# MICROFILM DIVIDER

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

ROLL NUMBER

DESCRIPTION

3050

2005 HOUSE HUMAN SERVICES

HCR 3050

2005 HOUSE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. HCR 3050

House Human Services Committee

❑ Conference Committee

Hearing Date Feb. 23, 2005

| Tape Number | Side A | Side B | Meter # |
|---|---|---|---|
| Number 2 | x | | 145-892 |
| | | | |
| | | | |

Committee Clerk Signature

Minutes:

**Chairman Price** opened hearing on HCR 3050.

**Senator O'Connell, Distr. 6.** This is a good start to make everyone aware of this and I would appreciate your support in passing this.

**Chairman Price:** We considered putting this with another bill, but decided that it needed to be addressed on its own.

**Deb Knuth, Government Relations Director for the American Cancer Society.**

See Attached Testimony.

**Rep. Potter:** Could you tell us about the structure issues.

**D. Knuth**: Structural issues are mostly in clinical/ hospital settings.

**Danelle Kenneweg, Director of the Division of Cancer Prevention and Control, ND Dept. of Health.** See attached Testimony.

Close Hearing.

Reopen the hearing on HCR 3050.

**Rep. Porter:** I move a Do Pass and be placed on the Consent Calendar.

**Rep. Kaldor**: Second.

**Vote: 9-0-3. Carrier: Rep. Potter**

MR# 83 -

**Date:** 2/23/05 **Roll Call Vote #:**

**2005 HOUSE STANDING COMMITTEE ROLL CALL VOTES**
**BILL/RESOLUTION NO.** HCR 3050

**House** Human Services Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number HCR 3050

Action Taken Do Pass - Placed on Consent Cald.

Motion Made By Rep Porter Seconded By Rep Kaldor

| Representatives | Yes | No | Representatives | Yes | No |
|---|---|---|---|---|---|
| Chairman C.S. **Price** | \ | | Rep.L. **Kaldor** | \ | |
| V Chrm.G. **Kreidt** | \ | | Rep.L. **Potter** | \ | |
| Rep. V. **Pietsch** | \ | | Rep.S. **Sandvig** | AB | |
| Rep.J.O. **Nelson** | AB | | | | |
| Rep.W.R. **Devlin** | AB | | | | |
| Rep.T. **Porter** | \ | | | | |
| Rep.G. **Uglem** | \ | | | | |
| Rep C. **Damschen** | \ | | | | |
| Rep.R. **Weisz** | \ | | | | |
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**Total** ( ) yes – 9 **No** – 0

**Absent** – 3

**Floor Assignment** Rep Potter

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

**REPORT OF STANDING COMMITTEE (410)**
**February 25, 2005 7:32 a.m.**

**Module No: HR-35-3634**
**Carrier: Potter**
**Insert LC: . Title: .**

## REPORT OF STANDING COMMITTEE

**HCR 3050: Human Services Committee (Rep. Price, Chairman)** recommends **DO PASS** and **BE PLACED ON THE CONSENT CALENDAR** (9 YEAS, 0 NAYS, 3 ABSENT AND NOT VOTING). HCR 3050 was placed on the Tenth order on the calendar.

# 2005 SENATE HUMAN SERVICES

HCR 3050

2005 SENATE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. HCR 3050

Senate Human Services Committee

☐ Conference Committee

Hearing Date March 21, 2005

| Tape Number | Side A | Side B | Meter # |
|---|---|---|---|
| 1 | X | | 37.4 - 53.6 |
| | | | |
| | | | |
| Committee Clerk Signature | | | |

Minutes:

**Senator Judy Lee,** Chairman of the Senate Human Services Committee, opened the hearing on HCR 3050 directing the Legislative Council to study data regarding colorectal cancer screening, current methods of public education, access to regular cancer screening, and to consider options for increasing screening accuracy.

All members of the Committee were present.

**Senator David O'Connell** of District 6, cosponsor of HCR 3050 introduced the resolution stating that a lot of expense and heartbreak can be avoided with early detection of diseases.

