2025 HOUSE INDUSTRY, BUSINESS AND LABOR

HB 1283

2025 HOUSE STANDING COMMITTEE MINUTES

Industry, Business and Labor Committee
Room JW327C, State Capitol

HB 1283
1/27/2025

A BILL for an Act to create and enact a new section to chapter 54-52.1 of the North Dakota Century Code, relating to diagnostic breast examination and supplemental breast examination cost-sharing restrictions; to provide for a report to the legislative assembly; to provide for application; and to provide an expiration date.

4:00 p.m. Chairman Warrey opened the hearing.

Members Present: Chairman Warrey, Vice Chairman Ostlie, Vice Chairman Johnson, Representatives Bahl, Brown, Christy, Finley-DeVille, Grindberg, Johnson, Kasper, Koppelman, D. Ruby, Schatz, Schauer, Vollmer

Discussion Topics:

- Supplemental imaging
- Cost share
- 25% of the population insured
- Early detection, better outcomes.
- Health savings
- Costly treatment
- Diagnostic imaging/evaluation
- Limitations could limit survival
- Increase breast imaging
- Ultrasound before biopsy
- Cost savings from long-term hospitalizations
- Free market economy
- Private business increases
- NDPERS pilot program

4:05 p.m. Representative Karen Karls, District 35, Bismarck, ND, introduced, testified and submitted testimony #31856 and #31945.

4:07 p.m. Bobbie L. Will, Policy and Advocacy Manager, Susan G. Komen, testified in favor and submitted testimony #31792, #31793 and #31953.

4:19 p.m. Ben W. Hanson, Government Relations Director, American Cancer Society Cancer Action Network, testified in favor and submitted testimony #31783, #31784 and #31785.

4:24 p.m. Dr. Christina M. Tello-Skjerseth, Chief of Staff, Chief Radiologist, Sandford Health, testified and submitted testimony #31664.

4:31 p.m. Mary Tello Pool, Nurse, Bismarck, ND, testified in favor and submitted testimony #38390.

4:37 p.m. Kelly Buettner-Schmidt, Volunteer, American Cancer Society Cancer Action Network (ACS CAN), submitted testimony in favor #31597.

4:39 p.m. Andrea Pfennig, Greater North Dakota Chamber (GNDC) testified in opposition.

4:47 p.m. Rebecca Fricke, Executive Director, NDPERS, testified as neutral and submitted testimony #31307.

Additional written testimony:
Stacey Will, Bismarck ND, submitted testimony in favor #31273.
Adrienne Frederick, Director, State Government & Regional Affairs, AdvaMed, submitted testimony in favor #31300.
Morgan Billman, Bismarck, ND, submitted testimony in favor #31328.
Heidi Allbee, Bismarck, ND, submitted testimony in favor #31329.
Michele R. Swanson, Bismarck, ND, submitted testimony in favor #31426.
Sherri Miller, Executive Director, ND Nurses Association, submitted testimony in favor #31699.
Cori R. Brothers, Bismarck, submitted testimony in favor #31486.
Kimberly A. Kuhlmann, Policy & Partnership Manager, Community HealthCare Association of the Dakotas (CHAD), submitted testimony in favor #31566 and #31605.
Brandy L. Braun, Legislative Liaison, ND Nurse Practitioner Association, submitted testimony in favor #31586.

4:53 p.m. Chairman Warrey adjourned the meeting.

Diane Lillis, Committee Clerk

HB 1283
House Industry, Business and Labor Committee
Written Testimony
January 27, 2025

Dear Chair and Members of the House Industry, Business and Labor Committee.

I appreciate the opportunity to share my perspective on HB 1283. My name is Stacey Will. I currently work in the health care industry and my job is to ensure our ND community members get timely, appropriate, and thorough screening.

Screening saves lives. To save lives and decrease medical expenses, we must find breast cancer early. Mammograms are the first level of screening to detect breast cancer, however, if anything is identified as potentially suspicious further evaluation is needed by additional mammographic views. This includes, but is not limited to, ultrasound, and/or MRI, and potentially a biopsy to confirm a cancer diagnosis.

Unfortunately, I have personally seen multiple patients decline additional steps in screening due to the inability to pay for them. This eventually leads to late-stage diagnosis which results in lower survival rate, more aggressive treatments at higher costs.

In addition to supporting our community in getting screened, I have been a victim of high-cost screening due to additional imaging. Due to dense breast tissue, cancer is harder to detect on regular mammogram. I am required to have additional imaging to ensure proper views are obtained. In addition to regular mammograms annually, I have had spot compressions, ultrasounds, CT guided mammograms, as well as a biopsy. This has cost thousands of dollars out of pocket every year.

As a healthcare professional, patient, mother of two daughters, and community member, I am committed to the fight against breast cancer and ensuring everyone has equal access to breast imaging. This could save your wife, mother, daughter, aunt, niece, neighbor etc. I support HB1283 and I urge you to pass this important, life-saving legislation.

Thank you for your consideration.

Sincerely,
Stacey Will
701-400-6930

AdvaMed
Advanced Medical Technology Association

AdvaMed The Medtech Association | MEDICAL IMAGING

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January 24, 2025

House Industry, Business and Labor Committee
North Dakota State Capitol
600 E Boulevard Ave
Room 327C
Bismarck, ND 58505

Re: Support of HB 1283

Dear Chair Warrey, Vice Chair Johnson, and Members of the Committee:

On behalf of AdvaMed, the MedTech Association, and the AdvaMed Medical Imaging Division, we are writing in support of HB 1283, a bill increasing access to medically necessary diagnostic and supplemental breast imaging by limiting the burden of patient cost-sharing. Simply, this legislation will help save lives and allow more families to enjoy additional meaningful moments together.

AdvaMed is the largest association representing medical technology innovators and manufacturers. Our members are the device, diagnostics, medical imaging, and digital technology manufacturers transforming health care through earlier disease detection, less invasive procedures, and more effective treatments. They range from the smallest startups to multinational corporations.

AdvaMed Medical Imaging Division represents the manufacturers of medical imaging equipment and focused ultrasound devices. Our members have introduced innovative medical imaging technologies to the market, and they play an essential role in our nation's health care infrastructure and the care pathways of screening, staging, evaluating, managing, and effectively treating patients with cancer, heart disease, neurological degeneration, COVID-19, and numerous other medical conditions.

We commend North Dakota for its leadership on this critical issue for patients. While mammogram screens are fully covered by many health plans, follow-up diagnostic exams due to abnormal results often are not. Similarly, diagnostic exams are needed for women who are asymptomatic but have other pre-existing health conditions that put them at a higher risk of breast cancer.

Unfortunately, according to a recent study, the fear or frustration of unexpected or high out-of-pocket costs, causes many women to delay or forego needed exams in

these situations.[1] Physicians also agree that cost is the primary reason women do not follow-up after their initial mammogram screening.[2]

Screening is also often underutilized in underserved populations, exacerbating health inequities.[3,4] The rate of cancer screening is lower among racial and ethnic minority populations, compared to the white population. Further, cancer outcomes are often worse in minority populations compared to the white population.[5]

Additionally, under-utilization of critical screening services was further compounded during the COVID-19 pandemic. As has been reported, screening fell dramatically over the last few years, potentially increasing the burden of cancer and other disease on the American public.[6,7,8,9]

Screening saves lives, reduces suffering, and lowers costs for patients. Unfortunately, it is underutilized. This legislation enables patients – and their families – to focus solely on what is best for their health, rather than on whether or not they can afford needed, life-saving exams.

AdvaMed and the AdvaMed Medical Imaging Division are proud to support this legislation that puts patients first.

Sincerely,

Adrienne Frederick
Director, State Government & Regional Affairs
AdvaMed

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[1] https://www.komen.org/news/new-susan-g-komen-study-unveils-high-cost-of-diagnostic-tests-for-breast-cancer-serves-as-a-barrier-to-needed-care/
[2] Id.
[3] https://www.auntminnie.com/index.aspx?sec=sup&sub=imc&pag=dis&ItemID=139085
[4] https://www.kff.org/racial-equity-and-health-policy/issue-brief/racial-disparities-in-cancer-outcomes-screening-and-treatment/
[5] ibid
[6] Changes in Cancer Screening in the US During the COVID-19 Pandemic, JAMA, https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2792956
[7] Association of Cancer Screening Deficit in the United States With the COVID-19 Pandemic, JAMA Oncology https://pubmed.ncbi.nlm.nih.gov/33914015/
[8] A national quality improvement study identifying and addressing cancer screening deficits due to the COVID-19 pandemic, Cancer, https://pubmed.ncbi.nlm.nih.gov/35307815/
[9] The Impact of COVID-19 on Cancer Screening: Challenges and Opportunities, JMIR Cancer, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7599065/

TESTIMONY OF REBECCA FRICKE

House Bill 1283 – Diagnostic or Supplemental Breast Exam Services

Good Afternoon, Mr. Chairman and members of the committee. My name is Rebecca Fricke and I am the Executive Director of the North Dakota Public Employees Retirement System, or NDPERS. I appreciate the committee taking the time to analyze House Bill 1283, which requires a pilot program under the NDPERS health insurance related to diagnostic and supplemental breast exam coverage, including a cost-share restriction. I am here today on behalf of the NDPERS Board to provide information in a neutral capacity so the policy makers are able to make an informed decision regarding the bill.

House Bill 1283 adds a new section under NDCC 54-52.1 related to diagnostic and supplemental breast exam coverage, including a cost-share restriction. In addition, the bill restricts imposing a deductible, copayment or any other cost-sharing requirement that forces a member to pay an out-of-pocket cost for diagnostic breast exams or supplemental breast exams. The bill stipulates that high-deductible health plans that qualify for health savings account are exempt from this cost-share limit until a member reaches their minimum deductible.

Under the provisions of NDCC 54-03-28, the bill applies to NDPERS health insurance plan for a pilot program during the 2025-2027 biennium.

Our consultant estimates that the bill would have a financial impact on the NDPERS health insurance plan and estimates an increase in premium of .5%, or $4,070,000, in the 2025-2027 biennium. The main driver of this additional premium is that under our current health plans, the initial mammogram is covered within recommended age bands or if medically necessary, but cost-sharing applies on supplemental breast exams.

House Bill 1283 was a bill introduced during the interim, with the analysis provided to the Employee Benefits Programs Committee, which gave the bill a favorable recommendation. The consultant and legal analysis provided to the committee is included as an attachment to the end of my testimony (please note this was draft bill 75 during the interim session).

Mr. Chairman, I appreciate the committee taking the time to learn more about the impact this bill will have to our state. This concludes my testimony, and I'd be happy to answer any questions the committee may have.

Deloitte Consulting LLP
50 South Sixth Street
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USA

Tel: 612 397 4000

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Memo

Date: June 7, 2024

To: Rebecca Fricke - Executive Director, North Dakota Public Employees Retirement System

Representative Austen Schauer - Chair, Legislative Employee Benefits Programs Committee, North Dakota State Government

From: Tim Egan, Dan Plante, Ford Edgerton, and Karno Sarkar - Deloitte Consulting LLP

Subject: **FINANCIAL REVIEW OF PROPOSED BILL 25.0075.02000**

Deloitte Consulting LLP (Deloitte [i]) was engaged to review the proposed legislation and the potential financial impact to the Uniform Group Insurance Program (Program) administered by the North Dakota Public Employees Retirement System (NDPERS), as well as other considerations that may contribute to the evaluation of the legislation.

The information included in the review relies on data provided by NDPERS, as well as publicly available data and industry studies. From the data provided by NDPERS, some of these data sources were developed by NDPERS, while others were prepared or created by third parties and delivered to NDPERS.

As part of the review, all data was reviewed for reasonableness, but an audit was not performed on the data. To the extent the data contains errors or anomalies that were unknown at the time the data was provided, the analysis may be affected by those issues.

OVERVIEW OF PROPOSED BILL

The Bill would create and enact a new section to chapter 54-52.1 of the North Dakota Century Code, relating to diagnostic breast examination and supplemental breast examination cost-sharing restrictions:

- defines "diagnostic breast examination" and "supplemental breast examination"
- restricts insurers and plan sponsors from imposing a deductible, copayment, or any other cost-sharing requirement that forces a member to pay an out-of-pocket cost for diagnostic breast exams or supplemental breast exams
- stipulates that high-deductible health plans that qualify for health savings accounts are exempt from this cost-share limit until a member reaches their minimum deductible

ESTIMATED FINANCIAL IMPACT

Based on the analysis, it is anticipated the proposed legislation will have a financial impact on the Uniform Group Insurance Program. It is estimated the financial impact of the proposed legislation on the Uniform Group Insurance Program is approximately $4,070,000 in the 2025-2027 biennium ending 6/30/2027.

The Uniform Group Insurance Program currently imposes a cost sharing requirement on supplemental breast exams. The initial mammogram is covered as a preventative service, but any additional exam is currently subject to member cost-sharing.

Using 24 months of NDPERS claims data from January 2022 through December 2023, it is estimated that covering supplemental breast exams without member cost-sharing will shift approximately $3,300,000 from the member to the Uniform Group Insurance Program in that period. Assuming medical trend of 5.7% per year, the additional cost in the 2025-2027 biennium is estimated to be approximately $4,070,000 (or approximately a 0.5% increase to the estimated total Program cost). The estimate does not assume changes to current utilization of breast exams.

OTHER CONSIDERATIONS

By covering supplemental breast examinations without any member cost-share, breast examinations will not accumulate towards a member's deductible. As a result, members may have to pay for other services out-of-pocket until they reach their deductible, which may negate some of the estimated 0.5% increase to the estimated Program total claims costs. Therefore, the $4,070,000 estimated increase in cost can be treated as a conservative estimate, assuming no other change in utilization.

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[i] This document is intended strictly for the client's internal use and not for any other third party. As such, Deloitte is not, by means of any resulting disclosure or publication of this document, rendering professional advice or services to any third party. This document and its contents should not be used by any third party as a basis for any decision or action. Deloitte shall not be responsible for any loss sustained by any third party who relies on this document or its contents.

Dear Chair and Members of the House Industry, Business, and Labor Committee,

Thank you for the opportunity to share my thoughts on HB 1283. My name is Morgan Billman, and I work in the healthcare industry in a role that focuses on ensuring that our community members have a positive patient experience, which is too often hindered by lack of access due to high costs.

One regular cost for most women is breast cancer screening. Mammograms are the first step in detecting breast cancer, but if anything suspicious is found, additional testing is necessary to confirm a diagnosis.

I have multiple family members who have required additional imaging, including ultrasounds and biopsies. While my family is fortunate to be able to afford such testing, many patients are not, which can lead to late-stage diagnosis as well as more aggressive and expensive treatments.

As a healthcare professional, a patient, and a member of this community, I am committed to ensuring that everyone has access to the screenings they need.

I fully support HB 1283 and urge you to pass this life-saving legislation.

Thank you for your time and consideration.

Sincerely,

Morgan Billman

HB 1283
House Industry, Business and Labor Committee
Written Testimony
January 27, 2025

Dear Chair and Members of the House Industry, Business and Labor Committee.

I appreciate the opportunity to share my perspective on HB 1283. My name is Heidi Allbee. I am a wife, mother, sister, daughter, nurse, community member and patient and I am asking you to support HB 1283. This will increase access to medically necessary diagnostic and supplemental breast imaging without the burden of patient cost sharing.

Screening saves lives. To save lives and decrease medical expenses, we must find breast cancer early. Mammograms are the first level of screening to detect breast cancer, however, if anything is identified as potentially suspicious further evaluation is needed by additional mammographic views. This includes, but is not limited to, ultrasound, and/or MRI, and potentially a biopsy to confirm a cancer diagnosis.

Many women decline additional screening due to the inability to pay for them. This eventually leads to late-stage diagnosis, which results in lower survival rate and more aggressive treatments at higher costs. Imagine the burden of having cancer and not having access to an answer due to financial concerns.

I am diligent in having yearly screening mammograms because I know the importance of early detection. Unfortunately, I have been required to have additional imaging due to abnormal findings. This additional imaging can cost thousands of dollars out of pocket. I am fortunate to be able to afford the recommended imaging, however not everyone can. Every woman in ND should have access to additional mammographic screening to rule out cancer regardless of their financial status. This could save you, your wife, mother, daughter, aunt, niece, neighbor etc. I support HB1283 and I urge you to pass this important, life-saving legislation.

Thank you for your consideration.

Sincerely,
Heidi Allbee
(701) 426-3107

Jan. 27, 2025
Bill # HB 1283
Industry, Business and Labor Committee

Dear Chair Warrey and Members of the House Industry, Business and Labor Committee,

Thank you for this opportunity to share my testimony regarding SCR 4009. When treating breast cancer, we know that early detection is key, which is why the added diagnostic imaging is recommended, the earlier that breast cancer is found the more treatment options there are and the better chance for survival for the women impacted.

In 2017, I went in for an annual mammogram, after which an ultrasound was recommended and then also an ultra sound guided biopsy which showed I had Atypical lobular hyperplasia. My doctor informed me that almost half of all women with this lesion will develop breast cancer at some point in their lives. At the time, my husband was active duty military and for several years, all my mammograms and annual MRI's were fully covered and I had no problem keeping up with the recommended imaging. Unfortunately, I was divorced after 28 years of marriage and am having to start over at age 54. As such, my insurance coverage has changed, and now I have not had a MRI screening that is recommended in the past 2 years due to the cost that I know I will incur. It would be wonderful to be able to have my screenings and live my life having peace of mind that I'm free of breast cancer, as opposed to worrying about how can I make this happen financially and the consequences of not having the imaging done.

I am in support of SCR 4009 because I feel that it would allow many more women become compliant with the screening recommendations of their doctors by removing expensive copays/co insurance costs, which are currently a barrier. In addition to providing financial peace of mind, mothers, daughters, sisters, and wives would also have peace of knowing the state of their health and be empowered to make the best choices for themselves, and to live their best lives.

Sincerely,

Michele Swanson
District 47
Phone#: 701-390-6140

Chair Warrey and Members of the House Industry, Business and Labor Committee:

I appreciate the opportunity to share my perspective on HB 1283. My name is Cori Brothers. I am a Radiologic Technologist, currently working as a CT technologist and a Mammographer in Bismarck, North Dakota. I like to say that working as a mammography is not just my profession but it is a my passion. My motivation to work every day as a radiology technologist comes from being a woman, a mother and a daughter. My mother lost her battle in 2015 to Ovarian cancer, that we now know was caused by the BRACA 1 gene, a gene that causes breast cancer. My maternal Grandmother and my Maternal Aunt also had breast cancer, as well as my maternal grandfather having prostate cancer. All cancers directly linked to breast cancer. So I know first had the importance of screening and early diagnosis. My prayer is that no other daughter will have to hold their moms hand as they take their last breaths on this earth.

