MICROFILM DIVIDER

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

ROLL NUMBER

DESCRIPTION

2169

2005 SENATE HUMAN SERVICES

SB 2169

2005 SENATE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. SB 2169

Senate Human Services Committee

☐ Conference Committee

Hearing Date January 19, 2005

Tape Number	Side A	Side B	Meter #
1		x	4,685-6238
2	x		1-4475
2	x		5,230-5045
2		x	1-0844
Committee Clerk Signature	Cathy Hinard		

Minutes:

Chairman Lee opened the public hearing on SB 2169.

All members were present.

Vice-Chairman Dever advised that a fiscal note was attached.

Testimony in favor of SB 2169

Chairman Lee was a sponsor on this bill which relates to public employees retirement system health insurance coverage of colorectal cancer screening. She discussed how important it was to catch this cancer early and the high rate of success when it is caught.

Deborah Knuth, Government Relations Director for the American Cancer Society. See written testimony (Attachment 2)

Dr. Fadel Nammour, Gastroenterologist with Dakota Clinic and American College of Gastroenterology See written testimony (Atttachment 3) Attachment 5 is in response to the testimony in opposition to the bill.

There was general discussion about colon cancer, polyps, colonoscopy and treatment among the committee members and Dr. Nammour.

Doug Bergland, Physician at Medcenter One and representing the American College of Surgeons.

Dr. Bergland is a colorectal surgeon and discussed how the incidents of colon cancer is coming down. He would much rather take out polyps that a colon. Since colon cancer is very treatable and preventable as long as its caught in time. This bill will help the incidence of colon cancer to keep declining. The committee members asked questions on the cost and how insurance companies won't pay for a colonoscopy unless there are signs of a problem. This bill will help screen more patients.

Dr. Bergland introduced his patient, **Gardell Hoffman,** who had colon cancer. He put off getting a colonoscopy too long, and his cancer progressed to the point of having his colon removed.

David Munch, patient of Dr. Bergland. His colonoscopy was paid for because he was in the hospital with appendicitis when his cancer was detected. When he wanted his wife to be screened, Blue Cross Blue Shield would not pay because she had no symptoms. He feels most people will not pay $1500-$1700 out of their pockets to get screened.

Neutral Testimony

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

See written testimony (Attachment 5)

Mr. St. Aubyn reminded the committee that mandated changes only apply to group health insurance, not to self-funded or individually insured. The last two groups amount to 50% of those covered. If this is mandated, only a small part of the population will be effected.

There was further discussion among the committee members and Mr. St. Aubyn concerning when screening was done, how many claims they have, other methods, like the fecal blood test, that detect problems. The physicians drive requests for colonoscopy, not patients.

Chairman Lee closed the public hearing on SB 2169

The committee discussed this bill after break. Sen. Lyson said he doesn't like mandates. People have to take some responsibilities, and money many times is a deterrent, but he is worried what a mandate would do to employers if this is mandated. Sen. Warner mentioned that the reimbursement rate to Blue Cross is about $1300, but the retail rate was twice that. Chairman Lee mentioned that Dr. Nammour said the cost of radiation and chemotherapy could be $50,000 to $80,000 and the cost of a colonoscopy is much less.

Sen. Brown is also opposed to mandates. Committee members discussed the publicity that colonoscopies are getting. Sen. Brown noted that if you're in need of a colonoscopy, you'll get one and it will be paid for. The committee decided to hold off on making a decision until getting Dr. Nammour's rebuttal information.

Discussion ended on SB 2169.

2005 SENATE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. SB 2169

Senate Human Services Committee

❑ Conference Committee

Hearing Date February 1, 2005

Tape Number	Side A	Side B	Meter #
3	x		1760-1870
Committee Clerk Signature			

Minutes:

Chairman Lee reopened discussion on SB 2169. All members were present.

Dr. Fadel Nammour's rebuttal letter was included (Attachment 5)

Also included is additional information (source unknown - Attachment 1)

Also inclosed is a letter from Mr. John D. Olsrud which was received 2/7/05) Attachment 2

Senator Brown moved DO NOT PASS on SB 2169, seconded by Senator Dever

Vote: 5 yeas, 0 nays, 0 absent Carrier: Senator Warner

Chairman Lee closed the meeting on SB 2169

FISCAL NOTE

Requested by Legislative Council
01/12/2005

Bill/Resolution No.: SB 2169

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			$322,435	$857,185	$322,435	$857,185
Appropriations			$322,435	$857,185	$322,435	$857,185

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
			$148,090	$78,019	$97,805	$148,090	$78,019	$97,805

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

The provisions of the bill would add colorectal cancer screening as a mandated benefit to the PERS plan

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.*

BCBS is the health carrier for the PERS plan. PERS submitted this bill to them to determine if it would have an effect on PERS premiums for the 2005-2007 biennium. They indicated that it would and the additional premium required would be $3.60 per contract per month. This is based upon an average cost of $1,100 for the screening (procedure and related services). The utilization assumptions reflect the NDPERS demographics and follow the AMA clinical recommendations of colonoscopy once every 10 years beginning at age 50, flexible sigmoidoscopy every 5 years beginning at age 50, double-contrast barium enema every 5 years beginning at age 50, fecal occult blood testing every year beginning at age 50.

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

The appropriation amount reflects the required additional premiums that will need to be paid by participating employers to support this provision.

Name:	Sparb Collins	**Agency:**	PERS

Phone Number:	328-3901	Date Prepared:	01/16/2005

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

2005 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. SB 2169

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. Warner

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) 5 No 0

Absent 0

Floor Assignment Sen. Warner

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

REPORT OF STANDING COMMITTEE

SB 2169: Human Services Committee (Sen. J. Lee, Chairman) recommends **DO NOT PASS** (5 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). SB 2169 was placed on the Eleventh order on the calendar.

2005 TESTIMONY

SB 2169

Attachment 2

Testimony

Senate Bill 2169

Senate Human Services Committee

Wednesday, January 19, 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 Senate Bill 2169, and ask for a "pass" recommendation from this committee.

I represent an organization committed to preventing disease and improving public health. I urge you to support SB 2169, an important cancer initiative that will expand the availability of screening for colorectal cancer. In 2002, in North Dakota, there were 387 cases of incidence and 156 people died of the disease. The real tragedy is that we have tools available now which can prevent unnecessary suffering and deaths from colon and rectal cancers.

We are fortunate to have two respected North Dakota doctors here today. Dr. Fadel Nammour and Dr. Doug Berglund will testify in support of SB 2169. May I introduce Dr. Fadel Nammour.

Note: Below, for your information are colorectal cancer statistics received from the North Dakota Cancer Registry and the Division of Vital Records.

	North Dakota Cancer Registry	Division of Vital Records
Year	Number of Cases	Number of Cases
	Incidence	Mortality
Total	2,380	903
1997	391	154
1998	419	143
1999	389	153
2000	385	151
2001	409	146
2002	387	156

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

Attachment 3

Colon Cancer Screening

Fadel Nammour, M.D.