**Senator Dick Dever** stated the committee heard a lot of testimony on another colorectal screening bill and that insurance companies will pay for screening if there are any indicators, but the problem is getting the people to do the screening testing.

**Senator O'Connell** agreed and that there needs to be more public awareness and this resolution will contribute to that end.

The hearing on HCR 3050 will be left open to allow cosponsor of the resolution **Representative Bette Grande** to make her comments.

**Deborah Knuth,** (41.3) government relations director for the American Cancer Society testified in support of HCR 3050. See written testimony (Attachment #1).

Testimony in support of HCR 3050 from **Danielle Kenneweg** , Director of the Division of Cancer Prevention and Control for the North Dakota Department of Health was presented to the committee by **Marlis Knell.** See written testimony (attachment #2).

**Senator Lee** asked for testimony in a neutral position and for opposing testimony and hearing non closed the hearing on HCR 3050.

2005 SENATE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. **HCR 3050**

**Senate Human Services Committee**

☐ Conference Committee

Hearing Date March 22, 2005

| Tape Number | Side A | Side B | Meter # |
|---|---|---|---|
| 1 | | x | 2550-2840 |
| | | | |
| | | | |
| Committee Clerk Signature | Diane Dawson | | |

**Concurrent resolution directing the Legislative Council to study data regarding colorectal cancer screening, current methods of public education, access to regular cancer screening, and to consider options for increasing screening accuracy.**

**Chairman J. Lee opens committee work on HCR 3050.**

(meter #2080, tape 1, side B)

**Senator Brown** - Moved for do not pass.

**Senator Lyson** - Seconded

**Senator Lyson** - Said he thinks there is enough information out there right now about this.

**Senator Lee** - Added that members of the assembly do not know enough about medicine and doesn't believe its their responsiblity to be directing public education.

Called the roll for a do not pass

Vote 4-1

**Senator Lyson** will carry.

(meter #2869, tape 1, side B)

Date: 3-22-05
Roll Call Vote #: 1

**2005 SENATE STANDING COMMITTEE ROLL CALL VOTES**
**BILL/RESOLUTION NO.** HCR 3050

Senate **Human Services** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken Do not Pass

Motion Made By Sen Brown Seconded By Sen Lyson

| Senators | Yes | No | Senators | Yes | No |
|---|---|---|---|---|---|
| Sen. Judy Lee - Chairman | ✓ | | Sen. John Warner | | ✓ |
| Sen. Dick Dever - Vice Chairman | ✓ | | | | |
| Sen. Richard Brown | ✓ | | | | |
| Sen. Stanley Lyson | ✓ | | | | |
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Total (Yes) 4 No 1

Absent _____

Floor Assignment Sen Lyson

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

## REPORT OF STANDING COMMITTEE

**HCR 3050: Human Services Committee (Sen. J. Lee, Chairman)** recommends **DO NOT PASS** (4 YEAS, 1 NAY, 0 ABSENT AND NOT VOTING). HCR 3050 was placed on the Fourteenth order on the calendar.

2005 TESTIMONY

HCR 3050

(1)

**Testimony**

**House Concurrent Resolution No. 3050**

**House Human Services Committee**

**Wednesday, February 23, 2005**

**Deborah Knuth**
**Government Relations Director, American Cancer Society**

Good morning, Chairman Price and members of the House Human Services Committee. My name is Deborah Knuth, and I am the government relations director for the American Cancer Society. I am here today to testify in support of House Concurrent Resolution No. 3050, and ask for a "do pass" recommendation from this committee.

I represent an organization committed to preventing disease and improving public health. I urge you to support HCR 3050, an important cancer study to expand the availability of screening for colorectal cancer. Colorectal cancer is the second most common cancer killer in the United States and is first for non smoking males. Yet only 6 of 10 Americans over age 50 report having had a recent colorectal cancer screening test. Although one in three of those diagnosed will die from the disease, just 37% of colorectal cancers are detected at the earliest stage when it is easiest to cure. Unfortunately, 70% of people are diagnosed at an advanced stage. We are certain that early detection and removal of polyps eliminates cancer risk and 90% of colon cancer deaths can be prevented by timely removal of polyps. In 2002, in North Dakota, there were 387 new cases and 156 people died of the disease. The real tragedy is that we have tools available now which can prevent unnecessary suffering and deaths, or even the occurrence of colon and rectal cancers.

