator Dennis Bercier, District 9 introduced SB 2233 This bill is important to him because of the number of friends and relatives with diabetes and these people were not afforded the training they should have had. There is a problem with diabetes, the cost and education. This is a disease that doesn't go away. The cost of this on a premium is minimal compared to the cost of diabetes that is out of control. North Dakota is a tough sell, its hard to get patients the equipment they need, like the pump. There is a diabetes epidemic in our country.

Sen. Tim Mathern, District 11, Fargo

See written testimony (Attachment 1)

Laura Thelander, Advocacy Director, American Diabetes Association

See written testimony (Attachment 2)

Mark Zander, Has type 2 diabetes. He ignored the disease for some time but recently started his blood sugar and his numbers were very high. After contacting his doctor, he was sent to a dietitian which has helped him tremendously.

Sandy Wheeler, a diabetic who takes her blood sugar level four to five times per day along with giving herself insulin shots. She described all the equipment she uses each day which is covered by Medicaid, but if she were to get off of Medicaid she wouldn't be able to get health insurance and wouldn't be able to afford it otherwise.

Kris Blees, Licensed registered dietitian.

See written testimony (Attachment 3)

Sen. Dever: Do you have a lot of patients that have a problem with insurance or are not covered.

Blees: We do run into that a little, but we are fortunate in our state that insurance covers our services. Diabetes educators don't have the insurance that we do.

Janelle Johnson, Medcenter One Health Systems

See attached testimony (Attachment 4)

A copy of proposed amendments for SB 2233 was distributed. The lines they had a problem with have an asterisk by them. (Attachment 5)

Donna Amundson, Certified Diabetes Educator from Medcenter One Health Systems,

See attached testimony (Attachment 6)

Chairman Lee mentioned the fiscal note on the bill.

<u>Neutral Testimony</u>

Sparb Collins, Executive Director of the North Dakota Employees Retirement System.

See attached testimony (Attachment 7 contains a proposed amendment)

Opposition Testimony

Rod St. Aubyn, Blue Cross Blue Shield

See written testimony (Attachment 8)

He reminded the committee to keep in mind that state mandates only apply to group plans, not self-insured or individual plans which account for 50% of our clients.

St. Aubyn: In 54-03-28 in the Century Code, the language will need to be amended to conform to the new mandate review process. You saw that before in the colorectal bill where it applies to PERS has to have an expiration date and submit a bill into the next legislative session to have it incorporated into all benefit plans. I don't know why this bill was drafted by the council in this format, but by law it does have to change.

If you amend this bill to change things to it, it has to go to the employee benefit committee, which is very frustrating but has to be done. As far as case management, it is not considered in this bill. We do case management internally to some degree. At one time we tried a program to incentivize the consumer to get them in for follow-up checks. We are looking at other ways to handle disease management with diseases like asthma, diabetes, congestive heart failure and others. As it relates to PERS, there's nothing in our plan, so that would have to be recalculated in terms of the fiscal note.

Chairman Lee: Mr. Collins, how does coverage for PERS compare to what Mr. St. Aubyn has just reviewed. Is there a significant difference in benefits or would yours be pretty much what he was talking about.

Collins: Our benefits are basically the same as theirs now.

David Straley, Greater North Dakota Chamber of Commerce, representing a coalition of associations.

See attached testimony (Attachment 9)

There was no further testimony on SB 2233

Chairman Lee closed the public hearing on SB 2233.

Senator Brown moved DO NOT PASS on SB 2233, seconded by Senator Dever

Vote: 4 yeas, 1 nay, 0 absent Carrier: Senator Brown

Chairman Lee closed the discussion on SB 2233

FISCAL NOTE

Requested by Legislative Council
01/18/2005

Bill/Resolution No.: SB 2233

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.*

	2003-2005 Biennium		2005-2007 Biennium		2007-2009 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues						
Expenditures			$17,913	$47,617	$17,913	$47,617
Appropriations			$17,913	$47,617	$17,913	$47,617

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

2003-2005 Biennium			2005-2007 Biennium			2007-2009 Biennium		
Counties	Cities	School Districts	Counties	Cities	School Districts	Counties	Cities	School Districts
			$8,227	$4,334	$5,433	$8,227	$4,334	$5,433

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

The estimated additional cost in premium to NDPERS to cover this bill will be $0.20 per contract per month for the 7-1-05/6-30-07 biennium. NDPERS currently covers diabetic services, but this additional cost is to change the current benefits to the SB 2233 benefits. This provides for $250 per individual per contract year for outpatient self-management and education, including medical nutrition therapy, for the management of diabetes. It also provides for all medically appropriate and necessary equipment and supplies used in the management and treatment of diabetes, including physician prescribed equipment and supplies; syringes; injection aids; devices for self-monitoring of glucose levels, including devices for the visually impaired; test strips; visual reading and urine test strips; one insulin pump for each policy or contract year; accessories to insulin pumps; and glucagon emergency kits. This assumes that all of these diabetic services would be subject to regular contract benefits.

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 additional premium expenses to pay for the enhanced benfit proposed in this bill

   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 additional appropriations necessary to pay the higher premiums for the enchanced benefit proposed in this bill

Name:	Sparb Collins	**Agency:**	PERS

Phone Number:	328-3901	Date Prepared:	01/23/2005

50006.0101
Title.

Prepared by the Legislative Council staff for
Senate Human Services
January 21, 2005

PROPOSED AMENDMENTS TO SENATE BILL NO. 2233

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to create and enact a new section to chapter 54-52.1 of the North Dakota Century Code, relating to public employees retirement system health insurance coverage of diabetes services; and to provide an expiration date.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. A new section to chapter 54-52.1 of the North Dakota Century Code is created and enacted as follows:

Insurance to cover certain diabetes services.

1. For all contracts or plans for health insurance which become effective after June 30, 2005, and which do not extend past June 30, 2007, the board shall provide medical benefits coverage under a contract for insurance pursuant to section 54-52.1-04 or under a self-insurance plan pursuant to section 54-52.1-04.2 for outpatient self-management training and education for the treatment of diabetes and for diabetic equipment and supplies.

2. Required coverage under this section must include:

   a. Outpatient self-management training and education, including medical nutrition therapy, for the management of diabetes. The training and education must be provided by a licensed, registered, or certified health care professional in a manner consistent with the national standards for diabetes self-management education established by the American diabetes association. Notwithstanding subsection 3, this coverage must provide no less than two hundred fifty dollars of benefit per individual, per policy or contract year, for outpatient self-management training and education for the treatment of diabetes.

   b. All medically appropriate and necessary equipment and supplies used in the management and treatment of diabetes, including physician-prescribed equipment and supplies; syringes; injection aids; devices for self-monitoring of glucose levels, including devices for the visually impaired; test strips; visual reading and urine test strips; one insulin pump for each policy or contract year; accessories to insulin pumps; and glucagon emergency kits.