I get to go work and perform a lifesaving exam knowing that the best chance of surviving breast cancer is early detection. However, only screening mammograms are currently cost free under the Affordable Care Act. This leaves diagnostic breast imaging, as well as supplemental imaging subject to cost sharing requirements. As a mammographer, I have witnessed recommendations for women to have further diagnostic and supplemental imaging exams after undergoing a screening mammogram, yet too many refuse further testing due to the out of pocket expenses and do not complete these critical imaging exams.

As a patient with a long family history of breast cancer it is the current recommendation that I receive 1 screening mammogram and 1 breast MRI yearly. The breast MRI is preventative but is not covered as a screening exam therefore subject to cost sharing requirements. Usually costing me around $4000-5000+ out of pocket every year. Please stop making women choose between their health and feeding their families.

Please vote yes on HB 1283 to provide coverage for diagnostic and supplemental breast examinations without cost sharing requirements. Furthermore do not delay any farther and make this available to the general population. Providing this coverage to only state insured patients first is discrimination and withholding life saving coverage to those that need it.

Thank you for your time and the opportunity to share my testimony in support of HB 1283.
Respectfully Submitted,
Cori Brothers RT (R) (CT) (M) (BD) (ARRT)

Community HealthCare Association of the Dakotas

Testimony
In Support of House Bill No. 1283
House Industry, Business, and Labor Committee
Representative Warrey, Chair
January 27, 2025

Chairman Warrey, Vice Chairman Johnson, and honorable members of the House Industry, Business, and Labor Committee:

On behalf of Community HealthCare Association of the Dakotas (CHAD) and our North Dakota member Community Health Centers, we offer our strong support for House Bill 1283. This important piece of legislation aims to improve access to diagnostic and supplemental breast cancer examinations by eliminating out-of-pocket costs for patients, including deductibles, copayments, and coinsurance, for these vital screenings.

Breast cancer remains a leading cause of death among women in North Dakota. According to the North Dakota Department of Health, nearly 1 in 8 women will be diagnosed with breast cancer in their lifetime. For many North Dakotans, the cost of diagnostic and supplemental breast examinations can be a significant financial hurdle, leading to delays in seeking care and resulting in more advanced stages of cancer upon diagnosis. This bill will directly address this issue by ensuring that women who need diagnostic screenings, including advanced imaging methods like MRIs and ultrasounds will not face the same financial barriers that they do now.

Early detection of breast cancer significantly improves the likelihood of successful treatment and survival. Additionally, catching breast cancer early can help reduce the long-term costs associated with more advanced treatments and hospitalizations, benefiting both patients and the state's healthcare system overall.

This legislation will have a positive impact on the most vulnerable populations in North Dakota, including many of the 35,000 individuals served by Community Health Centers each year, many of whom face financial barriers to care. By eliminating the financial obstacles to diagnostic and supplemental breast screenings, HB1283 will lead to earlier diagnosis, better health outcomes, and lower overall healthcare costs in the long run.

We strongly urge the Committee to support HB1283, as it represents a critical step forward in improving breast cancer detection and treatment for North Dakotans.

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Phone: (605) 275-2423 | Phone: (701) 221-9824
www.communityhealthcare.net

Community HealthCare Association of the Dakotas

Thank you for your time and consideration.

Sincerely,

Shelly Ten Napel, CEO
Community HealthCare Association of the Dakotas

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NDNPA
NORTH DAKOTA
Nurse Practitioner Association

January 26, 2025

Written letter to

69th Legislative Assembly

House Industry, Business, and Labor Committee

Re: HB 1283

Good morning Mr. Chairman and members of the committee,

My name is Brandi Braun, and I am the legislative liaison for the North Dakota Nurse Practitioner Association (NDNPA). I am writing to ask for your support of HB 1283. This bill increases access for breast cancer screenings for women throughout North Dakota. Our organization believes this legislation is an important step forward in addressing critical gaps in healthcare access for women.

Early detection of breast cancer through mammograms has been proven to save lives. Unfortunately, many women face significant cost barriers in accessing these life-saving screenings. By expanding access to mammograms and recommended diagnostic imaging, this bill will provide women with an opportunity for early detection, leading to better treatment outcomes and ultimately saving lives. By prioritizing preventive care and providing access to mammograms and breast cancer screenings, we can help save lives, reduce healthcare disparities, and improve the overall health of our state.

I strongly urge you to support and advocate for the passage of HB 1283. This bill represents a critical investment in the health and well-being of North Dakota women, and its passage would demonstrate a commitment to preventive healthcare and the fight against breast cancer.

Thank you for your time and consideration.

Sincerely,

Brandi Braun, DNP, FNP-C

NDNPA Legislative Liaison

Email: ndnpalegislative@gmail.com

HB 1283
House Industry, Business and Labor
January 27, 2025

Chair Warrey and Members of the House Industry, Business and Labor Committee,

My name is Kelly Buettner-Schmidt, and I am here in support of HB 1283. Thank you for the opportunity to share with you today about my work with the American Cancer Society Cancer Action Network (ACS CAN), my personal experience with cancer (Ca), and why affordable screening is important.

Background

- Volunteer & advocate for ACS CAN
- Have collaborated with the ACS since the mid-1990s.
- I believe in the ACS & trust their work to prevent deaths from Ca & support those who do have Ca.
- ACS CAN is an advocacy organization working for effective public policies.
- My work as a PHN included policy advocacy actions primarily r/t tobacco prevention
- My PhD in nursing included policy.
- Policies can affect so many lives. As nurses and with other nurses and doctors, we often can care for one patient at a time, but policy can impact the lives of thousands of people at a time.
- We can make fighting Ca affordable for everyone.

Personal

- My large extended family includes 18 aunts and uncles, in addition to the aunts and uncles I have through their marriages. I have more than 50 first cousins.
- Ca is part of our family's health history, with deaths from Breast (Br) Ca, blood Ca, throat Ca, & more. My aunt died young from Br Ca.
- Another best friend who recently had a double mastectomy after a Br Ca diagnosis (dx).

Why Screening

- It typically has no symptoms when it is small & easily treated, which is why screening is so important.
- Fortunately, early detection through screening improves survival by detecting Ca early when treatment is more effective.
- However, a mammogram alone cannot confirm a Ca dx & is only the initial step in the early detection of Br Ca.

Diagnostic / Ongoing Screening

- F-up diagnostic screenings help women who need more than a mammogram for a clean bill of health get the tests they need.
- F-up diagnostic screenings are often needed for abnormal results or high-risk points.
    - MRI or a higher-level diagnostic mammogram.
- These frequently involve significant out-of-pocket expenses, hundreds to thousands of dollars.
    - co-pays, co-insurance, & deductibles.
- These cost barriers may prevent many individuals from going forward with the screening.
- This is especially true among people with limited incomes, for whom these costs can be a significant portion of their income.
- This can lead to delayed or missed Br Ca screenings & delays in follow-up tests. Any delays can impact a person's survival.
- I cannot imagine having a positive mammogram & then not having the dollars to pay for the diagnostic screening.
- Really screening should not be thought of as a single test, it is more of a continuum of testing to determine if a person has Ca.
- The costs of all screening procedures, including the diagnostic mammogram & MRIs should be covered without costing the patients & making them decide between groceries & other bills & diagnosis of Ca.
- We should make fighting Ca affordable for everyone.

I encourage you to support HB 1283 to increase access to medically necessary diagnostic and supplemental breast imaging by eliminating cost sharing.

Thank you for your time.

Kelly Buettner-Schmidt

Testimony
House Bill 1283
House Industry Business and Labor Committee
Representative Warrey, Chairman
January 27, 2025

Chairman Warrey, Vice Chair Frelich, and honorable members of the House Industry Business and Labor Committee:

My name is Kim Kuhlmann, and I am here today in support of House Bill 1283 to eliminate out of pocket costs for patients getting preventative breast cancer screening.

In December 2024, I went in for my first mammogram and received a call that I needed to follow up with a second mammogram and ultrasound. One of my first questions was if the procedure would be covered by my insurance. It took me four hours of going back and forth between the provider and the insurance company to determine that the procedure codes were covered by insurance, but my insurance only pays for one screening mammogram per year and any additional screening I pay 100% out of pocket.

Screening mammograms are available without cost-sharing, but often a mammogram alone is not enough, especially for those of us with dense breast tissue. Often further diagnostic screening is needed for abnormal results or high-risk patients and these additional screenings involve significant out-of-pocket costs. The estimated cost for a mammogram and ultrasound for me was $859.00. I'm still waiting on my bill.

The technology for screenings has seen significant improvements, especially for those with dense breast tissue, making it possible to detect cancer earlier. However, the insurance for these new screening options has not kept up. I'm fortunate that I make enough to pay for these screenings out of pocket, but there are those whose life circumstances mean these additional screenings will cost too much, they will delay getting additional screenings, and could result in more costly cancer treatment with a late stage diagnosis.

We have the technology to find cancer early when the treatment options cost much less. We should encourage women to get FULLY screened by reducing as many barriers as possibly to early detection, including out of pocket expenses.

I ask you to please support HB 1283 to eliminate cost-sharing for all preventative breast cancer screenings.

Thank you. I'm happy to answer questions.

Kim Kuhlmann
Bismarck, ND

To ND Representatives considering HB 1283:

As you likely know, breast cancer is the most common cancer diagnosed among women. Appropriately, screening mammography, the most proven tool to find breast cancer, is currently well covered by insurers. Thanks to this coverage, mary asymptomatic women in North Dakota will have a screening mammogram, be told there is an early cancer, and be successfully treated without the need for chemotherapy or other aggressive treatment....without the loss of life. These are the success stories we often celebrate.

But what if a woman has a screening mammogram and is told there could be a cancer in her breast but that it would cost her $500 or more to find out, even with insurance? To be diagnosed, this woman must pay what feels to some like not only an obstacle to good health, but a ransom. And for those women, this is where early detection fails.

As a radiologist on the front lines of breast cancer detection, every day I see the impact of the large out of pocket costs that many women incur as a result of diagnostic breast imaging. Although we as a medical community have been reasonably successful in promoting screening mammography to detect early breast cancers, we have faced the challenge of getting women to follow through with the additional important imaging, such as diagnostic mammography, ultrasound and MRI needed to diagnose these cancers. We frequently deal with patients who are either hesitant or refuse to move forward with needed tests due to cost.

As a result of large out of pocket costs we see several common scenarios:

1) Patients do not come for their screening mammogram because they fear that something will be detected and that they will not be able to afford the additional testing that follows.
2) Patients intentionally omit important information or symptoms when they come for their screening mammogram, knowing that this may result in the need for a diagnostic mammogram that will not be covered under their health plan. This may limit our ability to find a subtle cancer. Note: We are required to code mammograms done for a symptom or for a follow up of a finding as a diagnostic procedure, not a screening exam.
3) Patients fail to return for a diagnostic test when an abnormality is found on their screening mammogram.
4) Patients fail to return for a follow up evaluation on findings that we are not going to biopsy. FDA/MQSA and our protocols require us to either biopsy suspicious findings right away or follow up findings which are new but not suspicious enough for biopsy every 6 months for 2 years. This is standard across the country. These follow up exams result in significant out of pocket cost for patients, typically requiring the patient to meet her deductible in 2 subsequent years before insurance shares the cost.
5) Patients with symptoms or who are in a follow up category seek care at another facility, hoping that these issues that cause them to be categorized as a diagnostic evaluation, won't be discovered. This has the potential to lead to a missed cancer diagnosis if the finding is subtle or seen on ultrasound only.

As you can see, all of these behaviors limit our ability to detect and diagnosis breast cancer. These limitations in turn may delay cancer diagnoses by several years and negatively impact survival.

The high out of pocket costs experienced by many insured women limit our ability to detect breast cancer when it is most treatable. In addition to decreasing survival, delays in diagnosis lead to more aggressive and costly treatment.

We have entered a time when women are increasingly willing to share openly about their healthcare experiences. This is a good thing. But when a woman tells her friends that her paycheck went towards diagnostic breast imaging, there is pause. Some of those friends will decide to forgo screening mammograms altogether, fearing the need for additional imaging and procedures.

Thank you for your willingness to consider improving breast imaging coverage in North Dakota. I feel that passage of this bill would both save lives and protect those with limited resources from being faced with an impossible choice. Every North Dakotan deserves coverage for early detection.

Sincerely,

Dr. Christina Tello-Skjerseth, MD

Sanford Health Bismarck, Chief of Staff

Diagnostic Radiology, Chief of Service

Edith Sanford Breast Center, Lead Interpreting Physician

UND School of Medicine and Health Sciences, Assistant Clinical Professor of Radiology

✧ 1912-2025 ✧
1515 Burnt Boat Drive
Suite C #325
Bismarck, ND 58503
701-335-6376

Testimony in Support of HB 1283
House Industry, Business, and Labor Committee

January 27, 2025

Chairman Warrey, Vie-Chair Johnson, and Members of the House Industry, Business, and Labor Committee:

Thank you for the opportunity to submit this testimony today. My name is Sherri Miller, and I am the Executive Director of the North Dakota Nurses Association. The North Dakota Nurses Association (NDNA) is the only professional organization representing all nurses in North Dakota. The mission of NDNA is to advance the nursing profession by promoting the professional development of nurses, fostering high standards of nursing practice, promoting the safety and well-being of nurses in the workplace, and advocating health care issues affecting nurses and the public.

NDNA knows that breast cancer screening saves lives. However, often women delay screening due to out-of-pocket costs. Out-of-pocket costs can lead to delayed or missed breast cancer screenings including delays in follow-up tests that are needed after an abnormal initial screening. Any delays in testing or missed screenings can ultimately impact a person's survival.

Removing cost sharing for preventive services has proven to increase the use of those services. For example, following the removal of cost sharing for preventive services in Medicare, there was a statistically significant uptake in mammography screenings among Medicare enrollees.

We urge the committee to support HB 1283.

Thank you,

Sherri Miller BSN, RN
Executive Director
director@ndna.org
701-220-0788
North Dakota Nurses Association

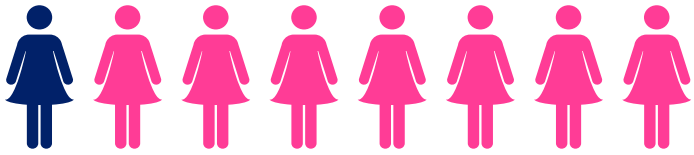
Early Detection Breast Cancer Screening

Barriers to Breast Cancer Screenings

Breast cancer occurs when cells in breast tissue change and divide uncontrolled, typically resulting in a lump or mass. Most breast cancers begin in the milk glands (lobules) or in the tubes (ducts) that connect milk glands to the nipple. Breast cancer typically has no symptoms when it is small and easily treated, which is why mammography screening is important for early detection. 1 in 8 women in the U.S. will be diagnosed with invasive breast cancer, and 1 in 43 will die from the disease.

Screening mammograms are widely available without cost sharing for individuals starting at age 40, increasing access and utilization. However, mammography alone cannot confirm a cancer diagnosis and is only the initial step in early detection of breast cancer.

Follow-up diagnostic screenings, often required for abnormal results or high-risk patients, frequently involve significant out-of-pocket costs. These financial barriers prevent many individuals from accessing the full benefits of early detection, limiting the effectiveness of breast cancer screening.



1 in 8 women will be diagnosed with breast cancer in their lifetime.

Breast Cancer in North Dakota

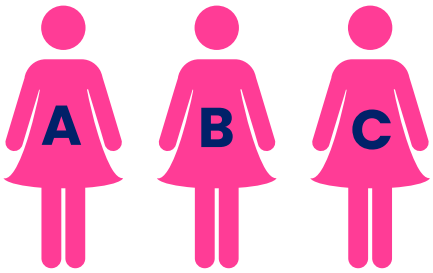
Breast cancer continues to be the most commonly diagnosed cancer among women in North Dakota and is the second leading cause of cancer-related deaths among women in the U.S. In North Dakota, approximately **490 women** will be diagnosed with breast cancer and an estimated **85 women** will lose their lives to the disease by the end of 2025.

Early detection through screening significantly improves survival rates by identifying cancer at an earlier, more treatable stage, underscoring the importance of accessible breast cancer screenings.

Breast Cancer Care: A Patient Comparison

Variations Breast Cancer Screening

Patients A, B, and C all work at the same organization, share the same health insurance plan, and prioritize their breast health by utilizing preventive care benefits. Despite their shared circumstances, they face significant differences in out-of-pocket costs for follow-up breast cancer screenings.



Patient A undergoes an annual preventive screening mammogram, which yields a normal result. Patient A incurs no out-of-pocket expenses, as this service is fully covered under the insurance plan's preventive care benefits. Their physician advises routine screening again next year.

Patient B also completes an annual screening mammogram. However, an abnormal finding necessitates a follow-up diagnostic screening, such as diagnostic mammography, breast ultrasound, or breast MRI. Patient B is required to pay out-of-pocket for this medically necessary screening and is forced to delay the procedure due to the high cost, increasing the risk that a potential breast cancer diagnosis could be made at a later, more advanced stage, when treatment is less effective and significantly more expensive.

Patient C is identified as high-risk for breast cancer based on National Comprehensive Cancer Network (NCCN) Guidelines. Their annual screening requires advanced imaging, such as a breast MRI or ultrasound, instead of a standard mammogram. However, these advanced screenings are not fully covered as part of the plan's preventive care benefits, leaving Patient C responsible for significant out-of-pocket costs. The results of their screening are normal, but they may delay screening next year because of the cost they incurred.

CHAPTER 367

HOUSE BILL NO. 1391
(Representatives J. DeMers, Myrdal, Kelly)
(Senators Heinrich, Nalewaja, Mushik)

MAMMOGRAM INSURANCE COVERAGE

AN ACT to create and enact a new section to chapter 26.1-36 and a new section to chapter 54-52.1 of the North Dakota Century Code, relating to health insurance coverage for mammogram examinations.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. A new section to chapter 26.1-36 of the 1987 Supplement to the North Dakota Century Code is hereby created and enacted to read as follows:

Health insurance policy and health service contract - Mammogram examination coverage.

1. An insurance company, nonprofit health service corporation, or health maintenance organization may not deliver, issue, execute, or renew any health insurance policy, health service contract, or evidence of coverage on an individual, group, blanket, franchise, or association basis unless the policy, contract, or evidence of coverage provides benefits, of the same type offered under the policy or contract for illnesses, for health services to any person covered under the policy or contract for:

   a. One baseline mammogram examination for each woman who is at least thirty-five but less than forty years of age.

   b. One mammogram examination every two years or more frequently if ordered by a physician for women who are at least forty but less than fifty years of age.

   c. One mammogram examination every year for women age fifty and over.