American Cancer Society has found that according to physicians, colorectal screening rates are low because:

- Believe that patients don't want screening
- Unclear about guidelines
- Low awareness of screening benefits
- Lack of skills to perform screening
- Structural issues (lack of practice "systems")
- Low reimbursement
- Context of visit

Colorectal screening rates may be low (according to patients) because:

- Low awareness of CRC as a health threat
- Lack of knowledge of screening benefits
- Fear, embarrassment, discomfort
- Time
- Cost

- Access
- "My doctor never told me to!"

American Cancer Society's Colorectal Goal

- Increase colorectal screening rates to 75% by 2015
- Reduce incidence of colorectal cancer by 40%
- Reduce mortality by 50%

The Society and its supporters urge lawmakers to study the true costs of these cancers properly, both of screenings and the costs of treating colorectal cancer. Both the General Accounting Office Report and Congressional Budget Office found that many of the studies out there on mandated benefits do not measure costs properly and tend to overestimate costs of screenings.* We urge also that lawmakers continue to ensure that all individuals have access to and coverage of early detection screening for cancer and other life-saving medical benefits.

Thank you for allowing me to speak in support of this important legislation.

Source: From General Accounting Office Report, "Private Health Insurance: Federal and State Requirements Requiring Coverage Offered by Small Business' (GAO Report 03-1133, Sept 2003)
Source: From Congressional Budget Office Pager, "Increasing small-Firm Health Insurance Coverage Through Association Health Plans and Healthmarts (SBO January 2000)

(2)

**Testimony**

**House Concurrent Resolution 3050**

**House Human Services Committee**

**Wednesday, February 23, 2005; 2 p.m.**

**North Dakota Department of Health**

Good afternoon, Madam Chair and members of the House Human Services Committee. My name is Danielle Kenneweg, and I am director of the Division of Cancer Prevention and Control for the North Dakota Department of Health. I am here today to provide testimony in support of House Concurrent Resolution 3050.

The vision of the Division of Cancer Prevention and Control is to reduce the incidence, mortality and morbidity of cancer in North Dakota. To achieve the vision and mission, the Division of Cancer Prevention and Control works to increase cancer prevention and awareness by collecting and reporting quality data, providing public and professional education, and ensuring availability of quality services.

Earlier this legislative session, you heard about the North Dakota Cancer Registry. Just as a refresher, the Cancer Registry collects cancer incidence, survival and mortality data to assist in the development of cancer education, prevention, screening and treatment programs. Between 1997 and 2002, more than 22,500 incidences of cancer were diagnosed in North Dakota residents and reported to the registry.

The department's *Women's Way* program works to reduce death from breast and cervical cancer by increasing screening among 40- to 64-year-old women who are uninsured or underinsured, and whose incomes are at or below 200 percent of the federal poverty level. Screening services have been provided to more than 6,700 women in North Dakota by local hospitals, clinics, Indian Health Service facilities and public health agencies. Thirteen percent of the women served are American Indian. Since the program's inception in 1997, *Women's Way* has provided 13,335 Pap tests to eligible women. Eighty-five breast cancers, 558 cervical dysplasias and eight cervical cancers have been diagnosed. Through the special Medicaid treatment program, 97 women have received services.