3. Coverage required under this section may not be subject to coinsurance, copayment, or deductible provisions that exceed the applicable hospital, medical expense, medical equipment, or prescription drug benefits under the policy or contract. Coverage under this section applies to an individual with gestational, type I, or type II diabetes.

SECTION 2. PUBLIC EMPLOYEES RETIREMENT SYSTEM - DIABETES SERVICES HEALTH MANDATE DIRECTIVE. Pursuant to section 54-03-28, the public employees retirement system shall prepare and request introduction of a bill to the sixtieth legislative assembly to repeal the expiration date of section 1 of this Act and to extend the diabetes services coverage to apply to all group and individual accident and health insurance policies. The public employees retirement system shall append to the bill a report regarding the effect of the diabetes services coverage requirement on the

system's health insurance programs; information on the utilization and costs relating to the coverage; and a recommendation on whether the coverage should continue.

SECTION 3. EXPIRATION DATE. Section 1 of this Act is effective through July 31, 2007, and after that date is ineffective."

Renumber accordingly

Date: 2-1-05
Roll Call Vote #: 1

2005 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2233

Senate **Human Services** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken DO NOT PASS

Motion Made By Sen. Seconded By Sen. Dever

Senators	Yes	No	Senators	Yes	No
Sen. Judy Lee - Chairman	✓		Sen. John Warner		✓
Sen. Dick Dever - Vice Chairman	✓				
Sen. Richard Brown	✓				
Sen. Stanley Lyson	✓				

Total (Yes) 4 No 1

Absent Ø

Floor Assignment Sen. Brown

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

REPORT OF STANDING COMMITTEE

SB 2233: Human Services Committee (Sen. J. Lee, Chairman) recommends **DO NOT PASS** (4 YEAS, 1 NAY, 0 ABSENT AND NOT VOTING). SB 2233 was placed on the Eleventh order on the calendar.

2005 TESTIMONY

SB 2233

Attachment 1

Senate Human Services Committee Testimony

Senate Bill 2233, February 1, 2005

Chairman Lee and members of the Senate Human Services Committee. My name is Tim Mathern, Senator from District 11 in Fargo.

I was contacted by a medical student a year ago on this issue. I have also served on the Council of State Government Heath Care Task Force which has studied this issue of proper insurance coverage for diabetes care.

Considering the other testimony you will receive, I will be brief.

I see Senate Bill 2233 as assuring proper coverage for persons who suffer from diabetes, and also making sure our health care costs, whether as insurance carriers, taxpayers, or contributors to non profit organizations are kept as low as possible.

Madam Chairman, I ask for your support of SB 2233. Thank you.

Attachment 2

American Diabetes Association.
Cure • Care • Commitment®

Mission
to prevent and cure diabetes and to improve the lives of all people affected by diabetes.

Dear Senator Judy Lee,

SB 2233 will require that individual and group state-regulated health insurance policies provide coverage for diabetes equipment and supplies and for diabetes education for self-management.

Since diabetes is a disease that is largely self-managed, in order to stay healthy a person with diabetes needs access to the proper supplies such as test strips, meters and insulin. But people with diabetes must also be trained on how to properly use these supplies in conjunction with diet and exercise to best manage their condition.

- **Both the devastation of the disease that results from poorly controlled blood sugar levels and the cost to society can be reduced.** SB 2233 moves in that direction. Two studies, the Diabetes Control and Complication Trial and the United Kingdom Prospective Study demonstrated that better control results in fewer of the complications. In fact, the DCCT showed tight control reducing blindness by 60%, kidney disease by 56% and micro-vascular nerve disease by 61%.

- **SB 2233 is not radical or new legislation**. To date 46 states have passed similar legislation. **They include large and small, rural and urban states. States as diverse as Minnesota, Utah and So. Dakota enacted similar laws.** Of the 46 states, half the legislation was signed by Republican and half by Democratic Governors. Legislatures of all political leanings have passed the legislation. In none of the states is there an effort by either insurers or the business community to eliminate this legislation as it has not driven up insurance costs.

- **The savings as a result of access to the proper supplies and education come in two ways. First, long term savings result from a reduction in costly complications of diabetes such as blindness, kidney disease and micro-vascular nerve disease and amputations.** Two recent studies demonstrate that better control leads to substantially reduced complications and hence cost savings.

- **Second, short term savings occur from fewer hospital and emergency room visits, and shorter hospital stays as people learn to self-manage their diabetes**. Studies from Maine, Maryland, and Rhode Island have shown this. A study done for the American Diabetes Association estimates savings of $917/patient/year as the most likely scenario.

- **What is more difficult to measure are the savings to business from healthier employees**—more productivity, fewer days missed to illness, less time off for doctors visits. More dramatic is the improvement in the quality of life for people with diabetes when they are able to dramatically improve their control.

Thank you for your attention. I urge your support of SB 2233. If you have questions or would like more information please contact: Laura Thelander, at 1(888) 342-2383 x 7207 or email at lthelander@diabetes.org.

Sincerely,

Laura Thelander
Advocacy Director

557 Roy Street, Lower Level, Seattle, WA 98109-4219
Tel: (206) 282-4616 or 1-888-DIABETES • Fax: (206) 282-4729

American Diabetes Association.

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North Dakota SB 2233

Mission
to prevent and cure diabetes and to improve the lives of all people affected by diabetes.

Questions and Answers

WHAT WILL THIS LEGISLATION DO?

It will require that individual and group health insurance policies provide coverage for diabetes equipment and supplies and for diabetes education for self-management.

WHO WILL BENEFIT AND WHY IS IT NEEDED?

In North Dakota 6.2% of the population (32,000 people) has diabetes, and an additional 24,000 people are estimated to have pre-diabetes. The number of people affected by diabetes has increased by 72% in ND since 1994 according to the North Dakota Department of Health. The CDC reports that this number is expected to increase by 156% by 2050 due to the increase in obesity in our population. Many have trouble obtaining the medically necessary equipment, supplies, and self-management education that providers prescribe. Numerous studies show that access to the proper equipment, supplies and education results in improved health care at no additional cost, and often a cost savings. Each year in ND over $300 million is spent just on the health care costs associated with diabetes and the high cost of diabetes long-term complications.

HOW CAN THERE BE COST SAVINGS?

Short-term savings due to fewer hospitalizations, length of hospital stays, and emergency room visits, as the following studies show:

- 32% fewer hospitalizations and hospital days in Maine
- 40-50% drop in hospitalizaiton and 50% lower frequency of emergency room visits
- in Maryland
- 63% reduction in emergency room visits for insulin using diabetics in Rhode Island

Long-term savings will result from a reduction in expensive long-term complications as documented in the Diabetes Control and Complications Trial:

- Blindness reduced by 60%
- Kidney disease reduced by 56%
- Microvascular nerve disease reduced by 61%

HOW MUCH WILL THE COST SAVINGS BE?