2. This section does not apply to individually guaranteed renewable supplemental specified disease, long-term care, or other limited benefit policies.

SECTION 2. A new section to chapter 54-52.1 of the North Dakota Century Code is hereby created and enacted to read as follows:

Insurance to cover mammogram examinations. The board shall provide medical benefits coverage under either a contract for insurance pursuant to section 54-52.1-04 or under a self-insurance plan pursuant to section 54-52.1-04.2 for:

1. One baseline mammogram examination for each woman who is at least thirty-five but less than forty years of age.

2. One mammogram examination every two years or more frequently if ordered by a physician for women who are at least forty but less than fifty years of age.

3. One mammogram examination every year for women age fifty and over.

Approved March 22, 1989
Filed March 23, 1989

01/19	House	COMMITTEE HEARING 01/27 10:30	
02/03	House	Reported back, do pass, placed on calendar y 011 n 001	HJ 515
02/08	House	Second reading, passed, yeas 091 nays 003	HJ 597
02/10	Senate	Received from House	SJ 531
		Introduced, first reading, referred NATURAL RESOURCES	SJ 560
02/23	Senate	COMMITTEE HEARING 03/03 9:30	
03/17	Senate	Reported back amended, amendment poc y 006 n 000	SJ1198
03/20	Senate	Amendment adopted, placed on calendar	SJ1209
03/22	Senate	Second reading, passed as amended, yeas 045 nays 000	SJ1304
03/27	House	Returned to House (12)	HJ1636
04/03	House	Concurred	HJ1837
		Second reading, passed as amended, yeas 096 nays 010	HJ1837
		Enrolled	HJ1901
04/05	House	Signed by Speaker	HJ1938
04/06	Senate	Signed by President	SJ1637
04/07	House	Sent to Governor	HJ1987
04/12	House	Signed by Governor 0410	HJ2177
04/13	House	Filed with Secretary of State 0411	

HB 1388

Rep. Shockman, Marks

A BILL for an Act to amend and reenact sections 61-04.1-08, 61-04.1-12, 61-04.1-33, 61-04.1-34, 61-04.1-35, and 61-04.1-38 of the North Dakota Century Code, relating to the powers and duties of the state atmospheric resource board, license and permit exemptions, bid requirements, performance and bid bond requirements, and the receipt and expenditure of funds by the board; to repeal sections 61-04.1-01, 61-04.1-02, 61-04.1-09, 61-04.1-10, 61-04.1-20, 61-04.1-21, 61-04.1-22, and 61-04.1-39 of the North Dakota Century Code, relating to state sovereignty over moisture, policy and purpose, research and development programs, creation of operating districts and district operations advisory committees, suspension of operations, and county appropriations.

01/16	House	Introduced, first reading, referred NATURAL RESOURCES	HJ 196
01/25	House	Request return from committee	HJ 341
		Rereferred to AGRICULTURE	HJ 341
02/02	House	COMMITTEE HEARING 02/09 9:00	
02/10	House	Reported back, do not pass, placed on calendar y 008 n 006	HJ 676
02/17	House	Second reading, failed to pass, yeas 021 nays 083	HJ 887

HB 1389

Rep. Myrdal, Goetz

A BILL for an Act to amend and reenact section 15-47-06 of the North Dakota Century Code, relating to recounts in school district elections.

01/16	House	Introduced, first reading, referred EDUCATION	HJ 197
01/18	House	COMMITTEE HEARING 01/23 9:30	
01/24	House	Reported back, do pass, placed on calendar y 015 n 000	HJ 337
01/25	House	Second reading, passed, yeas 104 nays 000	HJ 349
01/27	Senate	Received from House	SJ 321
		Introduced, first reading, referred EDUCATION	SJ 342
02/16	Senate	COMMITTEE HEARING 02/22 10:00	
03/10	Senate	Reported back amended, amendment poc y 008 n 000	SJ1078
03/13	Senate	Amendment adopted, placed on calendar	SJ1089
03/15	Senate	Second reading, passed as amended, yeas 051 nays 000	SJ1140
03/17	House	Returned to House (12)	HJ1499
04/03	House	Concurred	HJ1837
		Second reading, passed as amended, yeas 106 nays 000	HJ1837
		Enrolled	HJ1901
04/05	House	Signed by Speaker	HJ1938
04/06	Senate	Signed by President	SJ1637
04/07	House	Sent to Governor	HJ1987
04/12	House	Signed by Governor 0410	HJ2177
05/03	House	Filed with Secretary of State 0411	

HB 1390

Rep. Halmrast
Sen. Satrom

A BILL for an Act to create and enact a new section to chapter 15-38.2, relating to documentation of material in teachers' personnel files.

01/16	House	Introduced, first reading, referred EDUCATION	HJ 197
01/18	House	COMMITTEE HEARING 01/24 9:00	
02/02	House	Reported back amended, amendment poc y 012 n 004	HJ 484
02/03	House	Amendment adopted, placed on calendar	HJ 492
02/06	House	Second reading, passed as amended, yeas 069 nays 036	HJ 531
02/08	Senate	Received from House	SJ 489
		Introduced, first reading, referred EDUCATION	SJ 506
03/03	Senate	COMMITTEE HEARING 03/06 9:45	
03/15	Senate	Reported back amended, do not pass, y 006 n 002	SJ1143
03/17	Senate	Amendment adopted, placed on calendar	SJ1175
03/20	Senate	Second reading, failed to pass, yeas 006 nays 043	SJ1211

HB 1391

Rep. J.DeMers, Myrdal, Kelly
Sen. Heinrich, Nalewaja, Mushik

A BILL for an Act to create and enact a new section to chapter 26.1-36 and a new section to chapter 54-52.1 of the North Dakota Century Code, relating to health insurance coverage for mammogram examinations.

01/16	House	Introduced, first reading, referred INDUSTRY, BUSINESS AND LABOR	HJ 197

01/25	House	COMMITTEE HEARING 02/01 10:15	
02/03	House	Reported back amended, amendment poc y 015 n 000	HJ 515
02/06	House	Amendment adopted, placed on calendar	HJ 525
02/07	House	Second reading, passed as amended, yeas 103 nays 002	HJ 558
02/09	Senate	Received from House	SJ 507
		Introduced, first reading, referred INDUSTRY, BUSINESS AND LABOR	SJ 528
03/01	Senate	Request return from committee	SJ 934
		Rereferred to STATE AND FEDERAL GOVERNMENT	SJ 934
03/02	Senate	COMMITTEE HEARING 03/07 2:45	
03/08	Senate	Reported back, do pass, placed on calendar y 006 n 000	SJ1026
03/10	Senate	Second reading, passed, yeas 051 nays 000	SJ1058
03/14	House	Returned to House	HJ1413
		Enrolled	HJ1452
03/15	House	Signed by Speaker	HJ1453
03/16	Senate	Signed by President	SJ1150
03/20	House	Sent to Governor	HJ1515
03/23	House	Signed by Governor 0322	HJ1611
03/29	House	Filed with Secretary of State 0323	

HB 1392

Rep. Urlacher, Goetz, Wald
Sen. Krauter, Maixner

A BILL for an Act to create a new section to chapter 61-24.3 of the North Dakota Century Code, relating to the distribution of water through the southwest pipeline project.

01/16	House	Introduced, first reading, referred NATURAL RESOURCES	HJ 197
01/19	House	COMMITTEE HEARING 01/26 11:00	
01/27	House	Reported back, do pass, placed on calendar y 013 n 000	HJ 392
01/31	House	Second reading, passed, yeas 105 nays 000	HJ 425
02/02	Senate	Received from House	SJ 397
		Introduced, first reading, referred NATURAL RESOURCES	SJ 412
02/13	Senate	Committee hearing 03/02 10:30	
03/06	Senate	Reported back, do pass, placed on calendar y 006 n 000	SJ1004
03/09	Senate	Second reading, passed, yeas 050 nays 000	SJ1040
03/13	House	Returned to House	HJ1392
		Enrolled	HJ1411
03/15	House	Signed by Speaker	HJ1433
03/16	Senate	Signed by President	SJ1151
03/20	House	Sent to Governor	HJ1515
03/23	House	Signed by Governor 0321	HJ1611
03/29	House	Filed with Secretary of State 0323	

HB 1393

Rep. Knell, Gunsch
Sen. Keller

A BILL for an Act to amend and reenact section 11-15-08 of the North Dakota Century Code, relating to commissions collected by sheriff in certain proceedings.

01/16	House	Introduced, first reading, referred JUDICIARY	HJ 197
01/25	House	COMMITTEE HEARING 01/31 10:30	
02/01	House	Reported back amended, amendment poc y 014 n 000	HJ 464
02/02	House	Amendment adopted, placed on calendar	HJ 470
02/03	House	Second reading, passed as amended, yeas 103 nays 000	HJ 496
02/07	Senate	Received from House	SJ 465
		Introduced, first reading, referred JUDICIARY	SJ 486
02/23	Senate	COMMITTEE HEARING 03/01 3:30	
03/02	Senate	Reported back, do pass, placed on calendar y 005 n 000	SJ 961
03/06	Senate	Second reading, passed, yeas 051 nays 000	SJ1001
03/08	House	Returned to House	HJ1307
		Enrolled	HJ1337
03/10	House	Signed by Speaker	HJ1381
03/13	Senate	Signed by President	SJ1084
03/14	House	Sent to Governor	HJ1411
03/15	House	Signed by Governor 0314	HJ1433
03/16	House	Filed with Secretary of State 0315	

HB 1394

Rep. Sorensen

A BILL for an Act to create and enact a new section to chapter 40-01 and a new subsection to section 40-05-01 of the North Dakota Century Code, relating to an organization of city governments.

01/16	House	Introduced, first reading, referred POLITICAL SUBDIVISIONS	HJ 197
01/19	House	COMMITTEE HEARING 01/27 10:45	
02/03	House	Reported back, do pass, placed on calendar y 013 n 000	HJ 515
02/08	House	Second reading, passed, yeas 095 nays 000	HJ 597
02/10	Senate	Received from House	SJ 531
		Introduced, first reading, referred POLITICAL SUBDIVISIONS	SJ 560
02/16	Senate	COMMITTEE HEARING 02/23 10:30	
03/01	Senate	Reported back, do pass, placed on calendar y 005 n 000	SJ 939
03/03	Senate	Second reading, passed, yeas 048 nays 000	SJ 981
03/07	House	Returned to House	HJ1297
		Enrolled	HJ1307
03/09	House	Signed by Speaker	HJ1338
03/10	Senate	Signed by President	SJ1053
03/13	House	Sent to Governor	HJ1389
03/15	House	Signed by Governor 0314	HJ1433
03/16	House	Filed with Secretary of State 0315	

HB 1395

Rep. Tollefson, Wald

1989 HOUSE INDUSTRY, BUSINESS AND LABOR

HB 1391

1989 HOUSE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. HB 1391

House Committee on Industry, Business & Labor

Subcommittee on _____ Identify or check where appropriate

Conference Committee _____

Hearing Date 2-1-89

Tape Number 3 /Side A X Side B _____ Meter # 2312

Committee clerk signature Marsha Smith

Minutes:

HB 1289 Relating to reimbursement of erroneous overdraft service charges.

The Industry, Business and Labor Committee met at 10:15 in the Peace Garden Room with 17 members present and none absent.

Proponents

Rep. Judy DeMers, District 17 & 18, Grand Forks: Presented prepared testimony. See copy attached. Supports amendments by Tom Smith except for the Medicare supplement. This is important.

Rep. Rosemarie Myrdal, District 11: Am interested in the advancements of preventive medicine that are being developed and this a kind of health care cost containment measure. Encourages women to use it and it emphasizes the importance of using this kind of diagnostic tool to avoid advanced cases of cancer.

Michael Unhjem, Blue Cross and Blue Shield: We oppose any sort of mandate but we instituted the identical benefit schedule that you see in this legislation in January, 1987. We are pleased with it and for that reason we have no opposition to the bill.

Rep. Tish Kelly, District 21: Is the co-sponsor of the bill and glad that we have the backing of Blue Cross and Blue Shield. Could be cost saving measure.

Opponents

Tom Smith, Health Insurance Association of America: We support the concept but that decision should be left to individual company. This bill addresses all health insurance policies.

(Tom Smith testimony continued)

If full range then this type of coverage should be under these policies. There are specialty contracts that may offer cancer only coverage and specified diseases. Presented amendments. See copy attached.

Earl Pomeroy, Commissioner of Insurance: Is for the bill but opposed to the amendments of Tom Smith's with regard to the limited benefit policy. People obtain coverage over and above their major medical coverage for this particular condition. It doesn't seem right to write a cancer policy and cover mammograms. This bill is cost effective and should not increase premiums and good to get early detection.

Hearing closed.

COMMITTEE ACTION 2-1-89 HB 1391 Tape 4 Side A

Rep. Dorso moved to accept the amendments of Tom Smith but to take out Medicare Supplement, seconded by Rep. Lang. The motion carried on a vote of 15 ayes, 0 nays, and 2 absent. Rep. Oban moved a DO PASS AS AMENDED, seconded by Rep. Gerl. The motion carried on a vote of 15 ayes, 0 nays and 2 absent. Rep. Oban will carry the bill on the floor.

COMMITTEE CLERK
MARSHA SMITH

JAN 18 1988

(Return in triplicate) **FISCAL NOTE**

Bill/Resolution No.: HB 1391 Amendment to: _____

Requested by: Legislative Council Date of Receipt: 1/18/89

Please estimate the fiscal impact of the above measure for:

|X| State general or special funds |___| Counties |___| Cities

In the following space note the fiscal effect in dollars of this measure:

Narrative:

The bill requires that insurance plans cover certain mammogram examinations. This benefit will be included in the state's group health insurance plan and its cost is reflected in the premiums included in state agency budgets.

State Fiscal Effect:

1989-90		1990-91		Biennium Total	
General Fund	Special Funds	General Fund	Special Funds	General Fund	Special Funds
-0-	-0-	-0-	-0-	-0-	-0-

County and City Fiscal Effect:

1989-90		1990-91		Biennium Total	
Counties	Cities	Counties	Cities	Counties	Cities

If additional space is needed, attach a supplemental sheet.

Signed Alan Person

Typed Name Alan Person

Date Prepared: 1/18/89

Department Public Emp. Ret. Sys.

1989 HOUSE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION No. HB 1391

House Committee on INDUSTRY, BUSINESS & LABOR

Subcommittee on _____ Identify or check where appropriate

Conference Committee _____

Date of Hearing 2-1-89 Date of Action 2-1-89

Action Taken Amendments of Judy DeMars except medical case Sustained

Motion Made By Rep. Dorso Seconded By Rep. Lang

Representatives	Yes	No	Representatives	Yes	No
Whalen, Chairman	✓		Tokach	✓	
Dorso, Vice Chrm.	✓		Tollefson	✓	
Enget	✓		Vander Vorst	✓	
Frey		A			
Gerhardt	✓				
Gerl	✓				
Haugland		A			
Lang	✓				
Larson	✓				
Oban	✓				
Shide	✓				
Skjerven	✓				
Soukup	✓				
Starke	✓				

Total 15 (Yes) 0 (No)

Absent 2

Floor Assignment _____

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

1989 HOUSE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION No. HB 1391

House Committee on INDUSTRY, BUSINESS & LABOR

Subcommittee on _____

Conference Committee _____

Identify or check where appropriate

Date of Hearing 2-1-89 Date of Action 2-1-89

Action Taken Do Pass As Amended

Motion Made By Rep. Oban Seconded By Rep. Gerl

Representatives	Yes	No	Representatives	Yes	No
Whalen, Chairman	✓		Tokach	✓	
Dorso, Vice Chrm.	✓		Tollefson	✓	
Enget	✓		Vander Vorst	✓	
Frey		A			
Gerhardt	✓				
Gerl	✓				
Haugland		A			
Lang	✓				
Larson	✓				
Oban	✓				
Shide	✓				
Skjerven	✓				
Soukup	✓				
Starke	✓				

Total 15 (Yes) 0 (No)

Absent 2

Floor Assignment Rep Oban

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

13659

REPORT OF STANDING COMMITTEE

DATE: 2 / 1 / 89 CARRIER: Rep. Oban

(MR~~XXRESIDENT~~/MR. SPEAKER): Your Committee on IBL

to which was (~~are~~) referred HB 1391 has had the same under consideration and recommends by a vote of 15 YEAS, 0 NAYS, 2 ABSENT AND NOT VOTING that the same

( ) (DO PASS) (DO NOT PASS)
(and BE PLACED ON THE CONSENT CALENDAR)

( ) BE PLACED ON THE (CONSENT) CALENDAR
(WITHOUT RECOMMENDATION)

(X) BE AMENDED AS FOLLOWS and when so amended, recommends the same
(DO PASS/DO NOT PASS):

( ) and be rereferred to the Committee on _____

(X) AMENDMENT: (see attached) _____
(LC NUMBER)

( ) (title change and emergency clause added)

( ) (statement of purpose of amendment)

(SEN./REP.) _____, Chairman
Rep. Joe Whalon

****

(X) HB1391 was placed on the 6th order of business on the calendar for the succeeding legislative day.

****

( ) _____ was rereferred to the Committee on _____.

****

(1) LDP, (2) LDP, (3) DESK FILES, (4) DESK REPORTER 89-410 (8/15/88)

90430.0202

9NN
2/2/87

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1391

Page 1, line 9, after the period insert "1."

Page 1, line 17, replace "1." with "a."

Page 1, line 19, replace "2." with "b."

Page 1, line 22, replace "3." with "c."

Page 1, after line 22, insert:

"2. This section does not apply to individually guaranteed renewable supplemental specified disease, long-term care, or other limited benefit policies."