Facts

- Second most common cancer killer in the United States (10% of cancer deaths)
- First for non smoking males
- 147,500 new cases /year
- 57,100 death /year

Facts

- 6% lifetime risk
- One in three will die from the disease
- 70% diagnosed at an advanced stage

Facts

- Five-year survival:
  - stage I : 90-97%
  - stage II : 63-78%
  - stage III : 37-66%
  - stage IV : 4%
- No one is immune

Colon Cancer Facts

- Most cancers arise from polyps
- Two-thirds of all polyps are adenomas
- 30-40% of adults over the age of 50 have one or more adenomas

Colon Cancer Facts

- Early detection and removal eliminates cancer risk
- 90% of colon cancer death can be prevented by timely removal of polyps

Facts for North Dakota

- 150 death/year
- The annual death rate is 19.7/100.000
- Far from meeting the healthy people 2010 objective of 13.9 established by the Centers for Disease Control and Prevention

Facts for North Dakota

- 39.9 % sigmoidoscopy or colonoscopy within the last 5 years
- 16.2% hemoccult within the last year
- No laws to cover screening

Screening Tests

- Fecal occult blood test (FOBT)
- Sigmoidoscopy
- Colonoscopy
- Barium enema

FOBT

- Guaic-based
- Patient compliance low
- Sensitivity of a single test is 30%
- Not a good test to detect polyps

FOBT

- High false positive rate
- Two percent with positive test had cancer
- Colorectal cancer(CRC) mortality reduced by one third (if followed by colonoscopy)

Sigmoidoscopy

- Lighted camera tube that can reach up to 60cm into the colon
- Can identify one-half of colonic lesions
- If abnormal sigmoidoscopies are followed by colonoscopy, another 20% of lesions are identified

Sigmoidoscopy

- Incidence of proximal lesions increase with age
- Fails to detect 52-62% of all patients with advanced proximal neoplasia
- CRC mortality reduced by at least two-thirds

Detection Rates

	Detection
Sigmoidoscopy alone	68%
FOBT alone	24%
Sigmoidoscopy + FOBT	76%

NEJM 2001;345:555

Colonoscopy

- Considered the gold standard for CRC and polyps detection
- Evaluates the whole colon, and it is done under contra-sedation
- Diagnostic and therapeutic

Colonoscopy

- The conclusion of the most recent analysis is that colonoscopy could reduce CRC incidence by 58% to 86%, and mortality by 64% to 90%

Pignone et al. Ann Intern Med 2002;137:96-104

Double Contrast Barium Enema

- X-ray test
- Usually recommended if other procedures were incomplete or not optimal
- Identifies lesions better than FOBT
- evaluates the whole colon
- No study for effectiveness

Screening Recommendations

- Preferred : Colonoscopy every 10 years
- Alternative:
  - Flexible sigmoidoscopy every 5 years with yearly hemoccult test
  - DCBE every 5 years if above incomplete or refused by patient

Costs

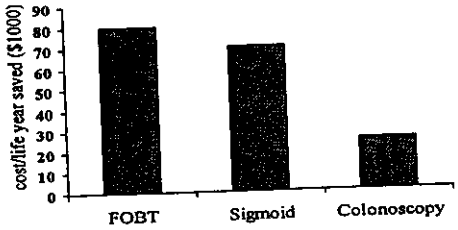
- Several cost-analysis demonstrate that screening for CRC is cost effective relative to other medical interventions
- Agree that patient compliance is important and there is a substantial cost to not screening

Cost Effectiveness Ratios

	Cost/life year gained
• Cervical screening	$250,000
• Heart transplantation	$160,000
• Mammogram	$22,000
• Colon screening	$6,600

Provenzale Am J Gastroenterol 1999;94:2682

Cost Effectiveness of Screening Tests for CRC



Sonnenberg et al Ann Intern Med 2000;133:573

Lewin Group Analysis

- Determine the short-term impact of CRC screening to health plans in the United States
- Calculate the total added costs for each screening method
- Evaluate the annual and per-member-per-month costs

Lewin Group Analysis

Results for CRC Cost Model

	FOBT Yearly	FSIG + FOBT @ 5 Years	COLONOSCOPY @ 10 years
Cost per member per year	$5.70	$7.92	$6.64
Cost per member per month	$0.47	$0.66	$0.55

Lewin Group Analysis

Results for Breast Cancer Cost Model

	Mammography
Cost per member per year	$8.99
Cost per member per month	$0.75

Lewin Group Analysis

- With the resulting cost per-member-per-month well below $1, all three strategies are reasonable for insurers and their members
- There is a fundamental difference between the cost of a single test and the cost of a screening strategy

Lewin Group Analysis

- Adding a colonoscopy as a covered benefit would only result in an additional 8 cents per-member-per-month
- The cost is less than the 75 cents per-member-per-month cost of mammography, an established and widely covered screening exam

The Case for Screening

- Important public health intervention
- Deflect the high costs related to cancer treatment
- Address screening capacity, patient preference, and provider concerns

Why Endorse This Bill ?

- This is the standard of care
- One of the best if not the best cancer prevention strategies we have
- With aging population the risk of cancer will increase
- Lessen the fiscal constraints of doing the appropriate tests- increase access for all

Final Message

- Greater access, along with increased promotion and education, will improve compliance
- Health care and provider organizations, professional associations, and private health plans, play a crucial role in the prevention of CRC

Final Message

- The message must be clear:
  Screening saves lives, and money, and everyone above the age of 50 should be screened

Entertainment Industry Foundation's

National Colorectal Cancer Research Alliance

&

American Gastroenterological Association

2004 COLORECTAL CANCER LEGISLATION REPORT CARD

National Colorectal Cancer
RESEARCH ALLIANCE™
An Entertainment Industry Foundation Program

MAKING COLORECTAL CANCER A NATIONAL PRIORITY

Colorectal cancer is the second leading cause of cancer deaths for men and women combined in the United States, but it doesn't have to be. Colorectal cancer can be successfully treated more than 90% of the time when detected early.

Getting tested is the first step to beating this disease.

For many people, a major obstacle to getting tested is the uncertainty of whether or not their insurance covers the cost of comprehensive colorectal cancer screenings. Unfortunately, there is no Federal legislation that requires insurance providers to cover preventative screenings.

Encouraging screenings is a wise investment, especially when you factor in the billions of dollars spent annually to treat colorectal cancer and the hundreds of thousands of lives forever affected by the disease.

In recent years, 19 states* have adopted some type of preventative colorectal cancer screening legislation. These laws range from comprehensive coverage of all preventative screening measures as recommended by current medical guidelines to merely recommending insurance providers *offer* coverage without actually *requiring* it.

To help you better understand these varied and complex laws, the Entertainment Industry Foundation's National Colorectal Cancer Research Alliance (EIF's NCCRA) and the American Gastroenterological Association (AGA) have prepared the 2004 Colorectal Cancer Legislation Report Card. In this report, you can learn if your state has passed colorectal cancer legislation and how it compares to other states.

COLORECTAL CANCER BY COMPARISON

	STATES* WITH CANCER SCREENING LEGISLATION			
TYPE OF CANCER	REQUIRE COVERAGE	OFFER COVERAGE	NO COVERAGE	DEATHS PER YEAR
Colorectal	18	1	32	57,310
Breast	47	3	1	40,580
Prostate	26	1	24	29,900
Cervical	23	1	27	3,900

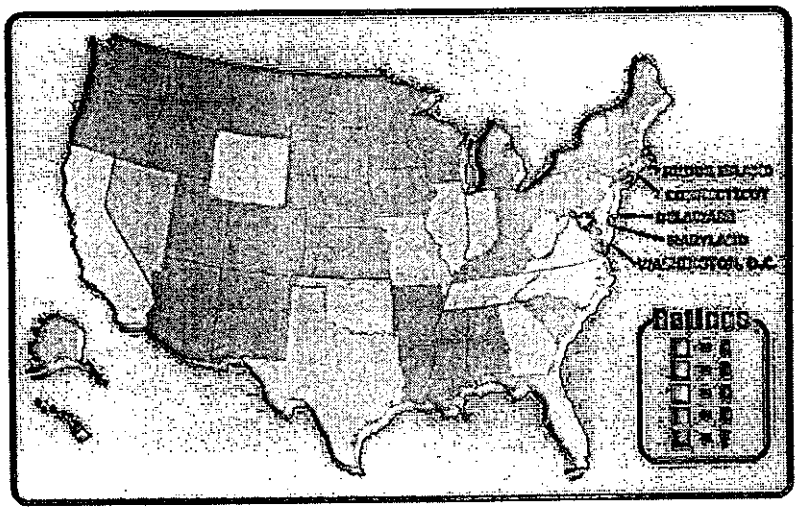
US figures estimated for 2004, American Cancer Society

*including Washington D.C.

STATES THAT MAKE THE GRADE [A] [B] [C]

A total of 18 states* receive a passing grade for adopting preventative colorectal cancer screening legislation.

- In 2000, Virginia was the first state to adopt comprehensive colorectal cancer screening legislation that meets AGA's current screening guidelines, receiving an A in this report. Since then, 12 other states* have followed its outstanding example.



- Illinois was the first state to enact a law to provide some coverage for preventative screenings; this year the state raised its grade to an A with a revised law that meets AGA's current screening guidelines.