It is hard to say exactly but experience and studies show:

- In Maine, $3 saved for every $1 spent on diabetes self-management training, saving $293 per participant
- Estimated savings of $2,319 per patient each year in a county hospital setting as reported in the New England Journal of Medicine
- Estimated savings of $437,500 per year for education involving 12,950 individuals with diabetes as reported in the Journal of the American Dietetic Association
- Estimates savings of $917 per patient in the most likely scenario of a study for the American Diabetes Association
- Per person costs for Medicaid patients after diabetes education dropped from $5,271 to 3,533.

IS THIS NEW, CUTTING EDGE LEGISLATION?

No. In fact, forty-six states have passed similar legislation. It has been signed by Republican and Democratic governors alike.

WILL INSURANCE PREMIUMS RISE?

Not according to a Utah study undertaken after its law passed. New Mexico and Maine report no expected increases in administrative costs.

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COMPREHENSIVE DIABETES COVERAGE FOR ONLY 89 CENTS IN UTAH

In October 2003, the Utah Insurance Department released the "2003 Diabetes Mandate Report," a thorough and comprehensive review of the Diabetes Treatment and Management Act-Managed Care (DTMA). The DTMA, know as the 'diabetes mandate' passed the Utah Legislature in 2003. Based on the findings of this report, the American Diabetes Association finds reauthorization of the "Diabetes Treatment and Management Act- Managed Care" to be a reasonable and appropriate action. The report details the findings from a study of the expanded coverage attributable to the mandate, its expected benefits to individuals, and its financial impact on losses and premiums.

EXPANDED COVERAGE AND BENEFITS TO INDIVIDUALS

Coverage for diabetes education grew from 80% to 100% of covered members. Coverage for Lancet Glucose Monitors (often used by the visually impaired) also increased from 91% to 100%. The report adds that, "There may also have been an increase in the levels of benefits covered for some insurers, particularly for diabetes education."

As to potential improvements in health and cost-effectiveness, the report states that "...the data did show an increase in the use of diabetes education and supplies that previous research has shown may benefit diabetics" and that "those who did use the services are likely to benefit from improved glucose control, improved health outcomes, and lower health care costs."

COST IMPACT-- CLAIMS

In the three year period of the study, comprehensive claims increased by 8.6%. Claims attributed to the items in the DTMA account for only .2% of the 8.6%. Without the DTMA comprehensive claims still would have increased 8.4% instead of the 8.6%

Of all claims paid by insurers, less than 1% (0.9%) was for diabetes coverage. In dollars the total claims paid for all coverage averaged $102 per member per month. Of this $102., only 89 cents went to diabetes coverage, which includes the coverage already in place before the DMA took effect.

The report emphasizes that 90% of the increase in the DTMA claims were driven by utilization and the costs of insulin and oral medications, and not due to the items that had expanded coverage under the DTMA; to wit, "...the increase is due to the more expensive nature of medical coverage for diabetes, rather than increases in the cost of the diabetes mandate." In other words, this increase would have occurred even if the mandate had never been put into place.

COST IMPACT-- PREMIUMS:

The best estimate is that .9% of premium is attributable to the diabetes mandate, or $13.07 per year or $1.09 per month using the premium per member per year cited in Table 10. However, the exact share of premiums attributable to the diabetes mandate could not be obtained and is not directly used in premium setting because, "Commercial insurers were unable to provide data that would provide the exact portion of premium attributable to the diabetes mandate. In practice, few insurers set premiums for an individual mandate; rather,

premiums are set relative to the broader medical trend, underwriting factors, and marketing and profit goals."

In the most extreme possible case, if as a result of the DTMA coverage went from absolutely no diabetes coverage to full DTMA coverage the increase in premium is estimated to be only .9% or $1.03 per member per month. Of the $1.03 only that portion due to increased diabetes education and lancet glucose monitors actually resulted from the legislation. The minimal increase is in line with the Legislative Fiscal Office analysis's previous estimate, when the legislation was passed.

As with claims, the percentage of premium attributed to the increased coverage required by the DTMA is negligible.

DOLLAR AND HEALTH IMPACT SUMMARY

The mandate had essentially no effect on the increase in the cost of diabetes coverage over the three-year period either in terms of losses or premiums. The increase was due to the rising costs of insulin and oral medications, an increase that would have occurred, regardless of the required coverage set forth in the mandate.

Because of the short time period for this study, any long-term savings, such as reductions in in-patient hospitalizations and emergency room visits, could not be ascertained. Therefore, conclusions on long-term savings had to be based on available literature. An objective summary of the literature suggests:

• "Programs that provide diabetes education and the supplies to normalize blood glucose appear to reduce Hb1Ac levels, improve health outcomes, and reduce health care costs.

• Studies of diabetes mandates suggests that the benefit typically costs around 1 percent of claims costs and several actuarial studies suggest that adding the benefit will not increase premiums significantly and may reduce health care costs."

•The financial impact of the mandate found in this report for Utah is reasonable and consistent with findings from similar studies conducted in other states.

SUMMARY

The report shows:

- expanded insurance coverage for diabetes education and lancet glucose meters
- comprehensive claims paid for all items included in the DTMA to be only 89 cents/month
- premiums attributable to all items included in the DTMA to be only $1.03/member/month
- studies show these types of improvements in diabetes care result in better health outcomes and reduced health care costs

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to prevent and cure diabetes
and to improve the lives of all
people affected by diabetes.

Enclosed you will find a list of studies and reports all indicating that the impact of comprehensive diabetes insurance legislation like SB 2233 is cost effective

Concerns are often raised over the impact of mandated coverage for Diabetes equipment, supplies and self-management education on insurance and health care costs and whether people with diabetes benefit from diabetes education.

Numerous studies and reports indicate that the cost impact of this legislation is minimal and may even save money while resulting in better health outcomes for people with diabetes. A summary of those reports is below, followed by specific cites for the information.

SUMMARY:

A study in Wisconsin following passage of its law found no appreciable impact on premiums. Reports by the states of Maine and New Mexico prior to passage reported no expected increase in premiums and a negligible impact on the insurance industry. Pennsylvania and California reviewed the possible impact of this legislation before passage and predict it to be cost and medically effective.

Other studies report positive health outcomes in people with diabetes as a result of diabetes education. Cost savings come from these health outcomes which include lower averages of blood glucose as measured by the A1c test (a three month blood glucose average), fewer amputations, fewer and shorter hospital stays, and reduced kidney disease.

Other studies in various states and settings show cost savings as a result of all these items, especially education, including one study which found an annual per patient reduction in cost from $5271 to $3533 per year.