The Comprehensive Cancer Control Planning Program is working with more than 50 partners to create a coordinated statewide cancer control plan and assemble available resources to carry out the plan. The first step in creating a comprehensive plan is to examine data. With the contracted services of the

Center for Rural Health at the University of North Dakota, we are in the middle of a study of the data. It is expected that the analysis will be complete by the end of June 2005. When all the necessary approvals are in place and using existing resources, we expect to begin a study of Medicare claims data from calendar year 2003 to better understand the burden of cancer on North Dakota residents who are covered by Medicare. Plans for the future include one cancer study per grant year. Therefore, the proposed study of colorectal cancer in the concurrent resolution would be a natural next step for the Comprehensive Cancer Program.

A summary sheet describing the Division of Cancer Prevention and Control is attached. Program brochures from the Cancer Registry and *Women's Way* are also attached.

This concludes my testimony. I am happy to answer any questions you may have.

**North Dakota Department of Health**
**Community Health Section**
**Division of Cancer Prevention and Control**

***Vision:***
The vision of the Division of Cancer Prevention and Control is to reduce the incidence, mortality and morbidity of cancer in North Dakota.

***Mission:***
The mission of the Division of Cancer Prevention and Control is to increase cancer prevention and awareness by engaging in partnerships, collecting and reporting data, assuring quality data, providing public and professional education, and assuring availability of quality services for screening, treatment, rehabilitation and palliative care.

***Programs and services within the division include:***

**Comprehensive Cancer Control Planning** – Works with stakeholders and partners to develop a common vision for comprehensive cancer control, create a coordinated statewide cancer control plan and assemble available resources to carry out the plan by:

- developing communication channels,
- identifying resources,
- integrating activities and networking with other state programs,
- identifying data sources and data gaps,
- analyzing data to define the cancer problem,
- identifying existing activities and strategies in the public and private sectors for prevention, early detection, treatment, rehabilitation and palliative care,
- identifying priority populations, and
- evaluating program effectiveness.

**Cancer Registry** - Collects cancer incidence, survival and mortality data to assist in the development of cancer education, prevention and screening programs by:

- performing data collection and continuous quality improvement activities,
- performing audits for case finding and re-abstracting,
- compiling reports,
- completing research and data requests,
- evaluating cancer cluster inquiries,
- coding cases for occupation and industry,
- executing death clearance procedures,
- submitting data to the North American Association of Central Cancer Registries, National Program of Cancer Registries-Cancer Surveillance System, and Central Brain Tumor Registry of the United States, and
- attaining annual central registry certification.

***Women's Way*** – Works to reduce mortality from breast and cervical cancer by increasing education and screening among low-income, underserved, high-risk and minority women by:

- establishing and maintaining partnerships and collaborations to augment achievement of program goals, objectives and activities,
- developing and disseminating public education materials on the importance of early detection and control of breast and cervical cancer,
- utilizing trained local volunteers in one-to-one recruitment of eligible women,
- meeting annual enrollment, re-enrollment, screening and re-screening goals with at least twelve percent of women screened being American Indian,
- ensuring all enrolled women receive timely and adequate screening, re-screening, diagnostic and treatment services,
- assuring clients are receiving best quality services,
- facilitating professional education opportunities to improve the education, training and skills of health care professionals in North Dakota, and
- monitoring and evaluating program progress and effectiveness by using state-developed program performance indicators.

**Division Staff**

Danielle Kenneweg, Division Director and Coordinator, Comprehensive Cancer Control
Mary Ann Foss, Coordinator, *Women's Way*
Vacant, Nurse Consultant, *Women's Way*
Ann Lunde, Data Manager, *Women's Way*
Marlys Knell, Coordinator, North Dakota Cancer Registry
Donna O'Shaughnessy, Quality Control Manager, North Dakota Cancer Registry
Joell Letzring, Abstractor, North Dakota Cancer Registry
Sandra Bush, Administrative Assistant

**Contact Information**

Division of Cancer Prevention and Control
North Dakota Department of Health
600 East Boulevard Avenue, Dept. 301
Bismarck, ND 58505-0200
Phone: 701.328.2333
Fax: 701.328.2036