STATES THAT FALL SHORT [D] [F]

- Nearly two-thirds of states receive failing grades.
- Of the states that fail, Oklahoma is the only state that has passed some type of legislation, however the law recommends that insurance providers *offer* rather than *require* coverage.
- Although Alabama, Kansas, Kentucky, Mississippi, and Pennsylvania received failing grades, these states all have legislation pending that, if passed, would require insurance providers to cover the cost of preventative colorectal cancer screenings.

GRADING CRITERIA

States with above average grades (A-B) generally cover all policyholders over the age of 50, and those under 50 at high risk. Coverage includes:

- Colonoscopy screenings every 10 years
- Flexible sigmoidoscopy and double contrast barium enema screenings every 5 years
- Fecal occult blood tests (FOBT) every year

[A] States receiving an A reference American Gastroenterological Association or American Cancer Society guidelines, which allows the legislation to include coverage of future advances in screening methods.

[B] States receiving a B do not reference current American Gastroenterological Association or American Cancer Society guidelines, thereby potentially falling short of providing coverage for future advances in screening methods.

[C] States receiving a C have passed legislation that covers preventative cancer screenings, but the legislation is vague and does not specifically mention which types of preventative colorectal cancer screenings are covered.

[D] States receiving a D have passed legislation that recommends insurance providers *offer* coverage, but does not *require* coverage.

[F] States receiving an F do not currently have any legislation that requires insurance providers to cover preventative colorectal cancer screenings.

STATE GRADES

A
Connecticut
Georgia
Illinois
Indiana
Maryland
Missouri
Nevada
New Jersey
North Carolina
Rhode Island
Tennessee
Virginia
Washington D.C.

B
Delaware
Texas
West Virginia

C
California
Wyoming

D
Oklahoma

F
Alabama
Alaska
Arizona
Arkansas
Colorado
Florida
Hawaii
Idaho
Iowa
Kansas
Kentucky
Louisiana
Maine
Massachusetts
Michigan
Minnesota
Mississippi
Montana
Nebraska
New Hampshire
New Mexico
New York
North Dakota
Ohio
Oregon
Pennsylvania
South Carolina
South Dakota
Utah
Vermont
Washington
Wisconsin

Graded by

MEDICARE

Medicare provides coverage for preventive colorectal cancer screening in accordance with American Gastroenterological Association and American Cancer Society guidelines. Medicare recipients are entitled to: colonoscopy screenings every 10 years (every 2 years for those at high risk), flexible sigmoidoscopy and double contrast barium enema screenings every 4 years, and annual fecal occult blood tests.

MEDICAID

Medicaid coverage for colorectal cancer screenings varies by state. Check with your state's health and human services agency to learn the specific coverage options available to you.

PRIVATE INSURANCE

For specific questions about your personal healthcare coverage for colorectal cancer screenings, please contact your insurance provider.

TAKE ACTION: VISIT EIF.NCCRA.org

On EIF's NCCRA website, you can view the full report, including summaries of and links to the actual legislation in each state. For those states with failing grades, a letter stressing the importance of colorectal cancer screening legislation can be e-mailed to the state's Senate Health Committee Chair. By petitioning for quality legislation, we can remove colorectal cancer from the ranks of our nation's leading cancer killers.

Founded in 1897, the American Gastroenterological Association is one of the oldest medical specialty societies in the United States. Its members include physicians and scientists who research, diagnose and treat disorders of the gastrointestinal tract and liver. Representing almost 14,500 gastroenterologists worldwide, the AGA serves as an advocate for its members and their patients, supports gastroenterology practice and scientific needs, and promotes the discovery, dissemination and application of new knowledge, leading to the prevention, treatment and cure of digestive and liver diseases.

National Colorectal Cancer Research Alliance
An Entertainment Industry Foundation Program

The NCCRA is dedicated to the eradication of colorectal cancer by promoting education about the importance of early medical screening and funding cutting-edge research to develop better tests, treatments and ultimately, a cure. The NCCRA was co-founded in March of 2000 by journalist Katie Couric, cancer activist Lilly Tartikoff, and the Entertainment Industry Foundation. As a result of the attention NCCRA and NBC's TODAY Show have focused on colorectal cancer, the number of colonoscopy screenings has increased almost 20% since March 2000. Researchers at the University of Michigan have referred to this as the "Couric Effect."

EIF ENTERTAINMENT INDUSTRY FOUNDATION

As the philanthropic heart of the entertainment industry, EIF has distributed hundreds of millions of dollars – and provided countless volunteer hours – to support charitable initiatives addressing some of the most critical issues facing society today.

EIF's NCCRA 11132 Ventura Boulevard, Suite 401, Studio City, CA 91604 1-800-872-3000 www.eif.nccra.org

Attachment 4

TESTIMONY OF
SPARB COLLINS
ON
SENATE BILL 2169

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 2169. 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 $3.60 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 will be necessary for the PERS Board to increase member's deductibles and/or co insurance to offset the cost of the enhancement.

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 2169

Page 1, line 3, after the semicolon insert "to provide an appropriation;"

Page 2, after line 2, 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:

		05-07 Funding Adjustments	
	Department	General	Other
101	Office of the Governor	$1,382.40	$0.00
108	Office of the Secretary of State	$2,101.74	$58.26
110	Office of Management and Budget	$10,216.52	$2,570.68
112	Information Technology Department	$1,220.75	$18,392.05
117	Office of the State Auditor	$2,796.75	$1,264.05
120	Office of the State Treasurer	$518.40	$0.00
125	Office of the Attorney General	$10,417.51	$3,665.69
127	Office of the Sate Tax Commissioner	$10,108.80	$0.00
140	Office of Administrative Hearings	$0.00	$604.80
150	Legislative Assembly	$11,491.20	$0.00
160	Legislative Council	$2,678.40	$0.00
180	Judicial Branch	$26,369.87	$759.73
190	Retirement and Investment Office	$0.00	$1,296.00
192	Public Employees Retirement System	$0.00	$2,419.20
201	Department of Public Instruction	$2,304.15	$4,953.45
226	State Land Department	$0.00	$1,468.80
250	State Library	$1,825.92	$247.68
252	School for the Deaf	$3,953.62	$193.58
253	N.D. Vision Services	$1,643.49	$516.51
270	Dept of Career and Technical Ed	$1,271.90	$628.90
301	North Dakota Department of Health	$8,039.77	$16,584.23
313	Veterans Home	$5,275.12	$2,846.48
316	Indian Affairs Commission	$259.20	$0.00
321	Department of Veterans Affairs	$518.40	$0.00
325	Department of Human Services	$95,241.37	$70,560.23
360	Protection and Advocacy Project	$486.30	$1,587.30
380	Job Service North Dakota	$74.60	$28,351.00
401	Office of the Insurance Commissioner	$0.00	$3,283.20
405	Industrial Commission	$3,721.44	$598.56
406	Office of the Labor Commissioner	$584.59	$193.01
408	Public Service Commission	$2,162.56	$1,207.04
412	Aeronautics Commission	$0.00	$432.00
413	Department of Financial Institutions	$0.00	$2,073.60
414	Office of the Securities Commissioner	$691.20	$0.00
471	Bank of North Dakota	$0.00	$14,860.80
473	North Dakota Housing Finance Agency	$0.00	$3,024.00
475	North Dakota Mill & Elevator Association	$0.00	$10,108.80
485	Workforce Safety & Insurance	$0.00	$17,798.40
504	Highway Patrol	$13,505.42	$1,700.98

512	Division of Emergency Management	$1,147.25	$1,012.75
530	Department of Corrections & Rehabilitation	$46,062.22	$4,654.58
540	Adjutant General	$2,890.71	$7,650.09
601	Department of Commerce	$3,111.82	$1,380.98
602	Department of Agriculture	$2,431.11	$1,888.89
616	State Seed Department	$0.00	$1,814.40
627	Upper Great Plains Transportation Institute	$166.92	$4,066.68
628	Branch Research Centers	$5,065.24	$1,587.56
630	NDSU Extension Service	$12,027.55	$10,954.85
638	Northern Crops Institute	$390.75	$300.45
640	NDSU Main Research Center	$18,766.29	$10,350.51
649	Agronomy Seed Farm	$0.00	$259.20
701	State Historical Society	$4,309.22	$529.18
709	Council on the Arts	$432.00	$0.00
720	Game & Fish Department	$0.00	$12,268.80
750	Department of Parks & Recreation	$3,874.75	$358.85
770	State Water Commission	$897.74	$5,582.26
801	Department Of Transportation	$0.00	$87,955.20
	Total	$322,434.96	$366,864.24

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

Renumber accordingly

Attachment 5

Testimony on SB 2169
Senate Human Services Committee
January 19, 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 2169. 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.