Renumber accordingly

1989 SENATE STATE AND FEDERAL GOVERNMENT

HB 1391

1989 SENATE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. HB 1391

Senate Committee on State and Federal Government

Subcommittee on _____

Conference Committee _____

Identify or check where appropriate

Hearing Date 03-07-89

Tape Number 2 /Side A X Side B _____ Meter # 890

Committee clerk signature _____

Minutes: Chairman D. Meyer opened hearing on HB 1391 and told the committee that Blue Cross/ Blue Shield of ND are in support of the bill. Rep. Judy De Mers testified in favor of the bill. See attached. Sen. Donna Nalewaja, District 45, testified in favor of hte bill. She said with passage of this bill the legislature would be encouraging women of this age bracket to have the exam done. The bill would definitely help to pay costs when the exam is recommended each year. Gene Sandwick, with the NDPEA, stated that they are in favor of the bill. They understand that this is to become available and feels it is an important tool in early detection. In response to a question raised by the committee, the answer was that payment would still be subject to teh deductible of an insurance company depending on what that person's policy stated. Sen. Lodoen moved a DO PASS and the motion was seconded by Sen. Axtman. Upon roll call the vote was 6 to 0 with 1 absent and not voting. **Sen. Lodoen will carry the bill.**

1989 SENATE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION No. HB 1341

Senate Committee on State & Federal Government

Subcommittee on _____ Identify or check where appropriate

Conference Committee _____

Date of Hearing 3-7-89 Date of Action 3-7-89

Action Taken Do Pass

Motion Made By Sen Lodoen Seconded By Sen Axtman

Senators	Yes	No	Senators	Yes	No
Meyer, Dean J.	X		Lodoen, Clayton A.	X	
Kinnoin, Meyer J.	X		David, Ray	X	
Meyer, Walter			Vosper, F. Kent	X	
Axtman, Ben	X				

Total 6 (Yes) 0 (No)

Absent 1

Floor Assignment Sen. Lodoen.

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

****
REPORT OF STANDING COMMITTEE
****

DATE: 03/07/89 CARRIER: Sen. Lodoen

(MR. PRESIDENT/~~MR. SPEAKER~~): Your Committee on State & Federal Government to which was (re)referred Engrossed HB 1391 has had the same under consideration and recommends by a vote of 6 YEAS, 0 NAYS, 1 ABSENT AND NOT VOTING that the same

(X) (DO PASS) (~~DO NOT PASS~~)

(~~BE PLACED ON THE CONSENT CALENDAR~~)

( ) BE PLACED ON THE (CONSENT) CALENDAR

(WITHOUT RECOMMENDATION)

( ) BE AMENDED AS FOLLOWS and when so amended, recommends the same

(DO PASS/DO NOT PASS):

( ) and be rereferred to the Committee on _____

( ) AMENDMENT: (see attached) _____.
(LC NUMBER)

( ) (title change and emergency clause added)

( ) (statement of purpose of amendment)

(SEN./~~REP.~~) Dean Meyer, Chairman
Dean Meyer

****

( ) _____ was placed on the _____ order of business on the calendar for the succeeding legislative day.

****

( ) _____ was rereferred to the Committee on _____.

****

(1) LDP, (2) LDP, (3) DESK FILES, (4) DESK REPORTER 89-410 (8/15/88)

1989 TESTIMONY

HB 1391

TESTIMONY - HOUSE BILL 1391

PRESENTED TO THE SENATE STATE AND FEDERAL GOVERNMENT COMMITTEE
BY REPRESENTATIVE JUDY L. DEMERS
MARCH 7, 1989

CHAIRMAN MEYERS AND MEMBERS OF THE SENATE COMMITTEE ON STATE AND FEDERAL GOVERNMENT. FOR THE RECORD, I AM JUDY DEMERS, STATE REPRESENTATIVE FROM DISTRICT 17-18, CONSISTING OF PART OF GRAND FORKS AND THE GRAND FORKS AIR FORCE BASE. I APPEAR BEFORE YOU THIS MORNING AS THE PRIME SPONSOR OF HOUSE BILL 1391.

HOUSE BILL 1391 MANDATES HEALTH INSURANCE COVERAGE FOR MAMMOGRAMS BASED ON THE AMERICAN CANCER SOCIETY RECOMMENDATIONS OF:

-- A BASELINE MAMMOGRAMS EXAM FOR WOMEN 35-40;
-- AN EXAM EVERY OTHER YEAR, DEPENDING ON CANCER RISK FOR WOMEN 40-50 (FAMILY HISTORY, ETC.)
-- A MAMMOGRAM EXAM EVERY YEAR FOR WOMEN AGE 50 AND OVER.

SECTION 1 OF THE BILL MANDATES COVERAGE BY ALL OF THE USUAL INSURERS, WHETHER AN INSURANCE COMPANY, NONPROFIT HEALTH SERVICE CORPORATION, OR A HEALTH MAINTENANCE ORGANIZATION. SECTION 2 AMENDS THE SECTION OF NDCC WHICH DEALS WITH THE NORTH DAKOTA PUBLIC EMPLOYEES SYSTEM SELF-INSURANCE PLAN.

AS OF JANUARY 1, 1987, BLUE CROSS OF NORTH DAKOTA TOOK A PROGRESSIVE STEP IN BEGINNING COVERAGE FOR MAMMOGRAPHY SCREENING. PRIOR TO THAT TIME, BLUE CROSS ONLY WOULD PAY FOR THIS EXAM IF THE PERSONAL PHYSICIAN SUSPECTED A LUMP OR CANCER. BLUE CROSS/BLUE SHIELD IS PLEASED WITH THIS SERVICE AND I AM HOPEFUL THEY WILL TESTIFY IN FAVOR OF HOUSE BILL 1391. ON THE OTHER HAND, THE NDPERS SELF-INSURANCE PLAN DOES NOT COVER MAMMOGRAMS. THEY, HOWEVER, INDICATED PLANS TO ME TO PROVIDE THIS COVERAGE IN THE FUTURE.

AS OF OCTOBER 14, 1988, 13 STATES HAVE MANDATED COVERAGE OF MAMMOGRAPHY SCREENING (ARIZONA, CALIFORNIA, CONNECTICUT, FLORIDA, KANSAS, MINNESOTA, OKLAHOMA, NEW HAMPSHIRE, NEW YORK, RHODE ISLAND,

TEXAS, MARYLAND, AND MASSACHUSETTS). MAMMOGRAPHY IS A FAIRLY SIMPLE, PAINLESS, X-RAY OF THE BREAST WHICH HAS THE CAPABILITY OF EARLY DETECTION OF BREAST CANCER, ONE OF THE LEADING CAUSES OF DEATH AMONG WOMEN. AT THE GRAND FORKS CLINIC, A MAMMOGRAM SCREENING ALONG WITH AN EDUCATIONAL PROGRAM ON BREAST SELF EXAMINATION COSTS $65 (THIS IS NOT EXPENSIVE IN A RELATIVE SENSE).

IT IS A FACT THAT ONE IN TEN WOMEN WILL DEVELOP BREAST CANCER AT SOME TIME IN THEIR LIVES. THE AMERICAN CANCER SOCIETY SAYS WOMEN WHOSE BREAST CANCERS ARE DETECTED EARLY HAVE A FIVE-YEAR SURVIVAL RATE OF 90% OR BETTER. THOSE WITH ADVANCED CASES HAVE A 60% SURVIVAL RATE. IF A LUMP IS DETECTED EARLY, THE ENTIRE BREAST OFTEN DOES NOT HAVE TO BE REMOVED. DETECTING CANCER EARLY, FROM A PRACTICAL STANDPOINT, COSTS THE INSURANCE COMPANY MUCH LESS THAN THE $60,000 TO $70,000 TO TREAT THE CANCER AT A LATER STAGE.

HOUSE BILL 1391 JUST MAKES GOOD SENSE ALL AROUND. IT SHOULD RESULT IN COST SAVINGS, IT IS GOOD PREVENTIVE MEDICINE, IT WILL SAVE MANY WOMEN FROM MUTILATING SURGERY, AND ABOVE ALL, WITH A MAMMOGRAM, A SMALL LUMP IS GOING TO BE FOUND, AND THAT WOMAN IS GOING TO BE ALIVE FIVE YEARS FROM NOW.

THANK YOU. PLEASE GIVE HOUSE BILL 1391 YOUR FAVORABLE CONSIDERATION.

REPRESENTATIVE JUDY DEMERS

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1391

Page 1, line 22, after the second "." insert "This section shall not apply to individually guaranteed renewalable supplemental specified disease, Medicare supplement, long term care or other limited benefit policies."

Renumber accordingly

To: House Industry, Business, and Labor Committee
From: Elise M. Donnelley
Re: House Bill 1391
Date: February 1, 1989

Chairman Whalen and Members of the Committee

This is to support the passage of HB 1391 on behalf of the Aging Network of North Dakota. This bill proposes that health insurance pay for the type of preventive medicine that should help older women by providing early diagnosis and, therefore, treatment of breast cancer. It should not only save lives and years of lingering illness, but is one step toward helping contain the rising costs of health care. The need for preventive health care for older persons is great. The Medicare Program does not address it. Since the vast majority of older persons are women, this bill is of great concern North Dakota's seniors.

We urge this Committee to give HB 1391 a "Do Pass" recommendation.

February 7, 1989

Prepared by the Legislative Council staff

BILL NO.: HB 1391

SUBJECT: Mammogram examinations

CREATES NDCC: New section to Chapter 26.1-36, new section to Chapter 54-52.1

BILL SUMMARY

GENERALLY, THIS BILL:

As amended, requires all health insurance policies to provide coverage for mammogram examinations for women who meet certain age requirements.

American Cancer Society Cancer Action Network
fightcancer.org

ACS CAN Supports Eliminating Cost Sharing for Breast Cancer Screening and Follow-up Tests

Despite the effectiveness of breast cancer screening, the full benefit of screening has not been achieved because barriers, like cost, still exist. Research shows that required cost sharing – including co-pays, co-insurance, and deductibles – can be a significant barrier for individuals who need preventive services.[1,2] This is especially true among people with limited incomes, for whom these payments can represent a significant percentage of their income.

Out-of-pocket costs for individuals can lead to delayed or missed breast cancer screenings including delays in follow-up tests that are needed after an abnormal initial screening. Any delays in testing or missed screenings can ultimately impact a person's survival. One study showed that even a 3-month delay in follow-up breast cancer screening tests can lead to later stage diagnosis and less favorable outcomes and less life years gained.[3]

Removing cost sharing for preventive services has proven to increase the use of those services. For example, following the removal of cost sharing for preventive services in Medicare, there was a statistically significant uptake in mammography screenings among Medicare enrollees.[4]

The Importance of Screening

In the U.S., breast cancer is the most diagnosed cancer and the second leading cause of cancer death among women. More than 297,000 women will be diagnosed and 43,000 will die from breast cancer in 2023.[8] Despite a lower incidence rate, Black women have a 40% higher mortality rate than White women. Fortunately, early detection of cancer through screening can improve survival and reduce mortality by detecting cancer at an early stage when treatment is more effective.

Current Insurance Coverage & Cost Requirements

Federal law requires all ACA-compliant private insurance plans to cover recommended breast cancer screening services starting at age 40 without cost sharing, thereby making it easier for individuals– especially individuals with limited incomes – to access these important services. This provision of the

[1] The Clinical Practice Guideline Treating Tobacco Use and Dependence 2008 Update Panel, Liaisons, and Staff. (2008). A Clinical Practice Guideline for Treating Tobacco Use and Dependence: 2008 Update: A U.S. Public Health Service Report. *American Journal of Preventive Medicine*, *35*(2), 158–176. http://doi.org/10.1016/j.amepre.2008.04.009
[2] Han X, Robin Yabroff K, Guy GP, Zheng Z, Jemal A. Has recommended preventive service use increased after elimination of cost-sharing as part of the Affordable Care Act in the United States? Prev Med. 2015 Sep;78:85-91. doi: 10.1016/j.ypmed.2015.07.012.
[3] Rutter CM, Kim JJ, Meester RGS, Sprague BL, Burger EA, Zauber AG, Ergun MA, Campos NG, Doubeni CA, Trentham-Dietz A, Sy S, Alagoz O, Stout N, Lansdorp-Vogelaar I, Corley DA, Tosteson ANA. Effect of Time to Diagnostic Testing for Breast, Cervical, and Colorectal Cancer Screening Abnormalities on Screening Efficacy: A Modeling Study. Cancer Epidemiol Biomarkers Prev. 2018 Feb;27(2):158-164. doi: 10.1158/1055-9965.EPI-17-0378. Epub 2017 Nov 17. PMID: 29150480; PMCID: PMC5809257.
[4] Cooper GS, et al. Changes in Receipt of Cancer Screening in Medicare Beneficiaries Following the Affordable Care Act JNCI J Natl Cancer Inst (2016) 108 (5): djv374 doi:10.1093/jnci/djv374

federal law has increased access and utilization of these life-saving services.[5] Some states have also enacted mandates that require plans to cover breast cancer screening beginning at age 40, but these laws do not often address patient cost.

However, in the absence of federal or state laws that define insurance benefits for screening, payers are determining what does or does not constitute a no-cost preventive service. This has led to individuals being charged when additional screening tests are recommended after an abnormal screening or if supplemental screening is recommended, such as when they are above average risk.

For a person being screened for breast cancer, this can include a charge for an imaging test after an initial abnormal mammogram. One study found that the out-of-pocket costs for follow-up screening image tests can average $234 for a diagnostic mammogram and $1,021 for a breast MRI.[6] Another study found women were less likely to undergo follow-up screening tests as the costs of those tests increased.[7] The costs associated with follow-up testing as part of screening undermines the progress of screening in reducing death from breast cancer, leaving people unscreened for cancer and having the potential to delay a diagnosis of cancer.

ACS CAN Position

ACS' "Position Statement on the Elimination of Patient Cost-Sharing Associated with Cancer Screening and Follow-up Testing[8]" states that screening is a "continuum of testing rather than a single recommended screening test, and that irrespective of individual risk, screening is a process that includes a recommended screening test and all follow-up tests described as diagnostic and judged to be integral and necessary to resolve the question of whether an adult undergoing screening has cancer." The statement makes clear that these "tests should be covered without any patient cost-sharing."

ACS CAN supports comprehensive insurance coverage and the elimination of cost sharing by all payers for recommended breast cancer screening and follow-up testing for asymptomatic individuals, regardless of risk.

[5] Office of Health Policy: Assistant Secretary for Planning and Evaluation, Access to Preventive Services without Cost-Sharing: Evidence from the Affordable Care Act, U.S. Dep't of Health and Hum. Serv., at 8 (Jan. 11, 2022), https://aspe.hhs.gov/sites/default/files/documents/786fa55a84e7e3833961933124d70dd2/preventive-services-ib-2022.pdf
[6] Susan G Komen & Martec. Understanding Cost & Coverage Issues with Diagnostic Breast Imaging. January 2019.
[7] Hughes DR, Espinoza W, Fein S, Rula EY, McGinty G. Patient Cost-Sharing and Utilization of Breast Cancer Diagnostic Imaging by Patients Undergoing Subsequent Testing After a Screening Mammogram. JAMA Netw Open. 2023;6(3):e234893. doi:10.1001/jamanetworkopen.2023.4893
[8] American Cancer Society. Cancer Facts & Figures 2023. Atlanta: American Cancer Society; 2023.
[8] American Cancer Society. Position Statement on the Elimination of Patient Cost-Sharing Associated with Cancer Screening and Follow-up Tests. 2023. Accessed October 20, 2023. https://www.cancer.org/health-care-professionals/american-cancer-society-prevention-early-detection-guidelines/overview/acs-position-on-cost-sharing-for-screening-and-follow-up.html

Diagnostic and Supplemental Breast Imaging

Fact Sheet – January 2025

Early detection of breast cancer reduces the chance of dying from the disease. While millions have coverage for screening mammography without cost sharing, individuals at a higher risk of breast cancer or those requiring follow-up imaging due to an abnormal screening mammogram result are subject to hundreds to thousands of dollars in cost sharing.

DIAGNOSTIC AND SUPPLEMENTAL BREAST IMAGING

- Early detection of breast cancer is not possible without the medically necessary diagnostic follow-up or supplemental imaging required to rule out breast cancer or confirm the need for a biopsy.
- A recent study published in Radiology found that 1 in 5 patients said they would not go in for recommended follow-up imaging if they had to pay a deductible.
- The same study noted that 18% of patients shared they would skip the initial screening mammogram if they knew they would have to pay a deductible for the follow-up testing.
- Out-of-pocket costs are particularly burdensome for high-risk individuals, including those previously diagnosed with breast cancer, as diagnostic and supplemental tests are recommended rather than traditional screening.
- Eliminating out-of-pocket costs for diagnostic and supplemental imaging would improve access and likely result in more patients receiving an earlier diagnosis.

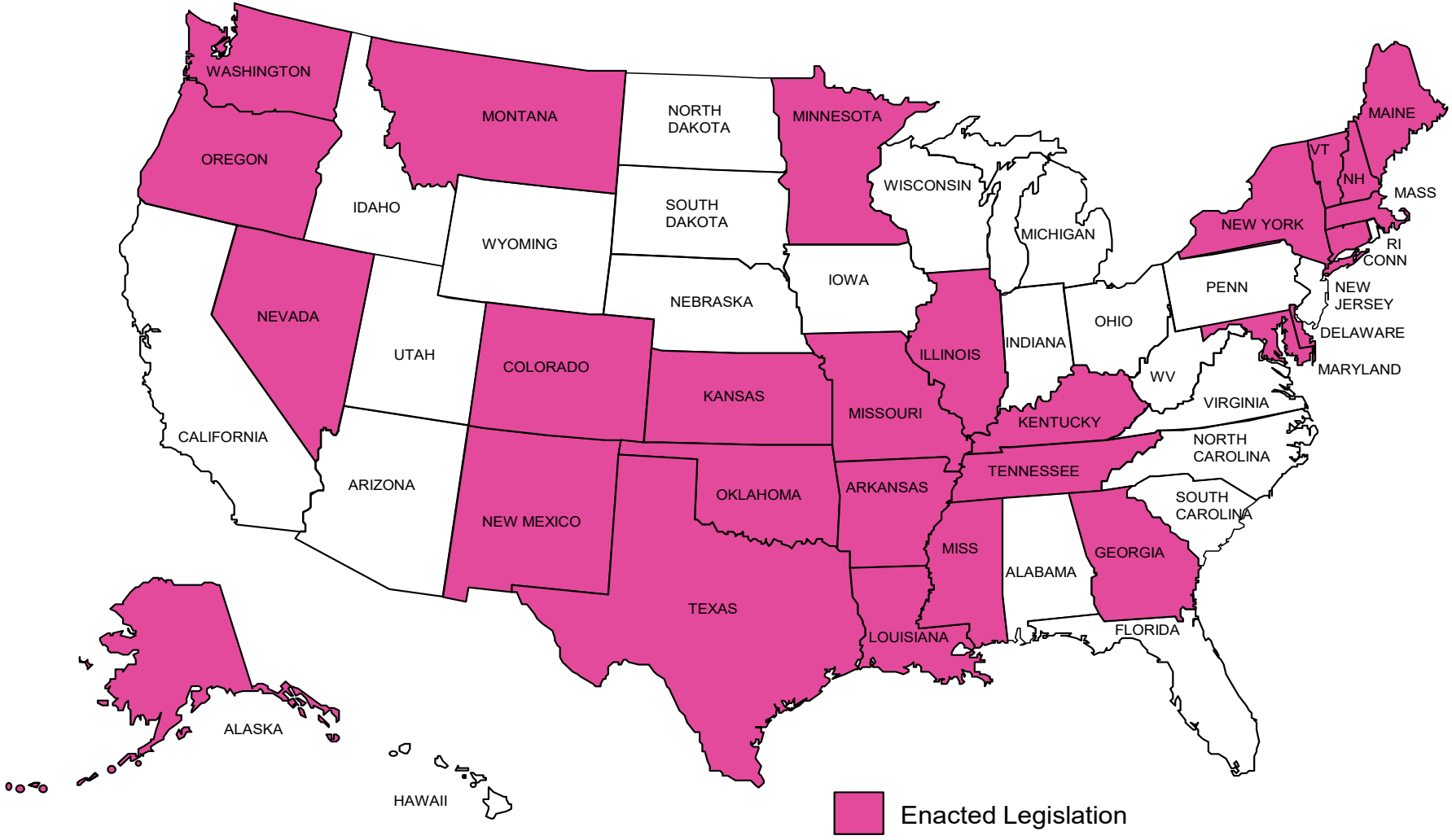
FAIR AND EQUAL COVERAGE

- In 2025 alone, more than 640 individuals will be diagnosed with breast cancer and more than 70 will die of the disease in North Dakota.
- Despite significant advancements in breast cancer screening and diagnosis over the past 30 years, disparities persist across some demographics. Evidence shows that American Indian women and Alaska Native women had lower rates of breast cancer screening compared to other women.
- Studies show that individuals facing high out-of-pocket costs associated with diagnostic and supplemental imaging are less likely to have the recommended follow-up imaging. This can mean that the person will delay care until the cancer has spread to other parts of the body making it more deadly and much costlier to treat.
- According to the National Cancer Institute's Financial Burden of Cancer report, breast cancer has the highest treatment cost of any cancer.
- It is imperative that we take measures to reduce the overall costs to the health care system, ensuring breast cancer is detected at the earliest possible stage helps to eliminate the exorbitant treatments costs associated with a later stage diagnosis.