NCDR north dakota cancer registry

WOMEN'S WAY
a breast and cervical cancer early detection program

January 2005

north dakota cancer registry

The North Dakota Cancer Registry (NDCR) is a statewide cancer registry that collects incidence and mortality data on all North Dakota residents who are diagnosed and treated for cancer either within or outside the state. The purpose of the state central cancer registry is to support cancer control by targeting, monitoring and evaluating programs that promote early detection, diagnosis and treatment of cancer. The NDCR supports local health care agencies by providing summary statistics on the distribution of cancer cases, following cancer incidence and treatment trends, facilitating rapid reporting of cancer, and providing accurate cancer data for cancer-related reports.

north dakota cancer registry

North Dakota Department of Health
Division of Health Promotion
North Dakota Cancer Registry
600 E. Blvd. Ave., Dept. 301
Bismarck, N.D. 58505-0200
Telephone: 701.328.2333
800.280.5512 (in state only)
Fax: 701.328.2360

Web: www.health.state.nd.us/cancerregistry

north dakota cancer registry

Source of Quality Cancer Incidence and Mortality Data

North Dakota Department of Health

## What Is a Cancer Registry?

The North Dakota Cancer Registry (NDCR) – a statewide, population-based cancer registry that collects incidence and mortality data on residents of North Dakota – was established in 1994. Previously, cancer statistical information was available only through analysis of death certificates.

In 1996, the North Dakota Health Council amended the Administrative Rules to include cancer as a reportable disease. Data collection of newly diagnosed cancers began in January 1997. The collection of newly diagnosed cancers enables the NDCR to:

- Analyze the overall picture of cancer in North Dakota.
- Identify how many residents are diagnosed with cancer.
- Name the most common type of cancer.
- Recognize the deadliest cancers and if any area of North Dakota has lower or higher cancer rates.
- Study trends and improve cancer education, prevention and cancer screening.

## Reportable Cancers

All in-situ or malignant cancers are reportable. This includes adenocarcinoma, carcinoma, leukemia, lymphoma, melanoma and sarcoma. All benign cancers of the central nervous system, pituitary gland, pineal gland and craniopharyngeal duct also are reportable. Basal and squamous cell carcinoma of the skin or carcinoma in-situ of the cervix is not collected.

## Data Collection

Each hospital, outpatient surgical center, clinic, pathology laboratory, radiation or oncology treatment center and physician office is required to submit data, including treatment on newly diagnosed cancers, to the state central cancer registry within six months of diagnosis. Other sources of data include death certificates and cancer registries from other states.

## What Type of Information Is Collected?

The registry collects only cancer-related information. This information can be sorted into four categories. *Demographic* includes the cancer patient's name, age, sex, race, ethnic background, marital status, birth-place, residence and occupation. *Administrative* includes the date the cancer was diagnosed and the source of the information. *Diagnostic* includes the type of cancer, the location of the cancer, the size of the cancer and the spread of the disease. *First course of treatment* includes all cancer treatment received.

## Data Confidentiality

Federal and state laws protect confidential medical information. Only aggregate data are published.

## Why Collect Identifying Information?

Patient identifiers are necessary because some cancer cases reported are diagnosed and/or treated at several facilities. This means that duplicate records are received at the state central registry. Patient identifiers assist the registry staff in determining whether a case has been submitted previously and also allows for a complete cancer record from all reporting sources.

## Quality Control

To assure accurate, complete and reliable data, the NDCR uses an EDITS software program that checks the validity of the data in the various data fields against a set of acceptable codes. Data validity also is verified by visual review of submitted records, external audits conducted by the Centers for Disease Control and Prevention and internal case-finding and reabstracting audits. Inaccurate information is reviewed and revised as necessary.

## Health Insurance Portability and Accountability Act

The North Dakota Cancer Registry, part of the North Dakota Department of Health, is authorized by law to collect cancer information for the purpose of preventing or controlling disease and to conduct public health surveillance, public health investigations and interventions. The Health Insurance Portability and Accountability Act (HIPAA) permits covered entities to disclose protected health information without individual authorization to public health authorities such as state health departments.