Many insurers have recognized these points and do a good job in diabetes coverage. Other insurers lag behind. Those that do a good job will not be affected by this legislation. The others are most likely to break even or even benefit economically, rather than be hurt. That's what the evidence shows.

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List of Studies and Reports

I. Impact on administrative or premium costs.

- "Insurance Issues Paper: Study of Costs of Mandated Benefits, Reports of Phases I (1989) and II (1990), *Wisconsin Office of the Insurance Commissioner*: Krohm Gregory and Grossman, Mary.

  Wisconsin enacted legislation in the late 1980s requiring insurers to provide coverage for diabetes treatments. Study found that **directing the private insurance market to offer a comprehensive diabetes benefit covering education, equipment and supplies did not have an appreciable impact on premiums.** It estimated that the mandate resulted in costs of 0.1% of premium. The benefit did not increase claims filed, did not increase disbursements by the insurer or costs when compared to other benefits.

- *Maine State Bureau* of Insurance Report to the Joint Standing committee on Banking and Insurance, March, 1996.

  "Of the 15 insurers responding to our request for coverage **information...most did not believe there would be an increase in premiums due to the proposed** (legislation)."

- New Mexico State *Corporation Commission's Insurance Department.*

  After a review of its own department's records and discussions with the managed care industry, found that "the cost of implementing this legislation, **projected costs on current insurance premiums, and financial impact on the insurance industry will be negligible**...it appears to us that two results of the act are 1) more efficient use of current health care resources and 2) ultimately lower costs. We found nothing in the act which we would oppose."

- "Mandated Benefits Review by *the Pennsylvania Health Care Cost Containment* Council (HB656)

  The Pennsylvania report "...finds evidence to suggest that providing diabetics with supplies, medication, self-management education, and medical nutrition therapy can be both medically and cost effective." *(Executive Summary can be attached)*

- "A Cost Analysis of Certain Mandated Coverages Under Private health Insurance Plans" July 5, 1999 by *PricewaterhouseCoopers LLP*

  This study was required in California to consider health mandate legislation. It concluded that "...research conducted on the cost effectiveness of these programs indicates that in the short run program costs approximately equal cost savings, and that over longer periods the programs are cost-effective." "Premium rates for these plans (the small number of plans that currently don't provide diabetes coverage) would likely increase in the short run by a small amount (up to 1%)."

II. Better control saves money

- Gilmer, TP, O'Conner, PJ, Manning, WG, Rush, WA, "The Cost to Health Plans for Poor Glycemic Control, " Diabetes Care, 1997 Dec; 20(12); 1847-1853

  Medical care charges increased significantly for every 1% increase of A1c above 7%. For a person with A1c of 6%, successive 1% increases resulted in cumulative increases in charges of 4, 10, 20 and 30%. For economic and clinical reasons, it may be beneficial to lower A1c when over 8% and to reduce cardiovascular risk factors because heart disease drives the largest percent of associated costs.

- Davidson, J.K. et al., "Spin-off Cost Benefits of Expanded Nutritional Care," Journal of the American Dietetic Association 1979, 75:250-7

  An intensive diabetes self-management program in a county hospital setting using 10,500 people with diabetes resulted in a 65% reduction in severe ketoacidosis and a 49% reduction in lower extremity amputations with estimated savings of $437,500 per year.

III. Impact on the cost of health care.

A 1997 study by Milliman and Robertson for the American Diabetes Association stated that "Numerous published studies support the view that cost savings will be achieved by utilizing various preventive measures to control diabetes." The study cited:

- State of *Maine, Dept. of Health and Human Services*, Reimbursement Pilot Study for the Ambulatory Diabetic Education and follow-up (ADEF) Program: Final Report Augusta: 1983

  Resulted in 32% fewer hospitalizations and hospital days in the year following completion of the education program with a **savings of $293 per participant, or $3 saved for every $1** spent on diabetes self-management training.

  State *of Maryland Diabetes Care Program* (DCP) report concludes that enrollment in the DCP resulted in 40-50% decreased risk of hospitalization and 50% lower frequency of emergency room visits.

- A 63% reduction in emergency room visits was seen as a result of Rhode Island's Diabetes Outpatient/Education Program for insulin-using diabetics.

- The Milliman and Robertson report states that, "numerous additional studies have shown reduced hospitalizations associated with diabetes education and care programs, ranging from 20% to a 73% reduction."

III. Diabetes Self-Management Education Improves Health...the results of studies cited below result from the patients using what they learn.

- "Impact of Endocrine and Diabetes Team Consultation on Hospital Length of Stay for Patients with Diabetes" Levetan and colleagues in the American Journal of Medicine: July 1995

  Showed that patients with diabetes who used a health care team approach, **that includes diabetes education, reduced their hospital stay by an astounding 56% or 5 days.**

  Abourizk et al, "An Outpatient Model of Integrated Diabetes Treatment and Education: Function, Metabolic and Knowledge Outcomes", The Diabetes Educator. Sep/Oct 1994; 20(5): 416-421

  Showed that mean **A1c** (a three-month measure of blood glucose) **decreased from 9.97% to 7.53%.**

- Stuart, M, "Redefining Boundaries in the Financing and are of Diabetes: The Maryland Experience", The Milbank Quarterly, 1994; 72(4), 679-694

  Primary Care Providers used Certified Diabetes Educators to deliver education on diet, exercise, medication, monitoring, hygiene, sick days, complication prevention, psychological adjustment, family involvement resulted in **reduced per person cost from $5271 to 3533 post education** with Medicaid patients.

- Ratner, Robert E., MD, FACP, "Long-Term health Care Outcomes in Diabetes: Economic & Political Implications", Current Therapies for Diabetes, Vo.26, Number 3 Sept. 1997, 487-498.d

  Concludes that studies are showing **short-term economic benefits of improved glycemic control and that the use of physician supervised diabetes educators expanded access to care in turn leading to better patient control.**

- Auabert, Ronald et al., "Nurse Case Management to Improve Glycemic Control in Diabetic Patients in a Health Maintenance Organization", Annals of Internal Medicine. 15 October, 1998, 129(8) pp.605-612

- Under nurse-case management hemoglobin A1c dropped 1.7% over twelve months.

Attachment 3

Testimony in Support
Of SB 2233
February 1, 2004

Chairman Lee and members of the Senate Human Services Committee,

My name is Kris Blees and I am a licensed registered dietitian. I appear before you today to urge you to consider the support of case management and education services for diabetic patients.

As a dietitian, the medical nutrition therapy I provide to patients with diabetes is covered under most insurance plans. I am able to see these patients two to four times a year to discuss the importance of balancing nutrition and exercise with their diabetes medications.