Susan G. Komen encourages legislators to support HB 1283 which will increase access to medically necessary diagnostic and supplemental breast imaging by eliminating burdensome patient cost sharing.

Contact: Bobbie Will bwill@komen.org (701)202-5840

Diagnostic/Supplemental Breast Imaging Enacted Legislation



susan g. komen.
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Testimony on HB 1283 – January 27, 2025

House IBL Committee by Rep. Karen Karls, District 35 - Bismarck

This is a bill for Women's Health and 1% of men also have breast cancer, so this legislation would include their screening, if necessary, at no cost share. It is a bill to expand screening tests at no cost share.

Currently, an initial screening (a mammogram), which is utilized for average-risk women is at no cost share.

This legislation ensures that a patient who needs follow-up or supplemental breast imaging, to rule out or confirm the need for a biopsy, or those at high-risk, based on personal or family medical history, are not forced to forego these medically necessary services due to high out-of-pocket costs.

This is not an insurance coverage bill, because all breast screening tests are included in the Essential Health Benefits plan, and insurance plans currently, this is a cost-share bill.

Cost is often prohibitive and delayed diagnosis can lead to advanced and even metastatic cancer (Metastatic breast cancer is an advanced stage of breast cancer where tumor cells have spread to other parts of the body)

Early detection, results in better outcomes, cost savings and fewer treatments.

Please support this life-saving bill. I'd like to introduce my constituent Bobbie Will who asked me to sponsor HB1283. Bobbie is State Policy & Advocacy Manager in MT, ND, SD and WY for Susan B Komen.

NovaRest
ACTUARIAL CONSULTING

January 10, 2025

HB1283

Analysis of Draft Bill 25.0075.02000 Diagnostic and Supplemental Breast Exam Coverage with Cost Sharing Restrictions

Prepared for the North Dakota Legislative Council
Pursuant to North Dakota Century Code 54-03-28

Amanda Rocha
Richard Cadwell, ASA, MAAA
Donna Novak, FCA, ASA MAAA

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NovaRest
ACTUARIAL CONSULTING

Table of Contents

I. Evaluation of Proposed Mandated Health Insurance Services

The North Dakota Legislative Council (NDLC) was asked to perform a cost-benefit analysis of Draft Bill 25.0075.02000[1] for the 69th Legislative Assembly pursuant to the North Dakota Century Code (NDCC) 54-03-28. The Draft Bill creates and enacts a new section to 54-52.1 of the NDCC, provides for a report, provides for an application, and provides an expiration date. The Draft Bill, as proposed, states that "the board may not impose a deductible, copayment, coinsurance, or other cost-sharing requirement that causes out-of-pocket costs for a diagnostic breast examination or a supplemental breast examination provided to an individual enrolled under the plan."

NovaRest, Inc., has been contracted as the NDLC's consulting actuary and has prepared the following evaluation of diagnostic and supplemental breast exams with limited cost sharing.

This report includes information from several sources to provide more than one perspective on the proposed mandate and provide an unbiased report. As a result, there may be some conflicting information within the contents. Although we only used sources that we considered credible, we do not offer any opinions regarding whether one source is more credible than another.

NovaRest was asked to provide estimates for the North Dakota Public Employee Retirement System (NDPERS), as well as the impact if the Draft Bill was expanded to the commercial market. We were provided information on four plans administered by NDPERS, 1. Grandfathered PPO/Basic Plan, 2. Non-Grandfathered PPO/Basic Plan, 3. High Deductible Health Plan (HDHP), and 4. Dakota Retiree Plan. For the commercial market we used information from the National Association of Insurance Commissioners Supplemental Health Care Exhibit (SHCE) for individual, small group, and large group markets. Generally, when considering benefits for the individual and small group we considered the Affordable Care Act (ACA) single-risk pool plans, and for large group we considered a sample of plans from the largest three insurers in the North Dakota market.

NovaRest estimates the additional impact of eliminating cost-sharing for diagnostic and supplemental breast exams on health care costs and premiums, which range from 0.2% to 0.5% of premium and $1.10 to $2.40 per member per month (PMPM) for NDPERS. The variation reflects the range of costs associated with breast examinations, the number of breast examinations that would be prescribed, and differences in plan deductibles and cost sharing

If similar language is implemented in the commercial market, we estimate the premium impact to be $0.70 PMPM to $2.30 PMPM, or 0.1% to 0.5% of premium. The variation reflects the range of costs associated with breast examination, the number of breast examinations that would be prescribed, and differences in plan deductibles and cost sharing

II. Process

NovaRest was responsible for addressing the following analyses regarding this proposed mandate:

- The extent to which the proposed mandate would increase or decrease the cost of the service;
- The extent to which the proposed mandate would increase the appropriate use of the service;
- 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
- The impact of the proposed mandate on the total cost of health care.

NovaRest reviewed literature (including reports completed for other states that were either considering or have passed similar legislation) and developed an independent estimate of the proposed mandate's impact on premiums.

III. Mandated Cost-Sharing Restriction for Diagnostic and Supplemental Breast Examination Benefits

The Draft Bill would mandate coverage for diagnostic and supplemental breast examinations without any deductible, copayment, coinsurance, or other cost-sharing requirement that causes out-of-pocket exam costs. The Bill defines a "diagnostic breast examination" as a medically necessary and appropriate examination of the breast, including an examination using contrast-enhanced mammography, breast magnetic resonance imaging, and breast ultrasound, to evaluate an abnormality seen or suspected from a mammogram examination or detected by any other means of examination. A "supplemental breast examination" means a medically necessary and appropriate examination, including those listed above, to screen for breast cancer when there is no abnormality seen or suspected and is based on personal or family medical history or the presence of increased risk factors.

Background

Condition

The types of breast exams outlined in the Draft Bill can find lesions that cannot be seen on routine mammography. [2] These routine mammograms, also known as screening mammograms, are x-rays of the breast and are performed routinely to detect breast cancer in women with no apparent symptoms. If a sign or symptom of breast cancer is found during this screening (or detected by another means as specified in the Draft Bill), a diagnostic exam is done. Any follow-ups to these diagnostic exams are known as supplemental exams. The Draft Bill specifies the same types of exams for both diagnostic and supplemental exams. Routine mammograms flag abnormalities that can include anything from a change in skin texture to a lump or breast pain.[3] More specifically, doctors look for calcifications, masses, asymmetries, architectural distortion, and breast density.[4]

Calcifications are calcium deposits within the breast tissue and appear as white spots of flecks on a mammogram. They are generally common and mostly noncancerous, but calcification patterns are suspicious. A diagnostic mammogram or biopsy is usually recommended to ensure they are not cancerous.[5] An area of abnormal breast tissue with different shapes and edges than the rest of the breast tissue would indicate a mass. These masses can be seen with or without calcification; like calcification, most solid breast masses are not cancer. Two common types of masses are cysts and non-cancerous solid tumors. Both types of masses can feel similar and look alike on a mammogram. Because of this, additional tests like a breast ultrasound or extra imaging tests are recommended. These can help the radiologist determine how likely the masses are to be cancerous.[6]

Asymmetry refers to an increased fibroglandular density in one area compared to others. If found during a screening, diagnostic work or additional imaging is necessary. According to the Breast Imaging Reporting & Data System (BI-RADS), four types of asymmetries can be found on a mammogram. An asymmetry is a finding only seen on one projection, and a focal asymmetry is a finding seen on two projections. A six-month imaging follow-up is usually sufficient if these symmetries have been evaluated and do not look suspicious. A developing asymmetry is an asymmetry that gets larger and more noticeable with each exam. These asymmetries are usually more concerning and may require additional tests and biopsies. Lastly, global asymmetries are seen on two projections, showing largely increased breast tissue in more than one quadrant. Follow-up diagnostics would be needed to determine whether these asymmetries with suspicious features are cancerous or not.[7]

Architectural distortion refers to the distortion of the breast parenchymal architecture without a definable mass. It can be due to either benign or cancerous lesions. In other words, it is a change in the breast's structure. This type of abnormality in mammograms is usually associated with inflammatory breast cancer (IBC) and lobular carcinoma.[8]

Breast density measures how much fibrous and glandular tissue is in the breast. There are four categories of breast density with varying degrees of fatty tissue found within the breast. These categories are category A (almost all fatty tissue), category B, category C (also known as heterogeneously dense), and category D (extremely dense). Most women, about half of all women in the US who have mammograms, fall into categories C and D. Dense tissue does make it more difficult to find breast cancer on a mammogram, thus increasing the risk for developing breast cancer. In this case, additional imaging and testing are recommended.[9]

Treatment

Additional diagnostic exams are part of the usual course of treatment for abnormalities found in a routine mammogram. The diagnostic and supplemental exams outlined in the Draft Bill include contrast-enhanced mammography, diagnostic mammography, breast magnetic resonance imaging, and breast ultrasound.

Diagnostic mammograms are similar to routine mammograms. Both are X-rays of the breast, and the same machines are used for both exams. However, diagnostic mammography requires more radiation and takes longer because more X-ray images are needed to view the breast from different angles.[10] Diagnostic examinations are especially recommended for detecting architectural distortion. The positive predictive value for architectural distortion varies from 10-67% for screening and 60-83% for diagnostic exams.[11]

A breast magnetic resonance imaging (MRI) scan is a non-radiation imaging technique. It is recommended as a follow-up diagnostic tool rather than a screening tool because it is more likely to find abnormalities that turn out not to be cancer, leading to unnecessary biopsies. However, the breast MRI can locate smaller breast lesions sometimes missed by mammography. This scan is recommended for women with breast implants and women with dense breasts since a regular mammogram would not be as effective in these cases. Additionally, since MRIs do not use radiation, they can increase the number of screenings per year for women who are at high risk for breast cancer.[12] [13]

A contrast-enhanced mammogram (CEM) is also similar to a routine mammogram. Patients receive an IV injection of iodine-based dye as part of the CEM before proceeding with the mammogram. This helps feature abnormal blood vessels and hyperactive tissues when cancers develop. CEM is recommended as a diagnostic exam for women who are at high risk for breast cancer and cannot have a screening MRI, women who have dense breast tissue, and women who have a history of breast cancer and had breast-conserving surgery that left post-surgical scars.[14]

A breast ultrasound is a secondary tool used when a lump or mass is felt but cannot be seen on a routine mammogram. It is especially useful for distinguishing between the previously mentioned main types of masses—fluid-filled masses like cysts and solid masses. In addition, it can be used to guide biopsies done on breasts.[15]

Prevalence of Coverage

State Employee Retiree Group Health Insurance

Sanford confirmed contrast enhanced mammography, diagnostic mammography, breast MRI, and breast ultrasound are currently covered services on the grandfathered and non-grandfathered North Dakota Public Employees Retirement System (NDPERS) plans. Additionally, they cover one mammogram screening service for Members between the ages of 35 and 40 and 1 mammogram screening service per year per Members ages 40 and older at 0% member cost and the deductible is waived, per the plans certificate of insurance available on the NDPERS website.[16]

The NDPERS Medicare plan services are determined by Medicare covered services, which covers screening, baseline, diagnostic and breast ultrasounds.[17]

Essential Health Benefits Benchmark Plan

We confirmed that Sanford Health Plan, Blue Cross Blue Shield, and Medica Insurance Company which cover a majority of the North Dakota commercial market (per the 2023 annual financial statements) currently cover contrast enhanced mammography, diagnostic mammography, breast MRI, and breast ultrasound. However, deductible and cost sharing typically applies.

Most individual and small group commercial plans follow the benefits outlined in the EHB Benchmark Plan. The current EHB Benchmark Plan for the individual and small group markets includes coverage for mammography screening. It covers 100% of Allowed Charges and waives the deductible for one service for consumers aged 35 to 40, and for one service per year for consumers aged 40 and older.

The extent to which the coverage will increase or decrease the cost of the service.
Mandating a service or product often increases demand for it, which typically increases the cost of the service, where allowed. Carriers can offset this upward pressure on price by contracting with providers.

North Dakota has 50 providers of mammography services covering 78 locations, providing approximately 90,000 mammography examinations each year. Typically, a mammogram requires 2 providers – a radiology technologist or mammographer to perform the exam and a physician radiologist to interpret the results.[18] We understand that diagnostic and supplemental breast examinations would be available at medical centers with breast imaging departments and, therefore, believe there are sufficient providers available for the NDPERS population. Potential increases in cost are not expected to significantly impact state-wide per member per month (PMPM) costs or percentage of premium estimates, as NDPERS already covers the services. While we expect an increase in usage due to lower member cost-sharing, we believe sufficient providers are available and do not anticipate an increase in the cost of services.

If the Draft Bill language is expanded to include the commercial market, we believe there would be additional utilization since the commercial market is 300% larger than the NDPERS enrollment. However, we confirmed services are already covered in the commercial market. While we expect an increase in usage due to lower member cost sharing, we believe sufficient providers are available and do not anticipate an increase in the cost of services.

The extent to which the coverage will increase the appropriate use of the service.
The United States Preventive Service Task Force (USPSTF) recommends biennial breast cancer screenings for women aged 40 to 74 years.[19] The USPSTF shows insufficient evidence regarding women over age 74 or for women with dense breasts. The Draft Bill does not specify ages range, gender, or the number of services covered at zero cost-sharing, so there is potential for inappropriate use, according to USPSTF recommendation. However, the Draft Bill does mention "medically necessary." While not defined, we believe the inappropriate use of breast examinations will be very low, even with zero-member out-of-pocket cost-sharing.

We estimate that approximately 3,700 NDPERS members use diagnostic and supplemental breast examinations annually. In addition, we expect 230 more NDPERS members will appropriately use diagnostic and supplemental breast examinations due to the removal of member costs for these services, and therefore we assume a 4,000 annual usage of diagnostic and supplemental breast examinations for NDPERS.

If similar language is expanded to the North Dakota commercial market, we expect 16,200 commercial members use diagnostic and supplemental breast examinations annually. In addition, we expect 1,000 more commercial members will appropriately use diagnostic and supplemental breast examinations due to the removal of member costs for these services, and therefore assume a 17,200 annual usage of diagnostic and supplemental breast examinations for the North Dakota commercial market.

The extent to which the coverage will increase or decrease the administrative expenses of carriers, including health maintenance organizations, or other organizations authorized to provide health benefit plans in the State, and the premium and administrative expenses of policyholders and contract holders.

The Draft Bill outlines four examination procedures that would need to be covered. These utilize mammogram, ultrasound, and MRI machines, which we understand are already common in various radiology and imaging centers. However, we are unclear about the level of coverage of each of these examination procedures. Expanding coverage could have minor administrative implications due to increased claim processing or costs for insurers to contract with additional facilities; however, we do not believe that it would have a significant impact.

We estimate the premium impact to be $1.10 PMPM to $2.40 PMPM to NDPERS, or 0.2% to 0.5% of premium. The variation reflects the range of costs for the type of breast examination, the number of breast examinations needed per member, as well as differences in plan deductibles and cost sharing. Please see Appendix B for more information on our assumptions and methodology.

If similar language is expanded to the commercial market, we estimate the premium impact to be $0.70 PMPM to $2.30 PMPM, or 0.1% to 0.5% of premium. The variation reflects different cost-sharing available by plan, and differences in the cost of procedures.

The impact of this coverage on the total cost of health care.

Changes to the cost of the service or utilization of the service would impact the total cost of health care in North Dakota. The primary impact of Draft Bill 25.0075.02000 is primarily shifting member cost sharing to the insurer which is not an increase to the total cost of health care. However, we do expect an increase in usage of breast examination due to lower member cost sharing which we do expect to increase the total cost of health care, in what we call "induced utilization."

We estimate $700,000 to $1.4 million annually in costs shifted from member cost-sharing to NDPERS, although we recognize this is cost-shifting and does not actually represent an increase to the total cost of health care. We estimate a $100,000 to $250,000 annual increase to the total cost of health care in the NDPERS market due to induced utilization if Draft Bill 25.0075.02000 is passed.

If language is expanded to the commercial market, we estimate $1.8 million to $3.9 million annually in costs shifted from member cost-sharing to commercial insurers, although we recognize this is cost-shifting and does not actually represent an increase to the total cost of health care. We estimate an additional annual $500,000 to $1.1 million increase to the total cost of health care in the individual, small group, and large group markets due to induced utilization.