Please address your envelope to:

WOMEN'S WAY
*a breast and cervical cancer early detection program*

1-800-44 WOMEN
1-800-449-6636
www.womensway.net

# American Cancer Society
## Recommended Screening Guidelines

## *Breast Cancer Screening*

The American Cancer Society recommends that women begin having mammograms annually starting at age 40. A clinical breast exam should be part of a woman's periodic health examination, about every three years for women in their 20s and 30s and annually for women 40 and older. Women should report any breast change promptly to their healthcare provider. Breast self-exam is an option for women starting in their 20s.

## *Cervical Cancer Screening*

The American Cancer Society recommends that cervical cancer screening should begin three years after a woman begins having vaginal intercourse, but no later than 21 years of age. Screening should be done every year with regular Pap tests or every two years using a liquid-based Pap test. At or after age 30, women who have had three normal tests in a row may get screened every two to three years. However, healthcare providers may suggest a woman get screened more often if she has certain risk factors such as HIV infection or a weakened immune system. Women 70 and older who have had three or more consecutive normal Pap tests and no abnormal results in the last 10 years may choose to stop cervical cancer screening.

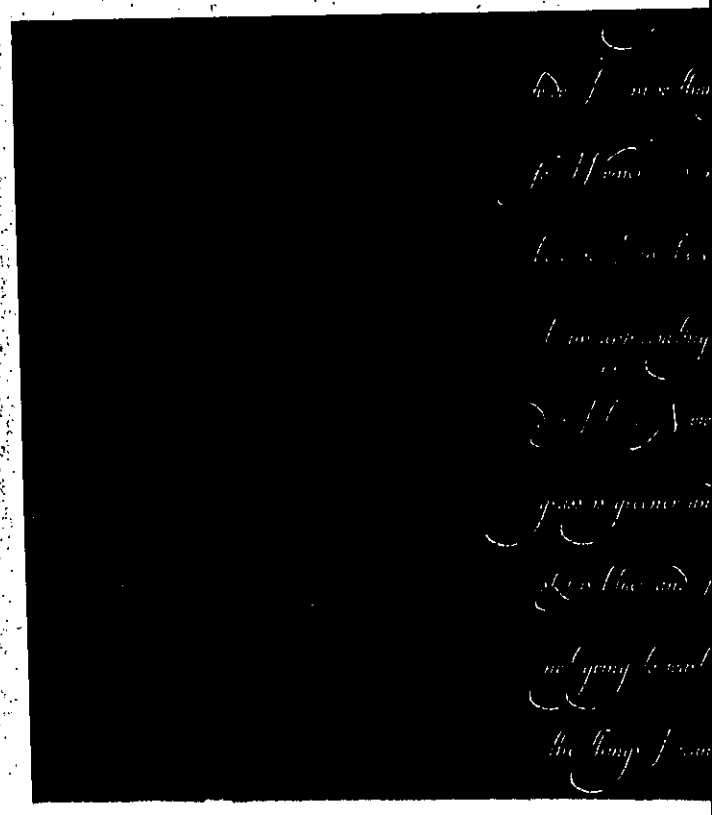
Division of Cancer Prevention and Control
North Dakota Department of Health
600 E. Boulevard Ave., Dept. 301
Bismarck, North Dakota 58505-0200

This publication is funded by a cooperative agreement with the Centers for

Need a mammogram [illegible] test?
*Women's Way* may provid[illegible] pay!

WOMEN'S WAY
*a breast and cervical cancer early detection program*

1-800-44 WOMEN
www.womensway.net



# What is Women's Way?

*Women's Way* may provide a way to pay for most breast and cervical cancer screenings and is available to eligible North Dakota women.

The program is made possible by funding from the Centers for Disease Control and Prevention.

# What is available?

Eligible women ages 40 through 49 can receive:
- Clinical breast exams
- Pap tests
- Pelvic exams

Eligible women ages 50 through 64 can receive:
- Mammograms
- Clinical breast exams
- Pap tests
- Pelvic exams

Limited services may be available for women ages 18 through 39.