Mandates increase health care costs and health insurance premiums.

Mandated coverage can significantly increase the cost of health care coverage premiums, with one actuarial firm estimating that 12 of the most common mandates in the United States increase the cost of health insurance by 30 percent. This is the third legislative session that BCBSND has provided legislators with a CD that we call the Legislative Blue Book. One of the sections of that CD shows the cost of health insurance mandates for BCBSND members. I have included a copy of the 2003-2004 report for your review. For the period of August 1, 2003 through July 31, 2004, health insurance mandates have cost our members $167,192,334. Compare that to the first year (1991 Legislative Session) when we compiled this same data for the same mandates (August 1, 1999 through July 31, 2000). The total then was $99,983,387. This is a 67% increase over a period of 5 years. I have also included a summary of the mandate costs for the last 3 sessions for your review. About 92 to 93 cents of every premium dollar goes directly to providers and pharmaceuticals. Only 7 to 8 cents is applied to administration and overhead. So as utilization and health care costs increase there is only one way to absorb those costs – increase health insurance premiums.

Mandates only affect part of the insured population.

Mandated coverage only applies to fully insured group insurance. These mandates do not apply to individual coverages or self-funded group insurance. Of our group insurance, approximately 50% of our plans are self-funded. Employers are struggling to maintain health insurance as a benefit for their employees. Their options are becoming fewer and fewer. Many have resorted to changing plans with higher deductibles, higher co-pays, or forcing the employee to pay a greater share of the premium in an effort to hold down the company's premiums. However, we are seeing more and more companies switching to self-funded plans, so they can design their own benefits. You may have read about a well-known Fargo hotel/motel company operating in several states that recently dropped

their insurance benefit for their employees. This left their employees searching for individual coverage. The major difference between group coverage and individual coverage is that group coverage is guaranteed issue, while the individual applicant must medically qualify. This can result in people becoming uninsured or paying significantly more for high-risk coverage. Employers are concerned! That is why the 2005 Greater North Dakota Chamber of Commerce Legislative Policy Statements and Guidelines lists the following under the category, Insurance – Health Care:

"The North Dakota Chamber will support reducing mandates for insurance companies that require coverage for specific health care services or conditions so individuals can choose the coverage that best fits their needs."

Mandates take away flexibility and choice.

Mandates dictate to employers that no matter which plan they provide, they must include all the mandates. The employers do not have any options to pick and choose optional coverages. Their only option is to go to other plans with higher deductibles and co-pays. It would be like mandating that all pickups that are sold must include leather seats, a moon roof, 6 CD Changer Stereo System, 4 wheel drive, and a GPS. Even if the individual just wants a basic farm pickup, the dealer would be unable to sell him one because of the mandates. In this particular case, we offer some plans with a screening benefit and others without the screening benefit. That way the employer has a choice of coverages.

Mandates tie the hands of insurers when technology and research changes medical procedures.

The entire area of health care is constantly changing. What is standard practice today is almost assured to not be the same in 10 years. When mandates are developed, it becomes very difficult, if not impossible to eliminate them in the future when technology or scientific evidence changes current medical practice. For example, for prostate cancer screening, there is little support today for annual PSA exams, which is currently mandated. I have included a summary of several guidelines for prostate cancer screening for your review.

Review of SB 2169

I would like to address this proposed health insurance mandate and the concerns we have in addition to our general opposition listed previously. Our medical policies for screening benefits are developed through the research of the U.S. Preventive Services Task Force, which is appointed by the Department of Health and Human Services and the Center for Disease Control (CDC). This is a totally unbiased research group who has no financial or personal interest in the development of their recommendations. I would like to read you their recommendation in the area of Colorectal Cancer Screening:
"The USPSTF strongly recommends that clinicians screen men and women 50 years of age or older for colorectal cancer. Rating: **A** recommendation."

They go on to say that the "USPSTF found fair to good evidence that several screening methods are effective in reducing mortality from colorectal cancer..... The USPSTF found good evidence that periodic fecal occult blood testing (FOBT) reduces mortality from colorectal cancer and fair evidence that sigmoidoscopy alone or in combination of FOBT reduces mortality. The USPSTF did not find direct evidence that screening colonoscopy is effective in reducing colorectal cancer mortality;...There are insufficient data to determine which strategy is best in terms of the balance of benefits and potential harms or cost-effectiveness."

BCBSND has a benefit re-write committee that meets over a period of 2 years to design new benefits and incorporate changes required by new federal and state laws. **That committee had already made recommendations to incorporate annual FOBT benefits in every fully insured plan**. Those changes would go into effect at the anniversary date of all plans after August 1, 2005.

It is important to note that even though many members currently have screening benefits, many do not utilize the benefit for colorectal cancer screening. We analyzed NDPERS members who were age 64 or 65 in June 2003 and had been continuously enrolled for eight and one half years (defined as enrolled at least 10 and one half months in each of the eight and one half years). The NDPERS members who matched this criteria were selected from the members table in the Blue Cross Blue Shield data system. This resulted in the inclusion of 671 NDPERS members in our analysis. Once the target population was identified, we were interested in the number of NDPERS members who had the following colon cancer preventative screening tests performed within the generally accepted timeframes:

1. Procedure: Colonoscopy **CPT codes:** G0105; G0121; Between 44388 and 44397; Between 45378 and 45387 **Timeframe Criteria:** Anytime during the 8.5 year period.

2. Procedure: Sigmoidoscopy **CPT codes:** G0104; Between 45300 and 45345 **Timeframe Criteria:** Within the previous five years.

3. Procedure: Barium Enema (BE) **CPT codes:** G0106; G0120; 74270; 74280 **Timeframe Criteria:** Within the previous five years.

4. Procedure: Fecal Occult Blood (FOB) **CPT codes:** 82270; 82274 **Timeframe Criteria:** Within the previous year.

In addition to examining the number of NDPERS members who received each screening test, we were also interested in the number of NDPERS members who did not receive any of the tests within the stated timeframes. That is, we were interested in identifying the members who do not have a current screening test for colon cancer.

294 (43.8%) of the target NDPERS population (671 members) have not received a screening test for colon cancer within the specified timeframe criteria even though some screening benefits were allowed in the plan. This same analysis was updated in 2004.

300 (49.3%) of the target NDPERS population (608 members) did not receive a screening test for colon cancer.

There is a significant difference in the cost for the different types of procedures. For the most common procedures the approximate reimbursements are as follows:

Fecal Occult Blood Test	$6.00 - $30.00
Barium Enema	$200.00 - $300.00
Sigmoidoscopy	$300.00 - $500.00
Colonoscopy	$1,000 - $1,300.00

Another concern with this bill is the ambiguity regarding the standards. It states "generally accepted standards of medical practice ..... such as guidelines established by the American cancer society or the American college of gastrenterology." Who is determining these standards? In effect, it basically gives a blank check to the individual physician. It is our belief that most physicians will not abuse this, however, if someone does, there is absolutely no ability to control aberrant practices. Are deductibles still permitted?

A final issue involves a possible unconstitutional delegation of legislative power to others such as the American Cancer Society or the American College of Gastroenterology. Since these standards are subject to change, which standard does the law refer to? That was the issue that the ND Supreme Court opinion for McCabe v. ND Workers Comp. Bureau, 1997 ND 145, 567 N.W.2d 201 determined when the Workers Compensation law referred to the most recent or most current version of a specific guide or standard.

Because of all the reasons stated, we strongly oppose this mandate and urge this committee to give it a Do Not Pass recommendation. Thank you for the opportunity to testify and I would be willing to try to answer the committee's questions.