However, having better access to breast cancer exams would likely catch the development of breast cancer sooner which could have health savings in the long run. Cost-effectiveness studies have shown that although costs may rise initially for increased screening, there will be cost savings by avoiding more costly cancer treatment.[20,21]

IV. Other State Diagnostic and Supplemental Breast Exam Laws[2223]

Thirty-six (36) states have passed some kind of law related to the coverage of diagnostic and supplemental breast exams. See the table below for a summary of these laws. For more information, please see endnote 23. The table utilizes the following abbreviations: 3D = 3D mammography (tomosynthesis); MBI = molecular breast imaging; MRI = contrast-enhanced breast magnetic resonance imaging; NCCN = National Comprehensive Cancer Network; US = ultrasonography.

State	Insurance Law: 3D and/or Supplemental Screening Coverage and Effective Dates	Do Copay and Deductible Apply for Supplemental Screening? (Effective Date if Different than Insurance Law)
Alaska	Screening + diagnostic imaging including CEM, diagnostic mammography, MRI, US; screening based on personal/family history or other risk factors (1/1/2025)	No
Arizona	Screening, diagnostic imaging based on NCCN high-risk recommendations, includes 3D/mammogram, MRI, US or other (effective 90 days after 2023 session ends)	Yes
Arkansas	All women, 3D; ages 35 – 40 mammography; if dense, US (8/2017)	No (amendment, 8/2021)
Colorado	If high risk, dense, or diagnostic, "non-invasive" modality coverage (1/1/2021)	No, if "non-invasive"
Connecticut	If dense or at increased risk, US (10/1/2006); High-risk, MRI (1/1/2012); All women, 3D (1/1/2017); mammogram ages 35-39 (1/1/2020), Or ages <35 if increased risk (1/1/2023)	No, 3D (1/1/2019) No, US, MRI (10/1/2021)
Delaware	All women, diagnostic imaging, supplemental screening (12/31/2024)	No less favorable than screening mammography
Georgia	All women, diagnostic imaging; supplemental based on NCCN/other guidelines (1/1/2024)	No
Hawaii	No law	No less favorable than screening mammography
Illinois	Diagnostic mammography (1/1/2020); Screening: if dense, US (3/27/2009); all, 3D (7/1/2016); If dense and medically necessary, MRI (1/1/2018); If dense or medically necessary, MRI, MBI (1/1/12026)	No

Indiana	If dense, not modality specific (7/1/2013)	Yes
Iowa	All women, supplemental screening and diagnostic imaging to include but not limited to MRI, CEM, or ultrasound (1/1/2025)	Out-of-pocket costs "can be no less favorable than screening mammography"
Kentucky	All women, 3D (7/31/2017); diagnostic imaging and supplemental screening to include, but not limited to, MRI or ultrasound (1/1/2025)	No
Louisiana	All women; 3D (1/1/2019); All women screening US, diagnostic mammography/US (1/1/2021); Pathogenic mutation/chest wall radiation age > 25, MRI, age > 30, mammogram; High-risk age > 35 mammogram/MRI; Dense, prior history age < 50, supplemental imaging (1/1/2022); Diagnostic imaging, diagnostic mammogram, CEM, MRI, or US (1/1/2025)	No, mammogram, screening US, diagnostic mammogram (1/1/2021) Coverage ambiguous (amendment, 1/1/2022)
Maine	All women, diagnostic or supplemental screening, MRI, US (1/1/2024)	No
Maryland	All women, 3D (1/1/2018); Supplemental MRI, US; Diagnostic mammogram, MRI, US (1/1/2024)	Yes, 3D No, all else (1/1/2024)
Massachusetts	All women, screening 3D; diagnostic imaging; and if medically necessary, supplemental screening, MRI, ultrasonography (1/1/2026)	No
Minnesota	Dense or other risk, 3D (1/1/2020); Diagnostic services/testing (1/1/2024)	No
Mississippi	Screening, diagnostic imaging based on NCCN guidelines, including CEM, diagnostic mammography, MRI, US (7/1/2024)	No
Missouri	All women, 3D (1/1/2019); medically necessary, not modality specific; above-average risk, US, MRI (08/28/2020)	No, 3D No, all else (amendment, 1/1/2024)
Montana	Supplemental US, MRI; diagnostic imaging (10/1/2023)	No
Nebraska	Mammo/3D age 35-39; increased risk based on NCCN guidelines, mammogram, 3D, US, diagnostic MRI; if dense, US; if dense and increased risk, MRI (1/1/2024)	Yes, MRI, if only risk is dense No, all else
Nevada	Screening, diagnostic imaging based on health provider recommendation (1/1/2024)	No

New Hampshire	All women, 3D (8/7/2018); screening, diagnostic imaging including MRI, US (1/1/2025)	Yes, 3D (9/10/2019) No, all else (1/1/2025)
New Jersey	All women, 3D (8/1/2018); If extremely dense, US, MRI (5/1/2014)	No, 3D Yes, all else
New Mexico	Supplemental US, MRI; diagnostic imaging (1/1/2024)	No
New York	All women, screening + diagnostic breast imaging including diagnostic mammogram, US, MRI (1/1/2017); ages 35-39, mammogram (9/1/2019); Coverage based on recommendation of physician based on nationally recognized clinical practice guidelines (1/1/2026)	No
Ohio	All women, 3D; supplemental screening based on ACR guidelines if dense or increase risk (9/23/2022)	Yes
Oklahoma	All women, 3D (11/1/2018); diagnostic mammogram ages 35 – 39 every 5 years, age 40+ annually; diagnostic exams/other modalities (11/1/2022)	No
Oregon	All women, diagnostic imaging, mammogram, MRI, ultrasonography, supplemental screening (1/1/2024)	No
Pennsylvania	All women, 3D (10/1/2015); if extremely dense, high-risk, or heterogeneously dense + high-risk, US, MRI (8/30/2020); all costs associated with 1 annual supplemental screening (1/1/2025)	No, 3D; Yes, all else* *No, all else (amendment, effective on plan renewals by 1/1/2025)
Rhode Island	<5-year survivor/high risk/high risk lesion, 2 screening mammograms/year; dense, screening per ACR guidelines incl. MRI, ultrasonography, or MBI (1/1/2024)	Yes
Tennessee	Mammogram, baseline ages 35-40, annually ages 35-40 if personal/family history, dense breasts or other risk factors; annually ages 40+; supplemental breast screening if personal or family history, dense breasts or other risk factors (5/25/2022)	No, amendment (8/9/2023)
Texas	All women, 3D (9/1/2017); If personal history or dense, ultrasonography/MRI; diagnostic imaging (9/1/2021)	No
Vermont	All women, 3D; if dense, US (1/1/2019) Screening/diagnostic ultrasound or MRI (1/1/2026)	No
Washington	All women, 3D (6/7/2018); supplemental US, MRI, diagnostic imaging (7/23/2023)	No
Washington D.C.	All women, 3D; if dense/high-risk, ultrasonography, MRI, MBI (3/22/2019)	No, 3D Yes, all else

V. Limitations

NovaRest has prepared this report in conformity with its intended use by persons technically competent to evaluate our estimate regarding Draft Bill 25.0075.02000. Any judgments as to the data contained in the report or conclusions about the ramifications of that data should be made only after reviewing the report in its entirety, as the conclusions reached by review of a section or sections on an isolated basis may be incorrect. Appropriate staff can explain and/or clarify any matter presented herein. It is assumed that any user of this report will seek such explanations regarding any matter in question.

NovaRest did not have access to actual insurer claims data by service type or reimbursement rates. NovaRest also did not perform an insurer data request for the commercial market or have access to the most recent rate filings in North Dakota. NovaRest has developed projections that conform to what we believe to be the current and proposed operating environments and are based on best estimates of future experience within such environments. It should be recognized that future results may vary from those projected in this report. Factors that may cause the actual results to vary from the projected include new insurance regulations, differences in implementation of the required coverage by NDPERS, changes in medical treatments and practices, accounting practices, changes in federal and/or local taxation, external economic factors such as inflation rates, investment yields and ratings, and inherent potential for normal random fluctuations in experience.

VI. Reliance and Qualifications

We are providing this report to you solely to communicate our findings and analysis of Draft Bill 25.0075.02000. The reliance of parties other than the North Dakota Legislative Council (NDLC) on any aspect of our work is not authorized by us and is done at their own risk.

To arrive at our estimate, we made use of information provided by Sanford Health Plan for NDPERS, carrier rate filings and other public sources including census data and National Association of Insurance Commissioners financial data. We did not perform an independent investigation or verification. If this information was in any way inaccurate, incomplete, or out of date, the findings and conclusions in this report may require revision.

This memorandum has been prepared in conformity with the applicable Actuarial Standards of Practice.

We have no conflicts of interest in performing this review and providing this report.

We are members of the American Academy of Actuaries and meet that body's Qualification Standards to render this opinion. We meet the Qualification Standards promulgated by these professional organizations to perform the analyses and opine upon the results presented in this Actuarial Report.

Appendix A: Definitions

a) "Diagnostic breast examination" means a medically necessary and appropriate examination of the breast, including an examination using contrast-enhanced mammography, diagnostic mammography, breast magnetic resonance imaging, and breast ultrasound, to evaluate an abnormality seen or suspected from a mammogram examination or detected by another means of examination.

b) "Supplemental breast examination" means a medically necessary and appropriate examination of the breast, including an examination using contrast-enhanced mammography, diagnostic mammography, breast magnetic resonance imaging, and breast ultrasound, to screen for breast cancer when there is no abnormality seen or suspected and is based on personal or family medical history or other factors that may increase the risk of breast cancer.

Appendix B: NovaRest Methodology and Assumptions

NovaRest Estimate

Data

- NDPERS provided the premiums, claims, and membership in NDPERS for 2023.
- The age and gender proportions of North Dakota's population are based on the 2023 Vintage population estimates.[24]
- Commercial market premiums, claims, and membership were from the 2023 National Association of Insurance Commissioners Supplemental Health Care Exhibit.

Assumptions

- There are no current screening guidelines for men. If a man is at high risk for breast cancer, it is recommended that they get a clinical breast exam annually.[25] However, breast cancer is very rare in men. Only about 1% of all breast cancers in the United States occur in males.[26] Because of this, the male population was excluded from the analysis as we believe the cost for male diagnostic exams will be negligible.
- It is recommended that women get a screening every 2 years for woman aged 40 and above. Please note this differs from the current coverage included in the EHB-BP and NDPERS plans of 1 screening per year.
- Not all women will utilize this benefit. The following are the annual percentage of mammogram screenings used. The source is based on percentages of those who have received screenings within two years, however, the report does not discuss the percentage that screen annually,[27] however, high risk are recommended to screen annually. Additionally most NDPERS and commercial plans cover screenings annually, therefore we used the following as the annual screening rates.
    - Women aged 35 – 39: 6.2%[28]
        - Unlike the other age ranges, this is the prevalence of ever receiving a mammogram within these ages (31%). As coverage and recommendations are for 1 screening within the 5 year period, we divided by 5 to get the 6.2%.
    - Women aged 40 – 49: 60.2%
    - Women aged 50 – 64: 76%
    - Women aged 65 – 74: 78%
    - Women aged 75 and up: 54%

- Usually, 10 – 12% of routine mammograms will require a follow-up diagnostic exam.[29] Out of these diagnostic exams, about 8% of those will need additional follow-up.[30]
- We assume 15% of women above age 34 are considered high risk and would be eligible for a supplemental breast examination.[31]
- We assume 13% of women above age 34 have had breast cancer and would be eligible for a supplemental breast examination.[32]
- 8-28% do not follow-up with recommended supplemental or diagnostic breast exam, which decreases to 1% and 4% for supplemental or diagnostic breast exam respectively with no member out of pocket costs.[33]
- Low and high costs for Contrast-enhanced mammography, Diagnostic mammography, Breast MRI, and Breast ultrasound were based on a variety of sources.
    - Contrast-enhanced mammography ranged from $200 to $1,000.[34,35]
    - Diagnostic mammography ranged from $200 to $300.[36]
    - Breast MRI ranged from $400 to $1,100[37,38]
    - Breast ultrasound ranged from $100 to $450.[39]
- Additionally, some patients may require multiple forms of breast examination, especially if high-risk. Assume low end cost is $500 and high end cost is $1,100 on average.
- Current average cost sharing for individual and small group market is based on projected cost sharing from 2023 rate filings. Average cost sharing for large group was set equal to small group. Average cost sharing for NDPERS was based on actual 2023 data provided.

Methodology

- Diagnostic and supplemental exams are done when an abnormality is found in a routine mammogram, so we began with the routine mammogram screening rates per age population of women 35 and over.
- Applied the percentage of diagnostic and supplemental exams to determine the total number of diagnostic and supplemental breast exams that will be done yearly.
- Induced utilization determined by comparing the difference between mammogram screening rates for insured to uninsured.
- Found a range of costs for each type of exam outlined in the Draft Bill. Averaged these costs since assume only one exam will be done, unless high risk or personal history of breast cancer.
- Applied the average cost to the number of diagnostic and supplemental exams to get a total year cost for these exams.
- Applied this cost to the commercial and NDPERS premiums and populations to determine the PMPM and percent of premium impact.
- Scenarios using average cost sharing compared to total cost represent the insurer cost if the procedure is currently covered to represent the member cost sharing was shifted to the insurer.

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Testimony on HB 1283 – January 27, 2025

House IBL Committee by Bobbie Will

Good afternoon, Chair Warrey and Members of the Committee,

I am Bobbie Will, Policy and Advocacy Manager with Susan G. Komen. I am here to testify in support of HB 1283 advocating for the women who call or email Komen due to the financial barrier to continue or start their yearly breast screening.

In 2010, the Affordable Care Act (ACA) set a floor for preventative coverage at no cost share. The ACA only considers people at average risk, therefore mammography. In HB 1283, we are looking at a medically necessary continuum of breast screening exams for average-risk patients and breast screenings for high-risk patients.

The bill creates a new code in ND century code for medically necessary diagnostic and supplemental examinations at no cost share.

These tests are requested by providers under two scenarios:

1) **Diagnostic**: The radiologist sees an abnormality in the screening mammogram and needs a better look, so a continuum of tests rather than a single mammography is recommended
2) **Supplemental**: The patient is high risk because of family or personal history with breast cancer or because of a genetic tie to breast cancer (payment parity to no cost mammography)

The ND Essential Health Benefits benchmark plan already includes coverage of these tests, HB 1283 isn't about covering services it is eliminating cost sharing for the tests. This bill is for state employees only, our end goal is to impact the state-regulated individual, small, and large group plans (approximately 20-25% of the ND health-insured population). The commercial market insured are the patients we hear from who forgo breast screenings.

I passed out a one-page, two-sided sheet labeled Diagnostic and Supplemental Imaging Fiscal Note-Premium Increases along with my talking points for this afternoon's verbal testimony. (A map of the 28 states that have enacted this legislation, and a fact sheet were uploaded online.)

1) Nineteen states do not have a fiscal note, also listed are the states with a fiscal note showing the premium increases they expect.

2) The NovaRest Report provided by ND LC, which is attached to your bill draft shows pages 3, and 10 per member per month (PMPM) increase for NDPERS at $1.10-2.40 and HB 1283 fiscal note from Deloitte shows a $7.48 PMPM cost to the NDPERS plan.
3) On page 11 of the NovaRest report, it states that having better access to breast cancer exams would likely catch the development of breast cancer sooner, which could have health savings in the long run. Cost-effectiveness studies have shown that although costs may rise initially for increased screening, there will be cost savings by avoiding more costly cancer treatment.

Please vote in favor of HB 1283 and join the 28 states that have already passed this life-saving early detection legislation which will save our families, communities, health systems, and businesses costs. I available for questions.

Bobbie Will
bwill@komen.org
701-202-5840

			States with no fiscal notes or reports show no premium increase.	
			Alaska, Arkansas, Colorado, Connecticut (none when passed will be reviewed in 2025), Delaware, Georgia, Illinois, Maine, Minnesota, Mississippi, Missouri, Montana, Nevada, New Hampshire, New Mexico, New York, Pennsylvania, Texas, Vermont	**19 States with no Fiscal Impact**
			States with a fiscal note or reports show a premium increase.	
State	**Year**	**Bill Status**	**Fiscal Analysis Premium Increase**	**Link**
CA	2022	Not passed	Among DMHC-regulated plans, CHBRP estimates that post mandate, premiums will **increase by $0.5343 per member per month** (PMPM) for large-group plans. Among small-group and individual DMHC plans, premiums will increase by an **estimated $0.6719 PMPM and $1.0437 PMPM**, respectively. Among CDI regulated policies, CHBRP estimates that post mandate, premiums will increase **by $0.6114 PMPM for large-group policies**. Among small-group and individual CDI policies, premiums will increase by an estimated **$0.9243 PMPM and $0.9364 PMPM, respectively.**	CHBRP Fiscal Analysis
KS	2024	Passed	The Department of Administration estimates enactment of the bill would increase expenditures to the State Employee Health Benefits Program by $75,477 in FY 2025 ($150,954 annually X 50.0 percent of the calendar year). For FY 2026, the agency assumes the growth in medical costs will be approximately 5.5 percent, resulting in increased expenditures totaling approximately $159,257.	KS Division of the Budget
KY	2024	Passed	Our estimated increase in premiums for health benefit plans, not including state employee plans. is approximately **$0.00 to $0.57 per member per month (PMPM)**. This represents an **increase of approximately 0.0% to 0.1%**	Fiscal Note
LA	2019	Passed	**PMPM totaling $0.04-$0.06;** Based upon the aforementioned assumptions, the estimated annual cost increases for insurance providers associated with claims are as follows: FY 21 - **$138,600 (550K members * $0.04 PMPM * 6 months * 1.05) - $207,900 (550K members * $0.06 PMPM * 6 months * 1.05)**	Fiscal Note

Bobbie Will-bwill@komen.org-701-202-5840

MA	2022	Passed	Requiring coverage for diagnostic examinations for breast cancer would result in an average annual increase, over five years, to the typical **member's monthly health insurance premium of between $0.19 and$0.33 per member per month (PMPM)**, or **between 0.03% and 0.06% of premium.**	CHIA Fiscal Report
MD	2022	Passed	The total cost PMPM is $0.33 on a cost basis. Assuming an 85% loss ratio, this translates to a $0.39 premium increase or 0.06% of the total. *This effect is small in comparison to the increased utilization of diagnostic screening because only one to two in 1,000 screening mammograms will result in a diagnosis of breast **cancer at an estimated savings of $15,000 per detected cancer. The net savings is $0.02 on a cost basis.**	MHCC Study
NC	2023	In progress	The projection assumes a 6.5% annual claims growth trend for medical claims, a 10.0% trend for pharmacy claims, a 7.0% trend for pharmacy rebates, benefit provisions and member-paid premiums as adopted by the Board for 2023, **and 4% employer premium increases in FY 2023-24.**	Actuarial Note
OK	2023	Passed	Aon, estimates the **annual cost impact to be $1.3 million, which is less than 0.25% increase in total premium cost.**	Fiscal Analysis
OR	2023	Passed	Based on input provided by PEBB's and OEBB's actuaries, OHA estimates that premiums for **plans offered by both Boards will increase by an average of 0.9% under the measure.** For PEBB, this increase would result in additional costs of **$862,793 in 2023-25, and $1,150,391 in 2025-27. For OEBB, the premium increase would result in additional costs of $582,469 in 2023-25, and $1,553,251 in 2025-27.**	Fiscal Note
TN	2023	Passed	Such legislation will result in an increase in the cost of health insurance premiums to cover the patient's share of the cost of procedures and treatments covered by plans. It is estimated that the increase to each individual's total premium will be less than one percent.	TN General Assembly
WA	2023	Passed	No fiscal impact, changes that require inclusion of this health care benefit in qualified health plans offered in the Exchange marketplace are not expected to require significant operational or Healthplanfinder system changes. There is an administrative fee.	Fiscal Note Summary