1-800-44 WOMEN · 1-800-449-6636
www.womensway.net

# Who qualifies?

To take part in this program, certain income and insurance guidelines apply:

## 2004 Income Guidelines

| Household Number | Income* Yearly | Income* Monthly |
|---|---|---|
| 1 | $18,620 | $1,552 |
| 2 | 24,980 | 2,082 |
| 3 | 31,340 | 2,612 |
| 4 | 37,700 | 3,142 |
| 5 | 44,060 | 3,672 |
| 6 | 50,420 | 4,202 |
| 7 | 56,780 | 4,732 |
| 8 | 63,140 | 5,262 |
| 9 | 69,500 | 5,792 |
| 10 | 75,860 | 6,322 |

## Insurance Guidelines

- No health insurance **OR**
- Unable to pay insurance deductibles and/or co-payments **OR**
- Pap tests and/or mammograms not covered by insurance plan

*Income before taxes

Medicare covers annual screening mammograms for all female beneficiaries age 40 and older.

Revised: June 2004

*"Now, the grass is greener and the sky is bluer and I'm not going to wait to do the things I want to do. I'm so thankful for Women's Way because I am here and I am appreciating every day I have."*

*Women's Way* Enrollee and Breast Cancer Survivor
Marleen Stammen
Palermo, N.D.

☐ Yes! I'd like to learn more about *Women's Way*

Name _____

Address _____

_____

_____

Phone _____

Date _____

WOMEN'S WAY
*a breast and cervical cancer early detection program*

1-800-44 WOMEN · 1-800-449-6636
www.womensway.net

Attachment 1

**Testimony**

**House Concurrent Resolution No. 3050**

**Senate Human Services Committee**

**Monday, March 21, 2005**

**Deborah Knuth**
**Government Relations Director, American Cancer Society**

Good morning, Chairman Lee and members of the Senate Human Services Committee. My name is Deborah Knuth, and I am the government relations director for the American Cancer Society. I am here today to testify in support of House Concurrent Resolution No. 3050, and ask for a "do pass" recommendation from this committee.

The American Cancer Society is raising awareness of this disease (causing 10 percent of all cancers) that it is largely preventable. The Society estimates that this year 145,290 Americans will be diagnosed with colorectal cancer (commonly referred to as colon cancer) and 56,290 will die of the disease, a number that could be cut in half if Americans followed American Cancer Society testing recommendations for colon cancer.

**Many Americans Fail to Get Tested**

Despite overwhelming evidence that testing can save lives, many Americans still are not getting tested starting at age 50. Colon cancer is the rare case in which testing can actually prevent the disease. Suspicious polyps (Precancerous changes or growths in the lining of the colon and rectum) are removed before they turn cancerous. Thanks in part to increase testing, colon cancer incidence rates decreased about three percent a year between 1998 and 2001. Increased testing and improvements in survival have also led to a lower death rate, which has decreased an average of 1.8 per year over the past 15 years.

When colon cancer is caught early, it has a 90 percent survival rate. Still, fewer than four in 10 (39 percent) of these cancers are discovered at the earliest, most treatable stage. The American Cancer Society says increasing colon cancer testing among adults 50 and older represents the single greatest opportunity to decrease colon cancer death rates in this country (more than 90 percent of cases are diagnosed in people over the age of 50).

"It's becoming clear that people 50 and older just do not see themselves as being at risk for colon cancer and needing to be tested," said Stephen F. Sener, MD, national volunteer president of the American Cancer Society. "If we can increase awareness and compliance to the level we've done with the Pap test and the mammogram, we will have a tremendous opportunity to save thousands of lives through prevention and early detection."

**Myths and Misperceptions About Colon Cancer**
The reasons for low testing rates include many misconceptions. One common colon cancer myth is that only people with a family history need to be concerned about colon cancer. While it is true that those who have a family history of the disease are at increased risk, the majority of cases occur in people whose only risk factor is their age, which is why people should start getting tested at age 50. Many women think of colon cancer as strictly a "man's disease," but the reality is that it kills more women than ovarian, uterine and cervical cancers combined. Other people think testing is necessary only when symptoms arise. Yet symptoms are often a sign that the disease has progressed into more advanced stages. Testing is most effective before a patient develops signs of illness.