Good care of a diabetic patient is a team effort. It takes the physician, the dietitian and a certified diabetes educator. The educator is qualified to provide case management and continuing education to the patient. They are qualified to help the patient set reasonable self-management goals and are available to answer any medical questions that patients may have.

Physicians are not always readily available for interaction with their patients. The team approach allows the patient to have more access to education so the patient is able to work through their specific concerns. If patients have high or low blood sugar readings, it is imperative that the patient has been trained to respond to their individual needs to prevent a trip to the emergency room.

Please support increased outpatient case management, self-management training and education for people with diabetes in North Dakota. I will answer any questions you may have.

Attachment 4

Testimony in Support
Of SB 2233

Chairman Lee and members of the Senate Human Services Committee,

My name is Janelle Johnson and I represent Medcenter One Health Systems. Medcenter One is an integrated health care provider which includes nine primary/specialty care clinics providing 360,000 patient encounters/year, a 238-bed level II trauma hospital, 331 nursing home beds and a diabetes care center.

All of us realize that diabetes is a very expensive disease. Your committee heard yesterday in a joint hearing related to Medicaid cost savings how important appropriate case management services are to the cost-effectiveness of care and the prevention of complications.

The staff members of our Diabetes Care Center were active participants in the PERS hearing last Wednesday afternoon. They brought back the concerns that were voiced by the committee following their testimony. Our concern is that the intent of the bill is admirable, but we would like to propose to the committee, amendments that would remove mandatory coverage of supplies, testing equipment, insulin pumps (at a cost of $6,000-$7,000/pump) and medical nutritional therapy. Much of this is currently available to patients with reasonable co-payments and co-insurance if supported by adequate documentation. The void in the care of diabetic patients is in case management services and continuing education.

Diabetes is a life-long illness. It can be managed to prevent complications, but at this time, there is no cure. These patients will live with diabetes for the rest of their life. They need case management support and continuing education on a regular basis to make and maintain the necessary behavior changes that will result in good control of their blood sugars. All of us have tried to make lifestyle changes, either as a result of a New Year's resolution or not being able to fit in our pants. So we all know how difficult behavior changes are to make, but more importantly maintain over time. Case management services and continuing education makes patients accountable on a regular basis and provides them with the encouragement and support they need to achieve their self-management goals.

I would suggest to the committee that instead of leaving the bill in its original form, I would propose modifying this bill to strengthen case management and education and remove all reference to other supplies and services.

Although the intention of SB 2233 is honorable, much of the mandates that are referred to are unnecessary at this time. Please strengthen case management in the care of diabetic patients in North Dakota to save not only for today, but down the road when this patient may qualify for Medicaid or Medicare coverage.

I would like to introduce Donna Amundson from Medcenter One Diabetes Care Center to provide statistical information that supports the concept of strengthening case management and education services available to diabetic patients.

Attachment 5

Proposed Amendments for Senate Bill No. 2233

Page 1, line 14 after "outpatient" insert "case management,"

Page 1, line 15, remove "and for diabetic equipment and supplies"

Page 1, line 18, after "Outpatient" insert "case management,"

Page 1, line 18, after "education," insert "not"

Page 1, line 23, after "provide" insert "for one group education course not to exceed one thousand dollars for individuals aged nineteen years and older. For individuals under the age of nineteen this coverage must provide no more than two group education courses not to exceed two thousand dollars per individual's lifetime and"

Page 2, line 1, after "outpatient" insert "case management,"

Page 2, Remove lines 3 through 8

Page 2, line 9, replace "may not be" with "is"

Page 2, line 9, remove "coinsurance"

Page 2, line 10, replace "or deductible provisions that exceed the applicable hospital, medical expense, medical" with "not to exceed current contract co-payment for physician services"

Page 2, line 11, remove "expense, medical equipment, or the prescription drug benefits"

Attachment 6

Testimony in Favor of

Expanding Insurance Coverage for Diabetic Patients

February 1, 2005

Chairman Lee and members of the Senate Human Services committee,

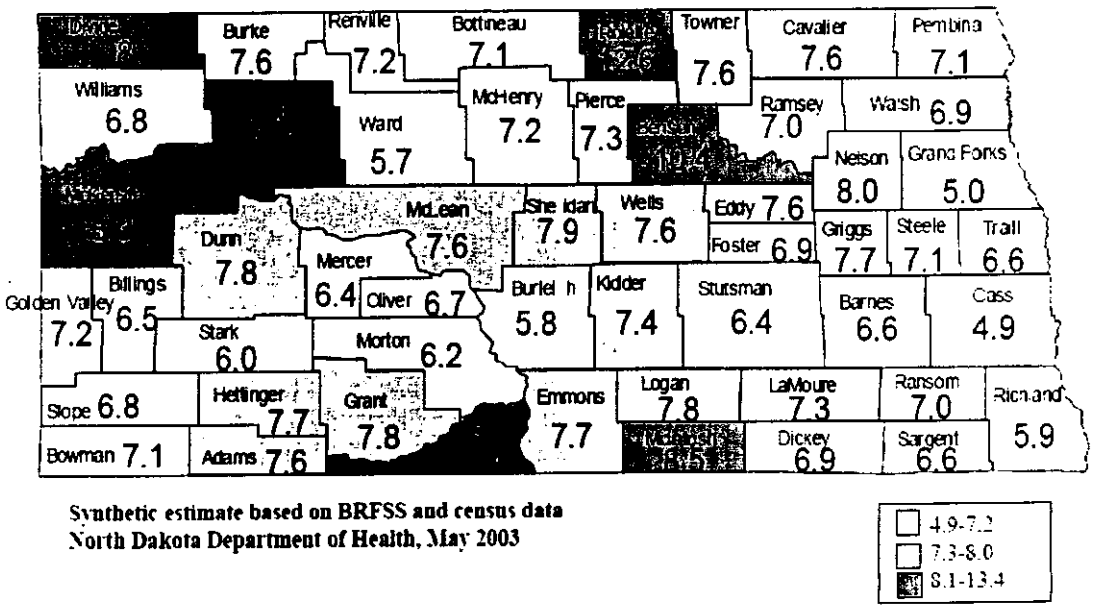
My name is Donna Amundson and I am a Certified Diabetes Educator from Medcenter One Health Systems. I am a registered nurse and have been working with diabetic patients for over 20 years. I am here today to testify in favor of expanding coverage of case management, outpatient self-management training and education for diabetic patients under group health insurance plans.

According to the 2002 Behavioral Risk Factor Surveillance Survey (BRFSS), the rate of diabetes mellitus for North Dakota is 6.1 percent of the general population (1). According to the North Dakota Department of Health, the estimated prevalence of diagnosed diabetes varies greatly from county to county. Figure 1 found on page two of my written testimony indicates the lowest prevalence 4.9 percent is found in Cass County and the highest prevalence is found in Sioux County at 13.4 percent (2).