The Cost of Health Insurance Mandates

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

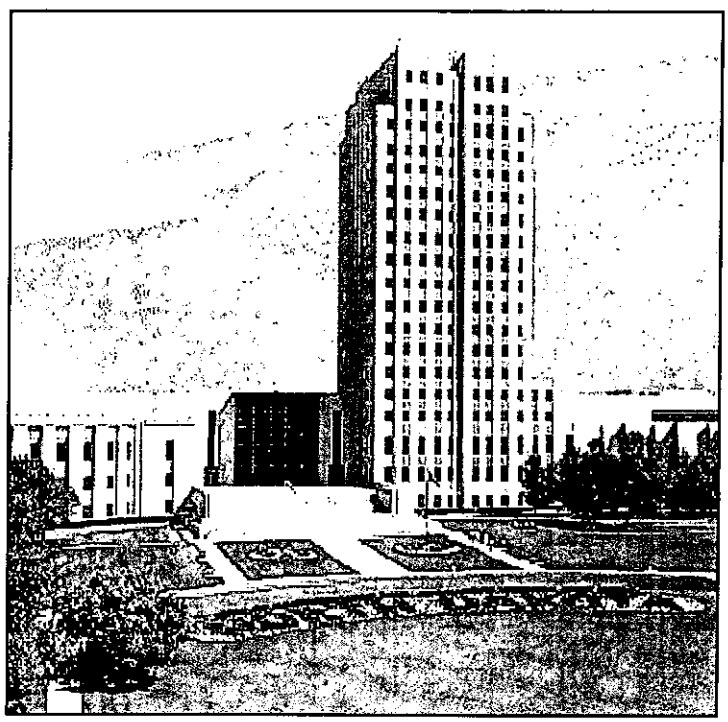
Benefits	Professional	Institutional
Alcohol/Drug Abuse Treatment	$ 2,037,705	$ 5,844,948
Breast Reconstruction	$ 231,087	$ 172,014
Dental Anesthesia	$ 54,447	$ 49,701
Emergency Services	$ 4,090,709	$ 72,155,664
Mammography Screening	$ 3,086,035	$ 963,603
Mental Health (General)	$ 16,316,437	$ 12,558,295
Minimum Maternity Stays	$ n/a	$ 14,197,355
Prostate Cancer Screening	$ 273,640	$ 50,359
TMJ Disorders	$ 54,118	$ 60,711
	$ 26,144,178	$106,052,650

Providers	Professional
Chiropractors	$ 10,537,716
Nurse Midwives	$ 432,523
Nurse Anesthetists	$ 6,357,354
Nurse Practitioners	$ 6,816,191
Nurse, Psychiatric	$ 383,707
Professional Counselors	$ 1,130,534
Psychologists	$ 6,199,756
Licensed Addiction Counselors	$ 1,464,519
Social Workers	$ 1,673,206
	$ 34,995,506

TOTAL $167,192,334

(*Dollar amounts are based on claims incurred 8/1/2003 – 7/31/2004 paid through 10/31/2004)

The Cost of Health Insurance Mandates



This won't cost much.

Alcohol/Drug Abuse Treatmnt
$7,882,653

This won't cost much.

Breast Reconstruction
$403,101

This won't cost much.

Dental Anesthesia
$104,148

This won't cost much.

Minimum Maternity Stay
$14,197,355

This won't cost much.

Emergency Services
$76,246,373

This won't cost much.

Mammography Screening
$4,049,638

This won't cost much.

TMJ Disorders
$114,829

This won't cost much.

Prostate Cancer Screening
$323,999

This won't cost much.

Lic. Addiction Counselors
$1,464,519

This won't cost much.

Mental Health
$28,874,732

This won't cost much.

Chiropractors
$10,537,716

This won't cost much.

Nurse Practitioners
$6,816,191

This won't cost much.

Psychiatric Nurses
$383,707

This won't cost much.

Psychologists
$6,199,756

This won't cost much.

Social Workers
$1,673,206

This won't cost much.

Nurse Anesthetists
$6,357,354

This won't cost much.

Nurse Midwives
$432,523

This won't cost much.

Professional Counselors
$1,130,534

Health Insurance Mandate Comparison

Benefits	08/1999 - 07/2000 Prof. & Insti.	08/2001 - 07/2002 Prof. & Insti.	08/2003 - 07/2004 Prof. & Insti.
Alcohol/Drug Abuse Treatment	$4,176,377	$6,174,592	$7,882,653
Breast Reconstruction	$523,856	$314,789	$403,101
Dental Anesthesia	$76,252	$68,244	$104,148
Emergency Services	$45,804,202	$48,097,757	$76,246,373
Mammography Screening	$1,290,844	$2,135,269	$4,049,638
Mental Health (General)	$21,223,774	$22,928,041	$28,874,732
Minimum Maternity Stays	$5,506,438	$10,970,781	$14,197,355
Prostate Cancer Screening	$81,466	$55,150	$114,829
TMJ Disorders	$745,644	$527,995	$323,999
Total	**$79,428,853**	**$91,272,618**	**$132,196,828**
Providers	**Professional**		
Chiropractors	$6,735,257	$6,766,233	$10,537,716
Nurse Midwives	$345,121	$280,833	$432,523
Nurse Anesthetists	$3,916,399	$4,480,820	$6,357,354
Nurse Practitioners	$2,304,480	$3,677,698	$6,816,191
Nurse, Psychiatric	$408,210	$405,751	$383,707
Professional Counselors	$512,902	$722,496	$1,130,534
Psychologists	$4,459,820	$4,657,986	$6,199,756
Licensed Addiction Counselors	$879,991	$1,029,712	$1,464,519
Social Workers	$992,354	$1,156,633	$1,673,206
Total	**$20,554,534**	**$23,178,162**	**$34,995,506**
Total Benefits & Providers	**$99,983,387**	**$114,450,780**	**$167,192,334**

Taken from the American Family Physician, March 15, 2001

TABLE 1
Summary of Cancer Screening Recommendations for Low-Risk Patients

Medical organization	Screening recommendations
	Breast cancer
	Mammography
AAFP	Every 1 to 2 years, ages 50 to 69; counsel women ages 40 to 49 about potential risks and benefits of mammography and clinical breast examination.
ACOG	Every 1 to 2 years starting at age 40, yearly after age 50
ACS	Annually after age 40
AMA	Every 1 to 2 years in women ages 40 to 49; annually beginning at age 50
CTFPHC	Every 1 to 2 years, ages 50 to 59
NIH	Data currently available do not warrant a universal recommendation for mammography for women in their 40s; each woman should decide for herself whether to undergo mammography.
USPSTF	Every 1 to 2 years, ages 50 to 69
	Clinical Breast Examination
AAFP	Every 1 to 2 years, ages 50 to 69; counsel women ages 40 to 49 about potential risks and benefits of mammography and clinical breast examination.
ACOG	Yearly (or as appropriate) general health evaluation that includes examination to detect signs of premalignant or malignant conditions
ACS	Every 3 years, ages 20 to 39; yearly after age 40; monthly breast self-examination beginning at age 20
AMA	Continuation of clinical breast examinations in asymptomatic women older than age 40
CTFPHC	Yearly, ages 50 to 69
USPSTF	Insufficient evidence to recommend for or against using clinical breast examination alone; optional every 1 to 2 years, ages 50 to 69
	Cervical cancer
AAFP	Pap test at least every 3 years to women who have ever had sexual intercourse and who have a cervix
ACOG	Annual Pap test and pelvic examination beginning at age 18 or when sexually active; after 3 or more tests with normal results, Pap test may be performed less frequently on physician's advice.
ACS	Pap test annually starting at age 18 or when sexually active; after 2 to 3 normal (negative) tests, continue at discretion of physician.
AGS	Pap test every 3 years until age 70; in women of any age who have never had a Pap test, screening with at least 2 negative smears 1 year apart