Bobbie Will-bwill@komen.org-701-202-5840

Good afternoon Chairman Sarney and members of the committee. My name is Mary Tello-Pool and I am here to provide support for House Bill 1283. In March of this year, I will proudly celebrate my 52nd year in the nursing profession. I am amazed at the enormous strides I have witnessed in the last 52 years in terms of diagnostics and treatment of many diseases…including breast cancer. I have held the hands of many patients and also close personal friends, who were shocked into disbelief, by hearing the words "you have cancer". I have also listened to their concerns and worries associated with the burdens of additional costs to further diagnose and treat their cancer. I am here today not only as a nurse, but also as a wife, a mother, a grandmother, a sister, and a friend, who just so happens to also be a breast cancer survivor. Three months ago, my routine mammogram indicated I had small microcalcifications. As a nurse, I thought…no big deal, that is common in women my age…especially in women with dense breasts. I had absolutely no indications or symptoms of breast cancer. I had none of the typical markers…there were no lumps, pain, or lesions, I never used tobacco, didn't drink alcohol, ate healthy foods, exercised on a regular basis…and rarely even had so much as a common cold. At any rate, my doctor encouraged me to undergo further testing. I trusted my doctor's opinion and consented to undergo a stereotactic breast biopsy. The biopsy samples were sent

to pathology for examination. At this point, my case was no longer considered preventative, but rather diagnostic. I assure you, these tests are not tests that women frivolously seek…or tests that doctors perform without careful consideration. Trust me, there is no thrill in having a large bore 10-gauge needle inserted into your breast. A few days after my biopsy, I received a call from my doctor and was told the pathology samples indicated I had DCIS-Ductal Carcinoma in Situ, which is a fancy Latin name for cancer in the breast ducts. It is a sneaky silent dangerous cancer that can quickly spread outside the ducts with no warning. I then underwent an ultrasound biopsy of my breasts and my sentinel lymph nodes (the nodes in the armpit area that the cancer cells like to latch onto and travel to other parts of the body). That procedure was followed by an MRI, which was performed to determine the extent of the cancer, and to determine my treatment plan. Even with my many years of medical knowledge and experience, the news was difficult to process. The flurry of additional tests and numerous doctor visits that followed were at times overwhelming. I have always been a woman of faith and that faith brought me calm in the midst of this cancer storm. The hardest part for me, was having to tell my husband and children, and to see the concern and worry in their faces. The support of my daughters (one of which is the brilliant physician you heard from earlier, who ironically specializes in breast cancer diagnosis) was invaluable.

However, it was my 10 year-old granddaughter who said, "Don't worry Mimi, we got this" that made me realize this is but a bump in the road. Nine weeks ago, both of my breasts and my sentinel lymph nodes were surgically removed. I am still recovering. In the future, I will need regular MRIs to determine if the cancer has returned. The MRIs have been shown to demonstrate the most accurate extent of cancer disease. If medical experts say these diagnostic tests are necessary, then I believe they should be covered at no cost to patients, just as preventive screenings are. I do believe there are significant cost savings if breast cancer is identified and treated in its early stages. I am an example of that. I believe they saved my insurance carrier thousands of dollars by avoiding any future lengthy hospitalizations and long-term cancer treatments and therapies. I am one of the fortunate ones, but having to choose between paying rent and getting the testing needed can be a serious dilemma for many other women. I also believe those tests are the reason I am here today. Quite simply put, those diagnostic tests saved my life. Thank you for the opportunity to share my story and my reasons for supporting this bill.

January 27, 2025

2025 HOUSE STANDING COMMITTEE MINUTES

Industry, Business and Labor Committee
Room JW327C, State Capitol

HB 1283
2/5/2025

A BILL for an Act to create and enact a new section to chapter 54-52.1 of the North Dakota Century Code, relating to diagnostic breast examination and supplemental breast examination cost-sharing restrictions; to provide for a report to the legislative assembly; to provide for application; and to provide an expiration date.

9:27 a.m. Chairman Warrey opened the hearing.

Members Present: Chairman Warrey, Vice Chairman Ostlie, Vice Chairman Johnson, Representatives Bahl, Brown, Finley-DeVille, Grindberg, Johnson, Kasper, Koppelman, D. Ruby, Schatz, Schauer, Vollmer

Member Absent: Representative Christy

Discussion Topics:

- Mandated mammography
- Additional detection expensive
- Preventative approach
- Meter indicator
- Load management

9:27 a.m. Representative Ruby moved a Do Not Pass.

9:27 a.m. Representative Bahl seconded the motion.

Representatives	Vote
Representative Jonathan Warrey	N
Representative Mitch Ostlie	N
Representative Landon Bahl	Y
Representative Collette Brown	N
Representative Josh Christy	AB
Representative Lisa Finley-DeVille	N
Representative Karen Grindberg	N
Representative Jorin Johnson	N
Representative Jim Kasper	N
Representative Ben Koppelman	Y
Representative Dan Ruby	N
Representative Mike Schatz	N
Representative Austin Schauer	N
Representative Daniel R. Vollmer	Y

Motion failed 3-10-1

9:36 a.m. Representative Johnson moved Do Pass and Rerefer to Appropriations.

9:36 a.m. Representative Koppelman seconded the motion.

Representatives	Vote
Representative Jonathan Warrey	Y
Representative Mitch Ostlie	Y
Representative Landon Bahl	N
Representative Collette Brown	Y
Representative Josh Christy	AB
Representative Lisa Finley-DeVille	Y
Representative Karen Grindberg	Y
Representative Jorin Johnson	Y
Representative Jim Kasper	Y
Representative Ben Koppelman	Y
Representative Dan Ruby	N
Representative Mike Schatz	Y
Representative Austin Schauer	Y
Representative Daniel R. Vollmer	N

Motion passed 10-3-1.

9:37 a.m. Representative Johnson will carry the bill.

9:37 a.m. Chairman Warrey closed the meeting.

Diane Lillis, Committee Clerk

REPORT OF STANDING COMMITTEE
HB 1283 (25.0075.02000)

Industry, Business and Labor Committee (Rep. Warrey, Chairman) recommends **DO PASS** and **BE REREFERRED** to the **Appropriations Committee** (11 YEAS, 3 NAYS, 0 ABSENT AND NOT VOTING). HB 1283 was rereferred to the **Appropriations Committee**.

2025 HOUSE APPROPRIATIONS

HB 1283

2025 HOUSE STANDING COMMITTEE MINUTES

Appropriations Committee
Roughrider Room, State Capitol

HB 1283
2/13/2025

A BILL for an Act to create and enact a new section to chapter 54-52.1 of the North Dakota Century Code, relating to diagnostic breast examination and supplemental breast examination cost-sharing restrictions; to provide for a report to the legislative assembly; to provide for application; and to provide an expiration date.

3:01 p.m. Chairman Vigesaa opened the hearing.

Members present: Chairman Vigesaa, Vice Chair Kempenich, Representatives: Anderson, Berg, Bosch, Brandenburg, Fischer, Hanson, Louser, Martinson, Meier, Monson, Murphy, Nathe, Nelson, Pyle, Richter, Sanford, Stemen, Swiontek.

Members Absent: Representatives O'Brien and Wagner

Discussion Topics:

- Breast Cancer Awareness
- Treatment costs for Breast Cancer
- Insurance Costs for Examinations
- Pilot plans

3:01 p.m. Representative Johnathan Warrey, District 22, introduced the bill.

3:08 p.m. Rebecca Fricke, Executive Director, Public Employee Retirement System, answered questions for the committee.

3:15 p.m. Chairman Vigesaa closed the meeting.

Sierra Schartz, Committee Clerk

2025 HOUSE STANDING COMMITTEE MINUTES

Appropriations Committee
Roughrider Room, State Capitol

HB 1283
2/21/2025

A BILL for an Act to create and enact a new section to chapter 54-52.1 of the North Dakota Century Code, relating to diagnostic breast examination and supplemental breast examination cost-sharing restrictions; to provide for a report to the legislative assembly; to provide for application; and to provide an expiration date.

4:42 p.m. Chairman Vigesaa opened the meeting.

Members present: Chairman Vigesaa, Representatives: Anderson, Berg, Bosch, Brandenburg, Fischer, Hanson, Louser, Martinson, Meier, Monson, Murphy, Nathe, Nelson, Pyle, Richter, Sanford, Stemen, Swiontek.

Members Absent: Vice Chair Kempenich, Representatives: Mitskog, Sanford.

Discussion Topics:

- Committee Action

4:48 p.m. Representative Meier moved a Do Pass.

4:48 p.m. Representative Hanson seconded the motion.

4:53 p.m. Roll Call Vote

Representatives	Vote
Representative Don Vigesaa	N
Representative Keith Kempenich	AB
Representative Bert Anderson	N
Representative Mike Berg	N
Representative Glen Bosch	N
Representative Mike Brandenburg	Y
Representative Jay Fisher	N
Representative Karla Rose Hanson	Y
Representative Scott Louser	N
Representative Bob Martinson	Y
Representative Lisa Meier	Y
Representative Alisa Mitskog	AB
Representative David Monson	Y
Representative Eric J. Murphy	Y
Representative Mike Nathe	N
Representative Jon O. Nelson	N
Representative Emily O'Brien	N
Representative Brandy L. Pyle	N
Representative David Richter	Y

Representative Mark Sanford	AB
Representative Gregory Stemen	N
Representative Steve Swiontek	N
Representative Scott Wagner	N

4:53 p.m. Motion failed 7-13-3.

4:54 p.m. Representative J. Nelson moved a Do Not Pass.

4:54 p.m. Representative Nathe seconded the motion.

4:55 p.m. Roll Call Vote

Representatives	Vote
Representative Don Vigesaa	Y
Representative Keith Kempenich	AB
Representative Bert Anderson	Y
Representative Mike Berg	Y
Representative Glen Bosch	Y
Representative Mike Brandenburg	Y
Representative Jay Fisher	Y
Representative Karla Rose Hanson	N
Representative Scott Louser	Y
Representative Bob Martinson	N
Representative Lisa Meier	N
Representative Alisa Mitskog	AB
Representative David Monson	N
Representative Eric J. Murphy	N
Representative Mike Nathe	Y
Representative Jon O. Nelson	Y
Representative Emily O'Brien	Y
Representative Brandy L. Pyle	Y
Representative David Richter	N
Representative Mark Sanford	AB
Representative Gregory Stemen	Y
Representative Steve Swiontek	Y
Representative Scott Wagner	Y

4:55 p.m. Motion passed 14-6-3. Representative Pyle will carry.

4:56 p.m. Chairman Vigesaa closed the meeting.

Krystal Eberle for Risa Berube, Committee Clerk

REPORT OF STANDING COMMITTEE
HB 1283 (25.0075.02000)

Appropriations Committee (Rep. Vigesaa, Chairman) recommends **DO NOT PASS** (14 YEAS, 6 NAYS, 3 ABSENT OR EXCUSED AND NOT VOTING). HB 1283 was placed on the Eleventh order on the calendar.

2025 SENATE INDUSTRY AND BUSINESS

HB 1283

2025 SENATE STANDING COMMITTEE MINUTES

Industry and Business Committee
Fort Union Room, State Capitol

HB 1283
3/18/2025

A bill relating to diagnostic breast examination and supplemental breast examination cost-sharing restrictions; to provide for a report to the legislative assembly; to provide for application; and to provide an expiration date.

9:00 a.m. Chairman Barta called the meeting to order.

Members present: Chairman Barta, Vice-Chair Boehm, Senator Klein, Senator Kessel, Senator Enget

Discussion Topics:

- Women's health
- Out-of-pocket costs and accessibility to follow-ups
- ND Public Employees Retirement System Plan (NDPERS)
- History of mammography as a covered tool
- Essential Health Benefits Plan
- Diagnostic and supplemental imaging
- Early detection and advancing technology
- Delayed diagnoses and negative implications
- Federal regulation and FDA mandates
- NDPERS premium increases
- Private sector implementation
- Pilot program and cost benefit analysis
- Cost share benefit plans and mandate designation

9:01 a.m. Representative Karen Karls, District 35, testified in favor, introduced the bill and submitte testimony #42859.

9:03 a.m. Representative Lisa Meier, District 32, testified in favor and submitted testimony #42858.

9:06 a.m. Bobbie Will, Policy and Advocacy Manager, Susan G. Komen, testified in favor and submitted testimony #42644 , #42645, #42646, and #42647.

9:13 a.m. Dr. Christina Tello-Skjerseth, Chief Radiologist, Chief of Staff, Sanford Health, testified in favor and submitted testimony #42197.

9:25 a.m. Mary Tello-Pool, nurse and breast cancer survivor, testified in favor.

9:30 a.m. Ben Hanson, Government Relations Director, American Cancer Society, Cancer Advocacy Network, testified in favor and submitted testimony #42761, #42762, #42763, #42764, and #42765.

9:38 a.m. Courtney Koebele, Executive Director, ND Medical Association, testified in favor and submitted testimony #42603.

9:40 a.m. Andrea Pfennig, Greater ND Chamber, testified in opposition and submitted testimony #42855.

9:44 a.m. Rebecca Fricke, Executive Director of the ND Public Employees Retirement System (NDPERS), testified in neutral and submitted testimony #41532.

9:55 a.m. Chrystal Bartuska, ND Insurance Department, answered the committee's questions.

Additional written testimony:

Kim Kuhlmann, policy and partnership manager, Community HealthCare Association of the Dakotas (CHAD), submitted testimony #42556 and #42667 in favor.

Kelly Schmidt-Buettner, volunteer, American Cancer Society Cancer Action Network (ACS CAN), submitted testimony #42594 in favor.

Shelly Ten Napel, CEO, Community HealthCare Association of the Dakotas (CHAD), submitted testimony #42542 in favor.

Adrienne Frederick, Director, State Government and Regional Affairs, AdvaMed, submitted testimony #42289 in favor.

Sherri L. Miller, Executive Director, ND Nurses Association, submitted testimony #42162 in favor.

Michele R. Swanson, resident of Bismarck, ND, submitted testimony #41916 in favor.

Lisa Peabody, Advocacy Manager, Facing Our Risk of Cancer Empowered (FORCE), submitted testimony #41729 in favor.

Penny M. Briese, nurse educator, submitted testimony #41724 in favor.

10:02 a.m. Chairman Barta closed the hearing.

Audrey Oswald, Committee Clerk

TESTIMONY OF REBECCA FRICKE

House Bill 1283 – Diagnostic or Supplemental Breast Exam Services

Good morning, Mr. Chairman and members of the committee. My name is Rebecca Fricke and I am the Executive Director of the North Dakota Public Employees Retirement System, or NDPERS. I appreciate the committee taking the time to analyze House Bill 1283, which requires a pilot program under the NDPERS health insurance related to diagnostic and supplemental breast exam coverage, including a cost-share restriction. I am here today on behalf of the NDPERS Board to provide information in a neutral capacity so the policy makers are able to make an informed decision regarding the bill.

House Bill 1283 adds a new section under NDCC 54-52.1 related to diagnostic and supplemental breast exam coverage, including a cost-share restriction. In addition, the bill restricts imposing a deductible, copayment or any other cost-sharing requirement that forces a member to pay an out-of-pocket cost for diagnostic breast exams or supplemental breast exams. The bill stipulates that high-deductible health plans that qualify for health savings account are exempt from this cost-share limit until a member reaches their minimum deductible.

Under the provisions of NDCC 54-03-28, the bill applies to NDPERS health insurance plan for a pilot program during the 2025-2027 biennium.

Our consultant estimates that the bill would have a financial impact on the NDPERS health insurance plan and estimates an increase in premium of 0.5%, or $4,070,000, in the 2025-2027 biennium. The main driver of this additional premium is that under our current health plans, the initial mammogram is covered within recommended age bands or if medically necessary, but cost-sharing applies on supplemental breast exams.

House Bill 1283 was a bill introduced during the interim, with the analysis provided to the Employee Benefits Programs Committee, which gave the bill a favorable recommendation. The consultant and legal analysis provided to the committee is included as an attachment to the end of my testimony (please note this was draft bill 75 during the interim session).

Mr. Chairman, I appreciate the committee taking the time to learn more about the impact this bill will have to our state. This concludes my testimony, and I'd be happy to answer any questions the committee may have.

Deloitte Consulting LLP
50 South Sixth Street
Suite 2800
Minneapolis, MN 55402
USA

Tel: 612 397 4000

www.deloitte.com

Memo

Date: June 7, 2024

To: Rebecca Fricke - Executive Director, North Dakota Public Employees Retirement System

Representative Austen Schauer - Chair, Legislative Employee Benefits Programs Committee, North Dakota State Government

From: Tim Egan, Dan Plante, Ford Edgerton, and Karno Sarkar - Deloitte Consulting LLP

Subject: **FINANCIAL REVIEW OF PROPOSED BILL 25.0075.02000**

Deloitte Consulting LLP (Deloitte [i]) was engaged to review the proposed legislation and the potential financial impact to the Uniform Group Insurance Program (Program) administered by the North Dakota Public Employees Retirement System (NDPERS), as well as other considerations that may contribute to the evaluation of the legislation.

The information included in the review relies on data provided by NDPERS, as well as publicly available data and industry studies. From the data provided by NDPERS, some of these data sources were developed by NDPERS, while others were prepared or created by third parties and delivered to NDPERS.

As part of the review, all data was reviewed for reasonableness, but an audit was not performed on the data. To the extent the data contains errors or anomalies that were unknown at the time the data was provided, the analysis may be affected by those issues.