Figure 1

North Dakota
Prevalence of Diagnosed Diabetes by County
Percentage of Adults 2002

Statewide Prevalence – 6.1%



Synthetic estimate based on BRFSS and census data
North Dakota Department of Health, May 2003

Studies have shown that quality health care and patient empowerment can help control and minimize the complications of diabetes. The Diabetes Control and Complications Trials (DCCT) studied individuals with type one diabetes and found that intensive treatment for diabetes reduced eye disease by 76 percent, nerve disease by 60 percent, and two forms of kidney complications by at least 39 percent (3). A population longitudinal study performed in the United Kingdom found that aggressive treatment to lower blood glucose in patients with type two diabetes resulted in the reduction of eye disease and kidney disease by 25 percent. The same study showed a 35 percent reduction in eye, kidney, and nerve damage and a 25 percent reduction in the risk of premature death from diabetes with reductions in HbA1C levels (4). It has

been shown that each increase of HgA1C of one percentage point increases the relative risk of death by a factor of 1.24 (5).

There have been two studies conducted with diabetic patients in North Dakota. The first was conducted in 1979-1981. One hundred and four persons with diabetes attended an outpatient 40 hours training which included 5 days of classroom instruction combining lectures, group sessions, and one-to-one counseling. Comparison of two years pre- and post-education showed that there was a 72 percent overall reduction in hospitalizations at the end of two years (6).

A smaller study of 25 patients in 1983 indicated that persons with diabetes that received the same intensive course as mentioned in the previously study. The study reviewed hospitalizations in the eleven months prior and the eleven months following the course. The study participants had been hospitalized 7 times in the 11 months preceding the course and there were no hospitalizations in the 11 months following the intensive diabetes training. This study showed a net savings of $11,470 and 48 hospital days (6).

Quality care of a patient with diabetes starts with developing a strong relationship between the diabetes care team and the patient. The care team includes not only the health care provider, but a certified diabetes educator and a dietitian. The physician visits and visits four times per year with a dietician are currently covered under most insurance plans. The void we see in diabetic patients is in the lack of case management and follow-up that is provided by a certified diabetes educator. It is only with adequate case management and education from a certified diabetes educator, that the patient can set and meet their self-management goals.

Another issue that can be resolved with case management is early detection of secondary complications. Currently, patients with diabetes in North Dakota are not being monitored closely by a certified diabetes educator to assure that they receive adequate testing to detect blood sugar problems and identify secondary complications. North Dakota falls short in meeting Healthy People 2010 goals. As demonstrated in Figure 2 of my written testimony, North Dakota rates are significantly less than those found in the top five state rates.

Figure 2

Percent of adults with diabetes who received:	North Dakota (%)	National average (%)[a]	Best-in-class average (%)[b]	Healthy People 2010 goal (%)
HbA1c testing	35.7	61	82	50
Retinal eye examination	71.5	67	81	75
Foot examination	67.8	65	82	75

Using BRFSS 2001 statistics found at: http://apps.nccd.cdc.gov/brfss (1)

[a] The overall average indicates where the average member of a group stands.

[b] Best in class estimate is the top 10 percent of State rates taken together as a simple average.

Patient self-care when supported by case management activities is particularly effective in the management of diabetes and prevention of complications. Studies have demonstrated that patient self-management programs are effective tools for improving patient outcomes. A Stanford University study funded by AHRQ found that over a 24-month period participants in a chronic disease self-management program showed reductions in health distress, had fewer visits to the physician's office and emergency room and did not experience any further increases in disability (7). Systematic reviews

of the literature on self-management programs for diabetes found positive effects on patients' knowledge, self-monitoring of blood glucose, diet, and HbA1C control (8).

If there is objective improvement in diabetes control (as measured by hemoglobin A1C) there is potential for huge savings in terms of medical and indirect costs. Diabetes is the sixth most expensive condition nationally (9). On average, medical expenditures for a person with diabetes in 2002 cost more than $13,000 per year versus just $2,500 for the average person without diabetes. About half of the lifetime health care costs for patients with diabetes are related to potentially preventable complications (10).

Within North Dakota, there is an estimated $547,341,922 spent each year in treatment and indirect costs for diabetes mellitus.

Figure 3

State	Population estimate [a]	Percent with diabetes [b]	Direct medical cost of diabetes [c]	Indirect cost of diabetes [d]	Total cost burden of diabetes
North Dakota	642,200	6.1%	$418,497,979	$128,843,944	$547,341,922
[a] Census 2000 at http://factfinder.census.gov					
[b] BRFSS 2002 at http://apps.nccd.cdc.gov/brfss (1)					
[c] Estimated direct medical cost per year per person with diabetes is $10,683 in excess of the cost of people without diabetes (Hogan P, Dall T, Nikolov P (2003))					
[d] The estimated indirect cost per year per person with diabetes is $3,289 (Hogan P, Dall T, Nikolov P (2003))					

Diabetes is a lifelong, chronic and unfortunately progressive illness that is, for the most part, self-managed. Maintaining good diabetes control is critical to preventing costly secondary complications, but it can only be achieved by giving patients with diabetes, the appropriate case management support and education that they need. Expanding coverage to include ongoing education and follow-up is critical to achieving

better blood sugar control. I urge you to modify this bill to address strictly the importance of case management services. This change will most likely be budget neutral or cost pennies per contract per month in comparison to the $.20 estimated in the fiscal note attached to the original bill (12).

Thank you for allowing me the opportunity to testify in front of your committee today. I would be happy to answer any questions you may have.

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Attachment 7

TESTIMONY OF
SPARB COLLINS
ON
SENATE BILL 2233

Madam Chair, members of the committee, my name is Sparb Collins. I am Executive Director of the North Dakota Public Employees Retirement System. I appear before you today neither in support or opposed to SB 2233. Instead I am here pursuant Chapter 54-03-28 (2) passed by the last Legislative session. That legislation states:

> b. The application of the mandate is limited to the public employees health insurance program and the public employee retiree health insurance program. The application of such mandate begins with every contract for health insurance which becomes effective after June thirtieth of the year in which the measure becomes effective.

Consequently, if this bill is passed it will become effective on July 1, 2005 for members of the PERS health insurance plan. Since this provision was not anticipated and, therefore, not funded in the health insurance premium requested by PERS and submitted by the Governor as part of the executive budget, the addition of this benefit will have an added cost. To determine this cost we requested that our health insurance carrier, Blue Cross Blue Shield, review the bill and determine the additional premium necessary to support this new benefit. They have indicated that it would cost $.20 more per contract per month to add this benefit to our plan design for 2005-2007. This estimate is the basis for the fiscal note. Since this is not provided for 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 add the additional appropriation authority to each agencies budget to pay the cost of the enhancement. If this bill were to pass and the additional appropriation authority was not granted, it may be necessary for the PERS Board to increase member's deductibles and/or co insurance to offset the cost of the enhancement or pass through the premium increase with state agencies having to make up the difference out of their budgets or try to make up the difference from other sources such as experience gains.