**The American Cancer Society Launches Nationwide Awareness Campaign**
To increase the awareness of personal risk and to boost colon cancer testing rates, the Society launched a nationwide advertising campaign in February 2005 to emphasize the importance of getting tested starting at age 50, part of a comprehensive strategy to combat the disease from every angle, including research, education, advocacy and patient services.

**The American Cancer Society and Colon Cancer**
As of January 2005, the Society funds 97 colon cancer-related research grants totaling approximately $50.8 million. Its science-based early detection guidelines help health care providers and consumers alike make decisions about testing. The Society is leading efforts to enact legislation that would require private health insurance plans to cover the full range of colon cancer testing in all 50 states. Currently 16 states and the District of Columbia guarantee such coverage, as does Medicare.

American Cancer Society's Colorectal Cancer Goal

- Increase colorectal screening rates to 75% by 2015
- Reduce incidence of colorectal cancer by 40%
- Reduce mortality by 50%

The Society and its supporters urge lawmakers to study the true costs of these cancers properly, both of screenings and the costs of treating colorectal cancer. Both the General Accounting Office Report and Congressional Budget Office found that many of the studies out there on mandated benefits do not measure costs properly and tend to overestimate costs of screenings.* We urge also that lawmakers continue to ensure that all individuals have access to and coverage of early detection screening for cancer and other life-saving medical benefits.

Thank you for allowing me to speak in support of this important legislation.

Attachment 2

**Testimony**

**House Concurrent Resolution 3050**

**Senate Human Services Committee**

**Monday, March 21, 2005; 9:20 a.m.**

**North Dakota Department of Health**

Good morning, Madam Chair and members of the Senate Human Services Committee. My name is Danielle Kenneweg, and I am director of the Division of Cancer Prevention and Control for the North Dakota Department of Health. I am here today to provide testimony in support of House Concurrent Resolution 3050.

The vision of the Division of Cancer Prevention and Control is to reduce the incidence, mortality and morbidity of cancer in North Dakota. To achieve the vision and mission, the Division of Cancer Prevention and Control works to increase cancer prevention and awareness by collecting and reporting quality data, providing public and professional education, and ensuring availability of quality services.

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The department's *Women's Way* program works to reduce death from breast and cervical cancer by increasing screening among 40- to 64-year-old women who are uninsured or underinsured, and whose incomes are at or below 200 percent of the federal poverty level. Screening services have been provided to more than 6,700 women in North Dakota by local hospitals, clinics, Indian Health Service facilities and public health agencies. Thirteen percent of the women served are American Indian. Since the program's inception in 1997, *Women's Way* has provided 13,335 Pap tests and 8,355 mammograms to eligible women. Eighty-five breast cancers, 558 cervical dysplasias and eight cervical cancers have been diagnosed. Through the special Medicaid treatment program, 97 women have received services.

The Comprehensive Cancer Control Planning Program is working with more than 50 partners to create a coordinated statewide cancer control plan and assemble available resources to carry out the plan. The first step in creating a comprehensive plan is to examine data. With the contracted services of the

Center for Rural Health at the University of North Dakota, we are in the middle of a study of the data. It is expected that the analysis will be complete by the end of June 2005. When all the necessary approvals are in place and using existing resources, we expect to begin a study of Medicare claims data from calendar year 2003 to better understand the burden of cancer on North Dakota residents who are covered by Medicare. Plans for the future include one cancer study per grant year. Therefore, the proposed study of colorectal cancer in the concurrent resolution would be a natural next step for the Comprehensive Cancer Program.

A summary sheet describing the Division of Cancer Prevention and Control is attached. Program brochures from the Cancer Registry and *Women's Way* are also attached.

This concludes my testimony. I am happy to answer any questions you may have.