AMA	Annual Pap test and pelvic examination starting at age 18 (or when sexually active); after 3 or more normal annual Pap tests, the Pap test may be performed less frequently at the physician's discretion.
CTFPHC	Pap test annually beginning at age 18 or following initiation of sexual activity; after 2 normal Pap results, perform Pap tests every 3 years to age 69.
USPSTF	Pap test at least every 3 years in women who have ever had sexual intercourse and who have a cervix; discontinue regular testing after age 65 if Pap test results have been consistently normal.
	Colorectal cancer
AAFP	No published standards or guidelines for low-risk patients
ACOG	After age 50, annual FOBT (DRE should accompany pelvic examination); sigmoidoscopy every 3 to 5 years
ACS	After age 50, yearly FOBT plus flexible sigmoidoscopy and DRE every 5 years or colonoscopy and DRE every 10 years or double-contrast barium enema and DRE every 5 to 10 years
AMA	Annual FOBT beginning at age 50, and flexible sigmoidoscopy every 3 to 5 years beginning at age 50
AGA	FOBT beginning at age 59 (frequency not specified); sigmoidoscopy every 5 years, double-contrast barium enema every 5 to 10 years or colonoscopy every 10 years.
CTFPHC	Insufficient evidence to recommend using FOBT screening in the periodic health examination of individuals older than age 40; insufficient evidence to recommend sigmoidoscopy in the periodic health examination; insufficient evidence to recommend screening with colonoscopy in the general population
USPSTF	After age 50, yearly FOBT and/or sigmoidoscopy (unspecified frequency for sigmoidoscopy)
	Prostate cancer
AAFP	No published standards or guidelines for low-risk patients
ACP-ASIM	Physicians should describe potential benefits and known harms of screening, diagnosis and treatment; listen to the patient's concerns, then individualize the decision to screen.
ACS and AUA	Offer annual DRE and PSA screening, beginning at age 50, to men who have at least a 10-year life expectancy and to younger men at high risk.
AMA	Provide information regarding the risks and potential benefits of prostate screening.
CTFPHC and USPSTF	DRE and PSA tests are not recommended for the general population.
	Skin cancer
ACS	Cancer-related checkup, including skin examination every 3 years between ages 20 and 40, and every year for anyone age 40 and older
AMA	Patients should talk to their physicians about the frequency of screening for skin cancer (those at modestly increased risk should see a primary care physician annually); skin self-examination should be performed monthly.
CTFPHC	Insufficient evidence to recommend for or against total-body skin examination

	or self-examination; counsel on avoiding sun exposure and wearing protective clothing.
USPSTF	Insufficient evidence to recommend for or against routine screening for skin cancer by primary care clinicians or counseling patients to perform periodic skin examination.
	Testicular cancer
ACS	Examine testicles as part of a cancer-related checkup.
CTFPHC	Insufficient evidence to recommend routine examination of testes by physician or by patient self-examination
USPSTF	Insufficient evidence to recommend for or against routine screening of asymptomatic men in the general population by physician examination or patient self-examination

DRE = digital rectal examination; FOBT = fecal occult blood testing; Pap = Papanicolaou; PSA = prostate-specific antigen.

Abbreviations for Medical Organizations: AAFP = American Academy of Family Physicians; ACOG = American College of Obstetricians and Gynecologists; ACP-ASIM = American College of Physicians-American Society of Internal Medicine; ACS = American Cancer Society; AGA = American Gastroenterological Association; AGS = American Geriatrics Society; AMA = American Medical Association; AUA = American Urological Association; CTFPHC = Canadian Task Force on Preventive Health Care; NIH = National Institutes of Health; USPSTF = U.S. Preventive Services Task Force.

NATIONAL GUIDELINE CLEARINGHOUSE™ (NGC™) GUIDELINE SYNTHESIS

SCREENING FOR COLORECTAL CANCER

Guidelines

1. American Cancer Society (ACS). American Cancer Society guidelines on screening and surveillance for the early detection of adenomatous polyps and cancer-update 2001. In: American Cancer Society guidelines for the early detection of cancer. CA Cancer J Clin 2002 Jan-Feb;52(1):8-22. [61 references]
2. American Gastroenterological Association, American Society for Gastrointestinal Endoscopy, American College of Physicians, American College of Gastroenterology (AGA/ASGE/ACP/ACG). Colorectal cancer screening and surveillance: clinical guidelines and rationale--update based on new evidence. Gastroenterology 2003 Feb;124(2):544-60. [102 references]
3. Canadian Task Force on Preventive Health Care (CTFPHC). Preventive Health Care, 2001 Update: Colorectal Cancer Screening. CMAJ 2001 Jul 24; 165(2):206-8 [20 references].
4. Institute for Clinical Systems Improvement (ICSI). Colorectal cancer screening. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2002 Jun. 45 p. [54 references].
5. U.S. Preventive Services Task Force (USPSTF). Screening for colorectal cancer: recommendations and rationale. Ann Intern Med 2002 Jul;137(2):129-31 [31 references].

INTRODUCTION:

A direct comparison of USPSTF, ACS, AGA/ASGE/ACP/ACG, ICSI, and CTFPHC recommendations for colorectal cancer screening is provided in the five tables below. Table 1 compares the objectives and scope, target population, intended users and screening options discussed in each guideline. Table 2 focuses on screening recommendations for asymptomatic patients who are at average risk for colorectal cancer. The various screening options are reviewed along with recommendations regarding frequency and administration of screening tests where applicable. Table 3 considers screening and surveillance recommendations for patients at increased risk for colorectal cancer. Table 4 compares the potential benefits and possible harms associated with screening. Table 5 provides a comparison of the various evidence rating schemes used by USPSTF, ICSI and CTFPHC to formulate recommendations.

Following the content comparison, areas of agreement and differences among the guidelines are discussed. In general, the timing of the guideline with respect to available data is an important factor to consider when evaluating areas of differences among guidelines.

Abbreviations used in the text and table follow:

- ACG, American College of Gastroenterology
- ACP, American College of Physicians American
- ACS, American Cancer Society
- AGA, American Gastroenterological Association
- ASGE, American Society for Gastrointestinal Endoscopy
- CRC, colorectal cancer
- CTFPHC, Canadian Task Force on Preventive Health Care

- DCBE, double contrast barium enema
- DRE, digital rectal examination
- FAP, familial adenomatous polyposis
- FOBT, fecal occult blood testing
- HNPCC, hereditary nonpolyposis colorectal cancer
- ICSI, Institute for Clinical Systems Improvement
- TCE, total colon examination
- USPSTF, United States Preventive Services Task Force

TABLE 2: COMPARISON OF RECOMMENDATIONS FOR SCREENING FOR COLORECTAL CANCER:
ADULTS, ≥50 YEARS, NO OTHER RISK FACTORS

Fecal occult blood testing (FOBT)	
ACS (2001)	• FOBT annually is an acceptable screening option. • The take-home multiple sample method (six samples from three consecutive stools at home) should be used. • A positive FOBT should be followed by a colonoscopy because of the possibility that an important lesion can be visualized and biopsied during examination.
AGA/ASGE/ACP/ACG (2003)	• Offer yearly screening with FOBT using a guaiac-based test with dietary restriction or an immunochemical test without dietary restriction. • Two samples from each of 3 consecutive stools should be examined without rehydration. • Patients with a positive test on any specimen should be followed up with colonoscopy.
CTFPHC (2001)	• There is good evidence to include screening with Hemoccult test in the periodic health examination of asymptomatic patients over age 50 with no other risk factors [A, I]. • For patients being screened with Hemoccult, it is recommended that they avoid red meat, cantaloupe and melons, raw turnip, radishes, broccoli and cauliflower, vitamin C supplements and aspirin and non-steroidal anti-inflammatory drugs for 3 days before fecal samples are collected. However, a recent meta-analysis of 4 randomized controlled trials found no improvement in positivity rates or change in compliance rates with moderate dietary restrictions.
ICSI	• An acceptable screening option is FOBT annually.

(2002)	• A minimum of 3 FOBT cards should be submitted by a patient annually. Standard protocols for obtaining the specimens should be followed as specified by the manufacturer and/or individual testing lab (usually based on 2 samples from 3 different stool specimens). Slide rehydration as an option when testing specimens is not strongly recommended. (Conclusion Grade I. Evidence supporting this recommendation is of classes: A, C, D, R, X)
USPSTF (2002)	• The USPSTF strongly recommends that clinicians screen men and women 50 years of age or older for colorectal cancer. **Grade A recommendation.** • The USPSTF found fair to good evidence that several screening methods are effective in reducing mortality from colorectal cancer. The USPSTF concluded that the benefits from screening substantially outweigh potential harms, but the quality of evidence, magnitude of benefit, and potential harms vary with each method. • There is good evidence that periodic FOBT reduces mortality from CRC. • Annual FOBT offers greater reductions in mortality rates than biennial screening but produces more false-positive results. • Proven methods of FOBT screening use guaiac-based test cards prepared at home by patients from three consecutive stool samples and forwarded to the clinician. Whether patients need to restrict their diet and avoid certain medications is not established. Rehydration of the specimens before testing increases the sensitivity of fecal occult blood testing but substantially increases the number of false-positive test results.