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 SENATE BILL 2233

Page 1, line 3, before the period insert "; and to provide an appropriation."

Page 2, after line 13, insert the following:

SECTION 3. 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, 2005, and ending June 30, 2007, as follows:

	Department	General	Other
101	Office of the Governor	$77	$0
108	Office of the Secretary of State	$117	$3
110	Office of Management and Budget	$568	$143
112	Information Technology Department	$68	$1,022
117	Office of the State Auditor	$155	$70
120	Office of the State Treasurer	$29	$0
125	Office of the Attorney General	$579	$204
127	Office of the Sate Tax Commissioner	$562	$0
140	Office of Administrative Hearings	$0	$34
150	Legislative Assembly	$638	$0
160	Legislative Council	$149	$0
180	Judicial Branch	$1,465	$42
190	Retirement and Investment Office	$0	$72
192	Public Employees Retirement System	$0	$134
201	Department of Public Instruction	$128	$275
226	State Land Department	$0	$82
250	State Library	$101	$14
252	School for the Deaf	$220	$11
253	N.D. Vision Services	$91	$29
270	Dept of Career and Technical Ed	$71	$35
301	North Dakota Department of Health	$447	$921
313	Veterans Home	$293	$158
316	Indian Affairs Commission	$14	$0
321	Department of Veterans Affairs	$29	$0
325	Department of Human Services	$5,291	$3,920
360	Protection and Advocacy Project	$27	$88
380	Job Service North Dakota	$4	$1,575
401	Office of the Insurance Commissioner	$0	$182
405	Industrial Commission	$207	$33
406	Office of the Labor Commissioner	$32	$11
408	Public Service Commission	$120	$67
412	Aeronautics Commission	$0	$24
413	Department of Financial Institutions	$0	$115
414	Office of the Securities Commissioner	$38	$0
471	Bank of North Dakota	$0	$826
473	North Dakota Housing Finance Agency	$0	$168
475	North Dakota Mill & Elevator Association	$0	$562
485	Workforce Safety & Insurance	$0	$989
504	Highway Patrol	$750	$94

512	Division of Emergency Management	$64	$56
530	Department of Corrections and Rehabilitation	$2,559	$259
540	Adjutant General	$161	$425
601	Department of Commerce	$173	$77
602	Department of Agriculture	$135	$105
616	State Seed Department	$0	$101
627	Upper Great Plains Transportation Institute	$9	$226
628	Branch Research Centers	$281	$88
630	NDSU Extension Service	$668	$609
638	Northern Crops Institute	$22	$17
640	NDSU Main Research Center	$1,043	$575
649	Agronomy Seed Farm	$0	$14
701	State Historical Society	$239	$29
709	Council on the Arts	$24	$0
720	Game & Fish Department	$0	$682
750	Department of Parks & Recreation	$215	$20
770	State Water Commission	$50	$310
801	Department Of Transportation	$0	$4,886
	Total	$17,913	$20,381

Page 2, line 14, replace "3" with "4"

Renumber accordingly

Attachment 8

Testimony on SB 2233
Senate Human Services Committee
February 1, 2005

Madam Chair and committee members, for the record, I am Rod St. Aubyn, representing Blue Cross Blue Shield of North Dakota and our 449,538 members. I appear before you today to oppose SB 2233. Even though we oppose mandates, we do not necessarily oppose the benefits being mandated. As a matter of fact, most of the mandated benefits were already part of many of our benefit plans. We oppose all health insurance mandates for several reasons. Those reasons include:

- Mandates increase health care costs, utilization, and health insurance premiums.
- Mandates only affect part of the insured population.
- Mandates take away flexibility and choice.
- Mandates tie the hands of insurers when technology and research changes medical procedures.

I have previously gone into more detail about each of these reasons in your committee. In the interest of time, I will not repeat myself today.

We actually support the initiatives listed in this bill and in fact provide the benefits listed. However, this bill goes beyond what is reasonable when it specifies that a new insulin pump be provided every year. In fact, the standard warranty for these pumps is typically good for 4 years. The expected life for this equipment exceeds the warranty period. The pumps cost about $5,000 each, and it's important to note that these are not always medically appropriate for every individual with diabetes.

In our standard benefit plan, we provide a diabetic educational lifetime benefit of $500. We periodically review our benefit plan and have a rewrite committee to review all benefits. In this particular area, this summer it was recommended and approved to increase this lifetime limit to $1,000, after the 2005 rewrite. However, in reviewing this, the change was made not just based on current utilization, but also based on recommendations from professionals in the area.

I am including a summary of Diabetes Education that our company completed this summer. In summary less than ½ of 1% of those getting diabetic education had reached their $500 maximum. It is important to note that in addition to the $500 lifetime diabetic educational benefit, we also offer a $250 lifetime benefit for insulin pump education. This used to be provided by the pump suppliers as part of their purchase. However, they stopped providing that education, so we included it as a standard benefit. In addition to these benefits, we provide 4 annual visits per year for nutritional education. Those visits can run up to $90 per visit.

Diabetic pumps are purchased through the standard home medical equipment benefit. That currently allows $6,000 for most plans each plan year.

In effect, our standard benefit plan provides all of the benefits mandated by this bill, with the exception of the $250.00 per year for diabetic education. However, we currently offer 4 visits (worth up to $360.00) per plan year for nutritional education. In addition, we are proposing to change our lifetime benefit for diabetic education from $500 to $1,000, even though very few people have yet maxed out. Passage of this mandate bill could actually reduce our current benefit plan. The mandated benefits could actually provide the ceiling and the floor for benefits.

As I indicated before, we oppose state mandates because they do not keep up with current technology and medical standards. We regularly review our utilization of services, new technology, and medical standards that often result in changes to our benefit plan. State mandates make these changes more difficult. It often requires the need to change state laws to incorporate the new technological changes.

As I have indicated before, state mandates only apply to group fully insured plans. They do not apply to self-funded group plans nor do they apply to individual health plans. It is important to note that about 50% of our market is provided by self-funded group plans.

As I indicated before, we actually support the benefits specified in this bill and currently provide them in our standard plans. We oppose them being mandated for the reasons I have stated. I would urge you to defeat this bill. I would be willing to try to answer any questions you may have.