Attachment 1

Additional Information: SB 2169
As Requested by Senator Judy Lee
1/26/2005

I. The Costs of Colorectal Screening

A. Costs disputed by the US Government agencies

1. The General Accounting Office found "The additional costs of state mandates beyond what businesses would typically incur are estimated to be relatively small."
2. The Congressional Budget Office Paper found that "potential savings from the mandate exemptions are smaller that the actuarial costs"
3. CBO calculations suggest a range of .28 to 1.15 percent as the effective marginal cost of five of the most costly state mandates versus the actuarial cost of 5.4 percent to 22 percent.

B. Premiums are rising faster that costs.

1. Cost of premiums increased 15% in 2003
2. Health care spending increased 7.4% in 2003

C. The Lewin Group Cost Model results on Colorectal Screening

1. Sample population of 81,565
   a. 14,941 over the age of 50
   b. Estimated 41% compliance with screening recommendations, base on CDC findings.
2. Model developed based on three colorectal cancer screening methods
   a. Annual Fecal Occult Blood Test (FOBT)
   b. Annual FOBT and Flexible Sigmoidoscopy every 5 years
   c. Colonoscopy every 10 years
3. Results
   a. FOBT - $0.47 PMPM, $5.70 annually
   b. FOBT + Flex. Sig. @ 5 years - $0.66 PMPM, $7.92 annually
   c. Colonoscopy @ 10 years - $0.55 PMPM, $6.64 annually

II. Colorectal Screenings

A. Why colonoscopy is considered the "Gold Standard"

1. U.S. Agency for Health Care Policy and Research found that among medical and scientific communities colonoscopy was the "gold standard" for screening.
2. Colonoscopy correctly detects over 90% of polyps or cancer
3. Colonoscopies need only be done once every 10 years
4. Allows for removal of polyps at time of detection

B. How does Flexible Sigmoidoscopy compare?

1. Only examines the lower third to one-half of the colon.
2. Performed once every 5 years
3. Usually performed in combination with FOBT
4. Not as complete or accurate as colonoscopy
5. Test combination with FOBT still misses 24 percent of cases as compared to colonoscopy.
6. Positive test requires follow-up colonoscopy

C. What about Fecal Occult Blood Test (FOBT)

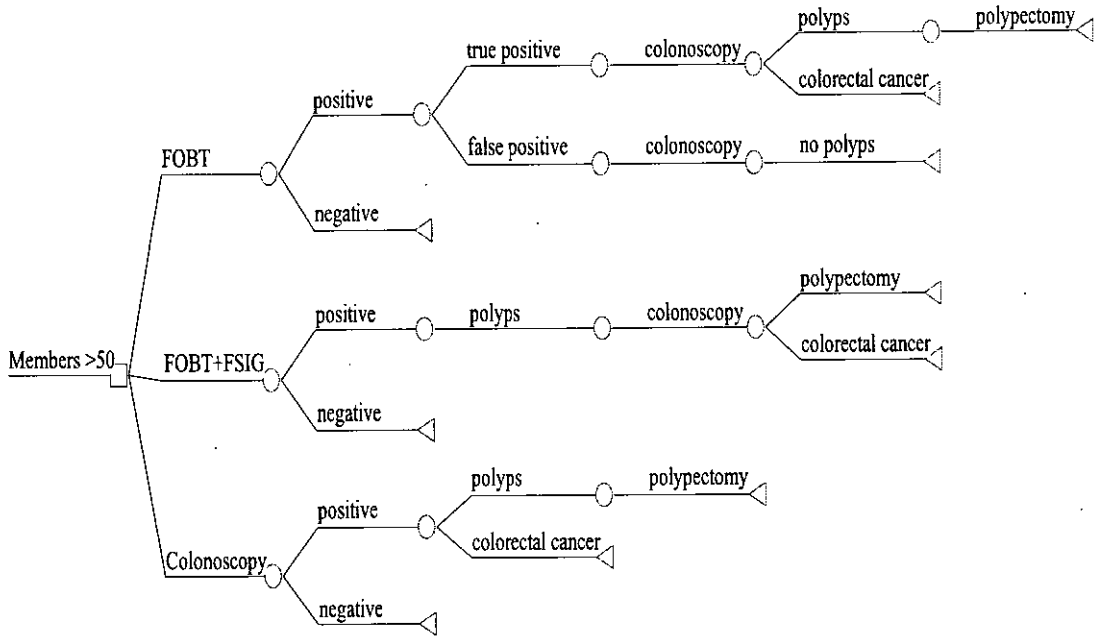
1. Least accurate method, detects blood shed by polyps and cancer
2. Used alone, test detects less than half of all colorectal cancers
3. False positive rates of 85 to 90 percent.
4. False positives result in considerable follow-up, including colonoscopy.

SCREENING COMPLIANCE		DATA SOURCE
ANNUAL FOBT/FLEXIBLE SIGMOIDOSCOPY@ 5YRS	41%	Palitz et al. The Colon Cancer Prevention Program (CoCaP): Rationale, Implementation, and Preliminary Results, *HMO Practice*, 1997.
COLONOSCOPY@ 10-YRS	41%	
FOLLOW UP COLONOSCOPY	80%	Frazier et al. Cost-effectiveness of Screening for Colorectal Cancer in the General Population. *Journal of the American Medical Association*, 2000.
SCREENING COMPLICATION RATE		**DATA SOURCE**
FLEXIBLE SIGMOIDOSCOPY	4 per 100,000 screens	Anderson et al. Endoscopic Perforation of the Colon: Lessons from 10 year Study. *American Journal of Gastroenterology*, 2000.
COLONOSCOPY	1.9 per 1,000 screens	

SCREENING AND TREATMENT COSTS (in 1998 US Dollars)*		DATA SOURCE
FOBT SCREEN	$12.64	Khandker et al. A Decision Model and Cost Effectiveness Analysis of colorectal cancer Screening and Surveillance Guidelines for Average Risk Adults. *International Journal of Technology Assessment in Health Care*, 2000.
FLEXIBLE SIGMOIDOSCOPY SCREEN	$201.89	
FLEXIBLE SIGMOIDOSCOPY+BIOPSY	$342.60	
COLONOSCOPY SCREEN	$768.38	
POLYPECTOMY/PATHOLOGY	$357.03	
COLONOSCOPY+POLYPECTOMY	$1,125.41	
SCREENING COMPLICATIONS	$32,356.49	

Decision Tree:

Colonoscopy versus other colorectal screenings



Attachment 2

A MILLIMAN GLOBAL FIRM

Milliman
Consultants and Actuaries

8500 Normandale Lake Blvd.
Suite 1850
Minneapolis, MN 55437
Tel +1 952 897.5300
Fax +1 952 897.5301
www.milliman.com

February 7, 2005

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

Re: Analysis of Senate Bill 2169

Dear Mr. Olsrud:

Thank you for your letter of January 18 requesting a cost-benefit analysis of the colorectal cancer screening mandate included in Senate Bill No. 2169. You asked that we provide information to help determine the following:

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

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

Background

This bill requires carriers to cover the cost of colorectal cancer screening examinations and laboratory tests of asymptomatic individuals in accordance with generally accepted standards of medical practice. For the first two years, this mandate would apply only to the state employee group. After that, the mandate would apply to other commercial individual and group health insurance products.

The American Cancer Society (ACS) estimates that in North Dakota there will be 360 new cases of colon and rectal cancer and 140 deaths due to these cancers in 2005. The Agency

for Healthcare Research and Quality of the US Department of Health and Human Services reports that colorectal cancer is the 2nd leading cause of cancer death in the U.S.

The American Cancer Society recommends men and women at average risk for developing colorectal cancer follow one of the follow five testing schedules beginning at age 50:

- yearly fecal occult blood test (FOBT) or fecal immunochemical test (FIT)
- flexible sigmoidoscopy every five years
- yearly FOBT or FIT plus flexible sigmoidoscopy every five years
- double-contrast barium enema every five years, or
- colonoscopy every 10 years.

People who are at above average risk for developing colorectal cancer (such as those who have a personal or family history with colorectal cancer or a personal history with adenomatous polyps or inflammatory bowel disease) are recommended to begin screening earlier and/or undergo testing more often. The recommendations of the American College of Gastroenterology are similar. Therefore, we expect that this benefit would be used by a significant portion of the population.

Impact on Premium Rates

Direct Impact

We analyzed the potential impact of a similar bill in 2003 (House Bill 1349). In our analysis of House Bill 1349, we estimated that mandate might increase insurance premiums in the range of 0.1% to 0.3%, for those health insurance products that do not currently include such coverage. We believe that estimate is still reasonable. We do not have information about the extent to which these screening exams are currently covered by health insurance products in North Dakota. If you wish, we can extend our analysis by seeking such information.

In calculating this estimate, we used the mandate pricing model we developed in 2002 for North Dakota, along with some relatively conservative assumptions regarding the compliance with the recommendations outlined above. In particular, we assumed that each year:

(1) 25 percent of adults between the ages of 50 – 65 received a FOBT, and
(2) either 10% received a sigmoidoscopy or 5% received a colonoscopy. These figures correspond to the guidelines above. They assume that 50% of affected members will elect either a sigmoidoscopy or colonoscopy.

As a point of reference, a study published by the Centers for Disease Control and Prevention (CDC) in 2004 reported that in North Dakota in 2002, just over 60% of adults aged 50 years or older reported *not* having had a sigmoidoscopy or colonoscopy in the previous five years.

We did not include the cost of any office visits or other services that may be incurred along with the actual colorectal screening test.

The actual increase will depend on a number of factors, including the demographics of the covered population, out of pocket costs (such as deductibles, coinsurance, and copays), and the degree of compliance with screening recommendations. The estimates provided above, assumed cost sharing of a $250 deductible and 10% member coinsurance. In terms of demographics, the state employee group, to which this mandate would apply over the first two years, may well be older than the typical commercial (non-Medicare) group in North Dakota. The estimated cost of this mandate could easily increase by 15% or more from the estimates provided above, to the extent that a higher proportion of the population is in the age group where routine screening is recommended.

This will be important to keep in mind when you are analyzing the experience of the state group. In fact, as part of that analysis, we would recommend collecting data on the distribution by age of the insured population in North Dakota and comparing it to the demographics of the state group.

According to information from the CDC, the following costs are a typical range of rates for colorectal cancer screening tests.

- flexible occult blood test (FOBT) - $10-$25
- flexible sigmoidoscopy - $150-$300
- double contrast barium enema - $250-$500
- colonoscopy - $800-$1,600

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

We were asked if mandating this coverage would increase the appropriate use of services. Given the costs associated with some of the tests as shown above, we do believe that providing coverage will increase compliance with ACS guidelines, although we do not have data to confirm or quantify this. In addition, costs may be higher the first year the mandate is in place, since many insureds may be behind schedule and may be incented to undergo screening after it becomes an insured benefit. On the other hand, to the extent that health plans have the ability to negotiate and appropriately monitor fee levels, we would not expect this mandate to increase the per service cost for these services dramatically,

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

Indirect Impact

There could also be offsetting benefits related to the early detection and treatment of colorectal cancer. A few years ago, the state of Pennsylvania recently considered a similar mandate and issued a report in which the American Cancer Society is cited as reporting

offsetting benefits. In particular, they report that a precancerous polyp can be removed during screening for about $1,100. They go on to say that if that polyp goes undetected and develops into Stage IV colorectal cancer, treatment costs can reach up to $58,000. They also stated that "the initial cost of treating rectal cancer that is detected early is about $5,700. This is approximately 75% less than the estimated $30,000 - $40,000 that it costs to initially treat rectal cancer that is detected further in its development."

This report was published in May 2002, and costs have likely risen since then. In addition, new and expensive therapies, such as Avistan which is used to treat advanced colon cancer, have and continue to become widely available since then. In addition, in interpreting these results, it is important to keep in mind that approximately 90% of colorectal cancers occur after age 50, so the financial benefit of early detection will largely be realized later in life when most people are covered by Medicare.

Also worth noting is the significant rate of false positives associated with the FOBT, which may introduce added follow up costs. The follow up test is typically a colonoscopy. We are not able to quantify this cost without additional research.

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

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

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

Sincerely,

Leigh M. Wachenheim

Leigh M. Wachenheim, FSA, MAAA
Principal & Consulting Actuary

LMW/mtf

Attachment 5

Lee, Judy E.

From: fadel nammour [fama6@yahoo.com]
Sent: Thursday, January 20, 2005 12:56 PM
To: Lee, Judy E.
Subject: colon cancer bill

Dear chairman Lee and committee members, I just would like to comment on the opposition testimony and bring up some points that were misinterpreted:

1- FOBT
US preventive task force do not recommend FOBT as the only screening method, and do not prefer it against all others. There is direct evidence that FOBT reduce mortality by one third if it's followed by a colonoscopy. It's the colonoscopy that reduces mortality and morbidity. Also the same task force by reviewing all articles available, states that colonoscopy could reduce incidence and mortality by 60 to 90%, based on indirect evidence. FOBT only detect 20-30% of lesions or early cancer but they don't detect polyps, and there is a very low compliance with patient, cause they don't like playing with their stool, and there is a strict diet to follow, 5 days prior to the test.

2.Flexibility
The bill is flexible since it gives patient and physicians the choice between 4 different screening methods, following guidelines established by medical associations. These guidelines are flexible, and reviewed every few years, as needed, to follow up with technology and improvement of screening methods.

3.Cost
The opposition mentioned the cost of screening, but what about the cost of treating colon cancer:
-hospital stay, surgeries, doctors visit, chemotherapy, side effect, without counting the emotional cost.
Some estimates hospital expenses around
$20-30,000/year and chemotherapy at $40-50,000/year.

Also procedures reimbursement for screening is on the decline, and each year the fees are reduced, and this is a trend that will continue in the years ahead.

4.Capacity
Maybe nationwide we don't have enough personnel. In ND, it's a little bit different:
- smaller population
- we are targeting 60% of the adult population age
50-65 years since the remaining 40% have already been screened.
- not only gastroenterolgist do the procedures , but also surgeons, family practice and internal medicine, and this maybe an incentive to bring more qualified people to the state.

5.Premiums
Premiums are on the rise with and without this bill, and chemotherapy is not getting cheaper. By having a healthier population less money will be paid, and preventive medicine have showing it's economical benefit over the last 2 decades.

Again, thank you very much for your time and consideration of this bill.
If I can be of any further assistance, or if more issues arise, and need clarification I'll be happy to discuss it to the best of my knowledge.

THANK YOU

=====
Fadel Nammour, M.D.
3000 32nd Ave. South

REPORT OF THE LEGISLATIVE COUNCIL'S EMPLOYEE BENEFITS PROGRAMS COMMITTEE SENATE BILL NO. 2169

Sponsor: Senator Judy Lee

Proposal: The bill adds colorectal cancer screening as a mandated benefit to the Public Employees Retirement System uniform group health insurance plan.

Actuarial Analysis: The cost of the proposal is $3.60 per contract per month.

Committee Report: Unfavorable recommendation.

February 2, 2005

GREATER NORTH DAKOTA CHAMBER of COMMERCE

Madame Chairman Judy Lee
Members of the Senate Human Services Committee
600 E Boulevard Ave.
Bismarck ND 58505

Dear Madame Chairman and Committee Members:

While testimony for SB 2169 has already been heard, I would like to submit this letter in lieu of testimony and to provide you with more information. I write to you today representing a coalition of chambers of commerce that speak for over 7,400 member businesses. I would like to urge you to **oppose** Senate Bill 2169.

The business community feels that mandates, such as the one included in SB 2169, 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 colorectal cancer screenings. 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 explain the business community's position on SB 2169. We urge a **DO NOT PASS** for SB 2169.

Sincerely,

David Straley

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