BlueCross BlueShield of North Dakota
NORIDIAN Mutual Insurance Company

Diabetes Education

The Diabetes Education Lifetime Maximum

Division of Medical Management

Jodi Carlisle
Director of Health Info Analysis

Mike Sjomeling
Utilization Data Analyst

May 2004
Last Updated: 7.19.2004

Overview

Currently, a $500 lifetime maximum exists for diabetes education. However, it is unclear if this maximum is needed because it is unknown how many members reach the maximum. Therefore, this analysis was conducted to determine the number of members who reach the lifetime maximum for diabetes education. The members selected for this analysis were obtained from the Blue Cross Blue Shield professional claims database. We examined claims for members who received either individual or group sessions for diabetes outpatient self-management training services (CPT-4 = G0108 or G0109).

The "PR_ACCUM_TBL" was used to identify the total amount of claims for diabetes education for each member (Accumulator 5150312). As illustrated below, 21 members have reached the $500 lifetime maximum for diabetes education as of May 2004. These 21 members would have incurred $8,135.11 (48 claims) in paid amounts over and beyond their lifetime maximum of $500 if not limit had not been in effect. The amount over the maximum ranged from $61.76 to $2,501.50. The first "over the maximum" claim occurred in July 2001 and most (32 of the 48) have occurred in 2003 or 2004. The number of members who reached $400 or more is also reported for an indication of the number of members who may be nearing the lifetime maximum.

A new coding for insulin pump education (S9145) was created in 2004 with its own $250 lifetime maximum. Previous, the insulin pump education expenditures were included in the $500 lifetime diabetes maximum. It is assumed that some of the 21 members who reached the diabetes education lifetime maximum would not have reached the $500 maximum if the separate $250 benefit for insulin pump education (S9145) had been implemented prior to 2004. The new benefit has had little impact on the $500 diabetes education maximum at this time because the first claims with code S9145 occurred in March 2004 and there are fewer than 10 claims for insulin pump education (S9145) at this point. Therefore, it is unknown at this point if fewer members will reach the $500 maximum because of the new coding.

The Number of "Diabetes Education" Services by Year

Year	"Unique" Members	Charged Amount	Allowed Amount*	Number of Services	"G0108"	"G0109"	Average # of Services Per "Unique" Member	Average Charge Per Service
1999	256	$29,551.40	$14,427.48	372	364	8	1.45	$79.44
2000	1,127	$153,797.28	$73,983.73	1,912	1,741	171	1.70	$80.44
2001	1,802	$285,597.91	$123,964.32	3,222	2,718	504	1.79	$88.64
2002	2,423	$373,627.11	$162,828.26	4,388	3,940	448	1.81	$85.15
2003	2,809	$522,000.60	$258,579.47	5,319	4,817	502	1.89	$98.14

*Estimated based on PR claims (approximately 88% of "Diabetes Education" claims")

The Number of Members Who Reached the $500 Lifetime Diabetes Education Maximum

The Diabetes Education Lifetime Maximum as of:	Total Members Who Received Diabetes Education At That Time	The Number of Members Who Reached $500 or More	Percentage of Members Who Reached $500 or More	The Number of Members Who Reached $400 or More	Percentage of Members Who Reached $400 or More
The End of 2002	3,228	4	0.12%	7	0.22%
The End of 2003	4,351	15	0.34%	41	0.94%
May 2004	4,672	21	0.45%	67	1.43%

Attachment 9

Testimony of David Straley
Greater North Dakota Chamber of Commerce
Presented to the Senate Human Services Committee
February 1, 2005

SB 2233

Madame Chairman and members of the Senate Human Services Committee, my name is David Straley. I am here today representing a coalition of a number of associations, many of which are in this room together with 17 chambers of commerce that speak for over 7,400 member businesses. I am here today to urge you to **oppose** Senate Bill 2233.

The business community feels that mandates, such as the one included in SB 2233, are part of the reason for increased health care costs. We understand that although the bill sponsors have good intentions, it comes with a problem. That problem is the mandate. Mandates have unintended consequences, ones not easily foreseeable, and it is because of this that we oppose this bill.

We want to make it eminently clear that we are not against diabetes or those with this disease. However, we oppose bad economic policy. Mandates restrict competition, infringe on free enterprise, and can result in supply/distribution problems in the economy. It takes away flexibility and choice for both the employer and the consumer, thus hurting those you are trying to help.

Thank you, Madame Chairman Lee and members of the Senate Human Services Committee, for this opportunity to discuss the business community's position on SB 2233. We urge a **DO NOT PASS** for SB 2233. Thank you and I would be happy to answer any questions at this time.

2000 Schafer Street PO Box 2639 Bismarck, ND 58502 Toll-free: 800-382-1405 Local: 701-222-0929 Fax: 701-222-1611
Web site: www.ndchamber.com E-mail: ndchamber@ndchamber.com

The following chambers are members of a coalition that support our policy statements:

Beulah
Bismarck-Mandan
Bottineau
Cando
Crosby
Devils Lake
Dickinson
Fargo
Grand Forks
Greater North Dakota Chamber of Commerce
Hettinger
Jamestown
Langdon
Minot
Wahpeton
Watford City
West Fargo
Williston

Total Businesses Represented= 7429

Jan. 31, 2005

Senator Judy Lee
600 East Boulevard Avenue
State Capitol
Bismarck, ND 58505-0660

Dear Senator Lee,

A bill in the North Dakota Senate would require state-regulated health insurers to cover diabetes education, equipment, and supplies for their customers who need these life-saving items.
The bill, SB 2233, enables better access to self-management education and regular monitoring of blood sugar levels, thereby preventing or delaying the serious complications associated with diabetes.
This legislation is already proving cost-effective in 46 other states where it is law. It's simple: prevention is cheaper than treatment.
As a member of the Senate Human Services Committee, you have a chance to give people with diabetes the means to stay healthy and keep health care costs down in North Dakota.
I urge you to support cost-effective diabetes care by supporting SB 2233 when your committee considers it on February 1st.

Sincerely,

Mrs. Cheri Goertz
PO Box 594
Hillsboro, ND 58045-0594

REPORT OF THE LEGISLATIVE COUNCIL'S EMPLOYEE BENEFITS PROGRAMS COMMITTEE SENATE BILL NO. 2233

Sponsor: Senator Dennis Bercier

Proposal: Requires health insurance coverage for outpatient self-management training and education for the treatment of diabetes and for diabetic equipment and supplies.

Actuarial Analysis: The cost of the proposal is 20 cents per contract per month.

Committee Report: Unfavorable recommendation.

REPORT OF THE LEGISLATIVE COUNCIL'S EMPLOYEE BENEFITS PROGRAMS COMMITTEE PROPOSED AMENDMENTS TO SENATE BILL NO. 2233

Sponsor: Public Employees Retirement System Board

Proposal: Appropriates $17,913 in general funds and $20,381 in other funds to various state agencies for the purpose of defraying the cost of the additional health insurance premiums necessary to pay the cost of the provisions of the bill.

Actuarial Analysis: The appropriation is sufficient to fund the benefit enhancement.

Committee Report: No recommendation.