OVERVIEW OF PROPOSED BILL

The Bill would create and enact a new section to chapter 54-52.1 of the North Dakota Century Code, relating to diagnostic breast examination and supplemental breast examination cost-sharing restrictions:

- defines "diagnostic breast examination" and "supplemental breast examination"
- restricts insurers and plan sponsors from imposing a deductible, copayment, or any other cost-sharing requirement that forces a member to pay an out-of-pocket cost for diagnostic breast exams or supplemental breast exams
- stipulates that high-deductible health plans that qualify for health savings accounts are exempt from this cost-share limit until a member reaches their minimum deductible

ESTIMATED FINANCIAL IMPACT

Based on the analysis, it is anticipated the proposed legislation will have a financial impact on the Uniform Group Insurance Program. It is estimated the financial impact of the proposed legislation on the Uniform Group Insurance Program is approximately $4,070,000 in the 2025-2027 biennium ending 6/30/2027.

The Uniform Group Insurance Program currently imposes a cost sharing requirement on supplemental breast exams. The initial mammogram is covered as a preventative service, but any additional exam is currently subject to member cost-sharing.

Using 24 months of NDPERS claims data from January 2022 through December 2023, it is estimated that covering supplemental breast exams without member cost-sharing will shift approximately $3,300,000 from the member to the Uniform Group Insurance Program in that period. Assuming medical trend of 5.7% per year, the additional cost in the 2025-2027 biennium is estimated to be approximately $4,070,000 (or approximately a 0.5% increase to the estimated total Program cost). The estimate does not assume changes to current utilization of breast exams.

OTHER CONSIDERATIONS

By covering supplemental breast examinations without any member cost-share, breast examinations will not accumulate towards a member's deductible. As a result, members may have to pay for other services out-of-pocket until they reach their deductible, which may negate some of the estimated 0.5% increase to the estimated Program total claims costs. Therefore, the $4,070,000 estimated increase in cost can be treated as a conservative estimate, assuming no other change in utilization.

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North Dakota Nurses Association
✧ 1912-2025 ✧
1515 Burnt Boat Drive
Suite C #325
Bismarck, ND 58503
701-335-6376

House Human Services Committee
Representative Ruby, Chairman
Testimony in Support of HB 1283
Tuesday, March 18, 2025

Chairman Barta, Vice-Chair Boehm, and Members of the Senate Industry, Business, and Labor Committee:

Thank you for the opportunity to submit this testimony today in **support of HB 1283**. My name is Dr. Penny Briese and I am a certified healthcare simulationist and associate professor of nursing at the University of Jamestown. I am also the Director of Advocacy for the North Dakota Nurses Association.

Removing cost sharing for preventive services has been proven to increase the use of breast cancer screening services across the nation. That is what this bill is all about. When cost sharing was removed from preventive screening for Medicare recipients, there was a statistically significant increase in mammography screenings. These screenings are able to detect breast cancer at early stages, when treatment is most likely to be successful. To put it bluntly, screenings save lives.

As a nurse educator, I know the importance of teaching student nurses how to perform breast cancer screenings. I advocated for equipment with which to do just that and the most recent human patient simulator (HPS) purchased by the University of Jamestown is a female who has realistic, palpable breasts for students to actually be able to feel the different abnormalities found when a patient has breast cancer at various stages. It is truly an amazing teaching tool! This training also encourages female students to pay attention to their own breasts and perform self-examinations.

But not every woman learns how to do a proper breast self-examination. The cost of seeing a professional healthcare provider often prevents women from receiving life-saving examinations, putting them at risk of delayed discovery and unsuccessful treatment for breast cancer. The longer women wait, the harder it is to treat breast cancer and survivability rates decrease. The simple act of removing cost sharing has been shown to increase women seeking professional breast examination.

Because of this, I urge the committee to **support** HB 1283. Thank you for your consideration of this and for all you do for the women of North Dakota.

Sincerely,

Dr. Penny Briese, PhD, MS, BSN, RN, CHSE
Director of Advocacy
North Dakota Nurses Association
Associate Professor of Nursing
Simulation Lab Coordinator
University of Jamestown

FORCE
Facing Hereditary Cancer EMPOWERED

March 15, 2025

RE: Proponent HB 1283

Coverage for Diagnostic and Supplemental Breast Examinations

Dear Chairman Barta, Vice Chairman Boehm and Esteemed Members of the Senate Industry and Business Committee,

I am writing to ask for your support of HB 1283 which would expand access to life-saving breast cancer screenings and diagnostic imaging in North Dakota. HB 1283 will be discussed in the upcoming Industry and Business Committee Hearing on 3/18. The House has already given its full support to the bill.

FORCE (Facing Our Risk of Cancer Empowered) is a national nonprofit that advocates for people facing hereditary cancers. The majority of our constituents carry an inherited genetic mutation that significantly increases their risk of cancers including breast, ovarian, prostate, pancreatic and colorectal cancer. Our organization and the North Dakota constituents we serve strongly support HB 1283.

Hereditary cancers often occur at younger ages and can be very aggressive. Members of our community also face a greater risk of recurrence and additional primary cancers. Accordingly, national medical guidelines recommend that high-risk individuals undergo more intensive, more frequent cancer screenings starting at younger ages than the general population.

For example, women who carry a BRCA1 genetic mutation have up to a 70% lifetime risk of breast cancer—versus a 13% risk in the general population. National Comprehensive Cancer Network (NCCN) guidelines recommend that these individuals start screening with annual breast MRIs at age 25. Yearly mammograms (3D mammography, if available) should commence at age 30, alternating with MRIs every 6 months. This regimen is advised until age 75 when screening is considered on an individual basis.

The only other option for those at high risk of breast cancer is prophylactic mastectomy. But surgery is never something to be taken lightly and isn't a feasible or desirable option for everyone.

These evidence-based options enable high-risk individuals to be proactive with their health, detecting cancer earlier when it is easier to treat, or preventing it altogether. Unfortunately, many of the

FORCE
Facing Hereditary Cancer EMPOWERED

guideline-recommended screenings and risk-reduction measures are not viewed as essential care by health insurers, and coverage policies vary. The cost of high-risk screenings is often applied to a person's deductible or denied altogether.
As a result, these patients face a dilemma: forgo the expert-recommended health services or shoulder the cost of tests such as annual breast MRIs—which can cost thousands of dollars—and mammograms before the age of 40 (when they are covered with no cost-sharing under the ACA). Ultimately, this exacerbates health disparities because the least financially stable individuals can't afford the recommended interventions. It also costs the health system more money due to later-stage cancer diagnoses.

Similarly, for individuals with any level of cancer risk, a suspicious mammogram can lead to a myriad of diagnostic tests. Once again, many patients face significant out-of-pocket costs for this imaging. Studies show that individuals facing high cost-sharing are less likely to have the recommended follow-up care. This leads to delayed cancer diagnoses, which are more challenging to treat and more expensive for our healthcare system.

Breast cancer is the most common cancer in North Dakota, exceeding the national average for disease incidence. We don't know why most people get cancer. However, with advances in the field of genetics about 10% of Americans learn that they have an inherited genetic mutation that increases their cancer risk. These are the ideal candidates for prevention and early detection.

We must ensure that those at high risk of breast cancer can be proactive with their health. It will save lives and money by providing greater access. This is why we strongly support HB 1283 and urge you to bring the legislation to a floor vote before the session closes. With the passage of this bill, we can ensure that North Dakota women have access to the breast screenings and diagnostic exams they need.

If you have any questions or would like to discuss this bill further, please contact me.

Sincerely,

Lisa S Peabody

Lisa Peabody
Advocacy Manager
202-381-1357

March 16, 2025
Bill# HB 1283
Senate Industry and Business Committee

Dear Chair,

Thank you for this opportunity to share my testimony regarding SCR 4009. When treating breast cancer, we know that early detection is key, which is why the added diagnostic imaging is recommended, the earlier that breast cancer is found the more treatment options there are and the better chance for survival for the women impacted.

In 2017, I went in for an annual mammogram, after which an ultrasound was recommended and then also an ultra sound guided biopsy which showed I had Atypical lobular hyperplasia. My doctor informed me that almost half of all women with this lesion will develop breast cancer at some point in their lives. At the time, my husband was active duty military and for several years, all my mammograms and annual MRI's were fully covered and I had no problem keeping up with the recommended imaging. Unfortunately, I was divorced after 28 years of marriage and am having to start over at age 54. As such, my insurance coverage has changed, and now I have not had a MRI screening that is recommended in the past 2 years due to the cost that I know I will incur. It would be wonderful to be able to have my screenings and live my life having peace of mind that I'm free of breast cancer, as opposed to worrying about how can I make this happen financially and the consequences of not having the imaging done.

I am in support of SCR 4009 because I feel that it would allow many more women become compliant with the screening recommendations of their doctors by removing expensive copays/co insurance costs, which are currently a barrier. In addition to providing financial peace of mind, mothers, daughters, sisters, and wives would also have peace of knowing the state of their health and be empowered to make the best choices for themselves, and to live their best lives.

Sincerely,

Michele Swanson
District 47
Phone#: 701-390-6140

North Dakota Nurses Association
✧ 1912-2025 ✧
1515 Burnt Boat Drive
Suite C #325
Bismarck, ND 58503
701-335-6376

House Human Services Committee
Senator Barta, Chairman
Testimony in Support of HB 1283
Tuesday, March 18, 2025

Chairman Barta, Vice-Chair Boehm, and Members of the Senate Industry, Business, and Labor Committee:

Thank you for the opportunity to submit this testimony today in **support of HB 1283**. My name is Sherri Miller, and I am the Executive Director of the North Dakota Nurses Association. The North Dakota Nurses Association (NDNA) is the only professional organization representing all nurses in North Dakota.

The mission of NDNA is to advance the nursing profession by promoting the professional development of nurses, fostering high standards of nursing practice, promoting the safety and well-being of nurses in the workplace, and advocating health care issues affecting nurses and the public.

We know that breast cancer screening saves lives. However, often women delay screening due to out of-pocket costs. Out-of-pocket costs can lead to delayed or missed breast cancer screenings including delays in follow-up tests that are needed after an abnormal initial screening. Any delays in testing or missed screenings can ultimately impact a person's survival.

Removing cost sharing for preventive services has proven to increase the use of those services. For example, following the removal of cost sharing for preventive services in Medicare, there was a statistically significant uptake in mammography screenings among Medicare enrollees.

Because of this, we urge the committee to **support HB 1283**. Thank you for your consideration.

Sincerely,

Sherri Miller BSN, RN Executive Director
North Dakota Nurses Association
director@ndna.org
701-220-0788

To ND Senators considering HB 1283:

As you likely know, breast cancer is the most common cancer diagnosed among women. Appropriately, screening mammography, the most proven tool to find breast cancer, is currently well covered by insurers. Thanks to this coverage, many asymptomatic women in North Dakota will have a screening mammogram, be told there is an early cancer, and be successfully treated without the need for chemotherapy or other aggressive treatment....without the loss of life. These are the success stories we often celebrate.

But what if a woman has a screening mammogram and is told there could be a cancer in her breast but that it would cost her $500 or more to find out, even with insurance? To be diagnosed, this woman must pay what feels to some like not only an obstacle to good health, but a ransom. And for those women, this is where early detection fails.

As a radiologist on the front lines of breast cancer detection, every day I see the impact of the large out of pocket costs that many women incur as a result of diagnostic breast imaging. Although we as a medical community have been reasonably successful in promoting screening mammography to detect early breast cancers, we have faced the challenge of getting women to follow through with the additional important imaging, such as diagnostic mammography, ultrasound and MRI needed to diagnose these cancers. We frequently deal with patients who are either hesitant or refuse to move forward with needed tests due to cost.

As a result of large out of pocket costs we see several common scenarios:

1) Patients do not come for their screening mammogram because they fear that something will be detected and that they will not be able to afford the additional testing that follows.
2) Patients intentionally omit important information or symptoms when they come for their screening mammogram, knowing that this may result in the need for a diagnostic mammogram that will not be covered under their health plan. This may limit our ability to find a subtle cancer. Note: We are required to code mammograms done for a symptom or for a follow up of a finding as a diagnostic procedure, not a screening exam.
3) Patients fail to return for a diagnostic test when an abnormality is found on their screening mammogram.
4) Patients fail to return for a follow up evaluation on findings that we are not going to biopsy. FDA/MQSA and our protocols require us to either biopsy suspicious findings right away or follow up findings which are new but not suspicious enough for biopsy every 6 months for 2 years. This is standard across the country. These follow up exams result in significant out of pocket cost for patients, typically requiring the patient to meet her deductible in 2 subsequent years before insurance shares the cost.
5) Patients with symptoms or who are in a follow up category seek care at another facility, hoping that these issues that cause them to be categorized as a diagnostic evaluation, won't be discovered. This has the potential to lead to a missed cancer diagnosis if the finding is subtle or seen on ultrasound only.

As you can see, all of these behaviors limit our ability to detect and diagnosis breast cancer. These limitations in turn may delay cancer diagnoses by several years and negatively impact survival.

The high out of pocket costs experienced by many insured women limit our ability to detect breast cancer when it is most treatable. In addition to decreasing survival, delays in diagnosis lead to more aggressive and costly treatment.

We have entered a time when women are increasingly willing to share openly about their healthcare experiences. This is a good thing. But when a woman tells her friends that her paycheck went towards diagnostic breast imaging, there is pause. Some of those friends will decide to forgo screening mammograms altogether, fearing the need for additional imaging and procedures.

Thank you for your willingness to consider improving breast imaging coverage in North Dakota. I feel that passage of this bill would both save lives and protect those with limited resources from being faced with an impossible choice. Every North Dakotan deserves coverage for early detection.

Sincerely,

Dr. Christina Tello-Skjerseth, MD

Sanford Health Bismarck, Chief of Staff

Diagnostic Radiology, Chief of Service

Edith Sanford Breast Center, Lead Interpreting Physician

UND School of Medicine and Health Sciences, Assistant Clinical Professor of Radiology

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March 17, 2025

Senate Industry and Business Committee
North Dakota State Capitol
600 E Boulevard Ave
Fort Union Room
Bismarck, ND 58505

Re: Support of HB 1283

Dear Chair Barta, Vice Chair Boehm, and Members of the Committee:

On behalf of AdvaMed, the MedTech Association, and the AdvaMed Medical Imaging Division, we are writing in support of HB 1283, a bill increasing access to medically necessary diagnostic and supplemental breast imaging by limiting the burden of patient cost-sharing. Simply, this legislation will help save lives and allow more families to enjoy additional meaningful moments together.

AdvaMed is the largest association representing medical technology innovators and manufacturers. Our members are the device, diagnostics, medical imaging, and digital technology manufacturers transforming health care through earlier disease detection, less invasive procedures, and more effective treatments. They range from the smallest startups to multinational corporations.

AdvaMed Medical Imaging Division represents the manufacturers of medical imaging equipment and focused ultrasound devices. Our members have introduced innovative medical imaging technologies to the market, and they play an essential role in our nation's health care infrastructure and the care pathways of screening, staging, evaluating, managing, and effectively treating patients with cancer, heart disease, neurological degeneration, COVID-19, and numerous other medical conditions.

We commend North Dakota for its leadership on this critical issue for patients. While mammogram screens are fully covered by many health plans, follow-up diagnostic exams due to abnormal results often are not. Similarly, diagnostic exams are needed for women who are asymptomatic but have other pre-existing health conditions that put them at a higher risk of breast cancer.

Unfortunately, according to a recent study, the fear or frustration of unexpected or high out-of-pocket costs, causes many women to delay or forego needed exams in

these situations.[1] Physicians also agree that cost is the primary reason women do not follow-up after their initial mammogram screening.[2]

Screening is also often underutilized in underserved populations, exacerbating health inequities.[3,4] The rate of cancer screening is lower among racial and ethnic minority populations, compared to the white population. Further, cancer outcomes are often worse in minority populations compared to the white population.[5]

Additionally, under-utilization of critical screening services was further compounded during the COVID-19 pandemic. As has been reported, screening fell dramatically over the last few years, potentially increasing the burden of cancer and other disease on the American public.[6,7,8,9]

Screening saves lives, reduces suffering, and lowers costs for patients. Unfortunately, it is underutilized. This legislation enables patients – and their families – to focus solely on what is best for their health, rather than on whether or not they can afford needed, life-saving exams.

AdvaMed and the AdvaMed Medical Imaging Division are proud to support this legislation that puts patients first.

Sincerely,

Adrienne Frederick
Director, State Government & Regional Affairs
AdvaMed

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[1] https://www.komen.org/news/new-susan-g-komen-study-unveils-high-cost-of-diagnostic-tests-for-breast-cancer-serves-as-a-barrier-to-needed-care/
[2] Id.
[3] https://www.auntminnie.com/index.aspx?sec=sup&sub=imc&pag=dis&ItemID=139085
[4] https://www.kff.org/racial-equity-and-health-policy/issue-brief/racial-disparities-in-cancer-outcomes-screening-and-treatment/
[5] ibid
[6] Changes in Cancer Screening in the US During the COVID-19 Pandemic, JAMA, https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2792956
[7] Association of Cancer Screening Deficit in the United States With the COVID-19 Pandemic, JAMA Oncology https://pubmed.ncbi.nlm.nih.gov/33914015/
[8] A national quality improvement study identifying and addressing cancer screening deficits due to the COVID-19 pandemic, Cancer, https://pubmed.ncbi.nlm.nih.gov/35307815/
[9] The Impact of COVID-19 on Cancer Screening: Challenges and Opportunities, JMIR Cancer, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7599065/

Community HealthCare Association of the Dakotas

Testimony
In Support of House Bill No. 1283
Senate Industry and Business Committee
Senator Jeff Barta, Chair
March 18, 2025

Chairman Barta, Vice Chairman Boehm, and honorable members of the Senate Industry and Business Committee:

On behalf of Community HealthCare Association of the Dakotas (CHAD) and our North Dakota member Community Health Centers, we offer our strong support for House Bill 1283. This important piece of legislation aims to improve access to diagnostic and supplemental breast cancer examinations by eliminating out-of-pocket costs for patients, including deductibles, copayments, and coinsurance, for these vital screenings.

Breast cancer remains a leading cause of death among women in North Dakota. According to the North Dakota Department of Health, nearly 1 in 8 women will be diagnosed with breast cancer in their lifetime. For many North Dakotans, the cost of diagnostic and supplemental breast examinations can be a significant financial hurdle, leading to delays in seeking care and resulting in more advanced stages of cancer upon diagnosis. This bill will directly address this issue by ensuring that women who need diagnostic screenings, including advanced imaging methods like MRIs and ultrasounds will not face the same financial barriers that they do now.

Early detection of breast cancer significantly improves the likelihood of successful treatment and survival. Additionally, catching breast cancer early can help reduce the long-term costs associated with more advanced treatments and hospitalizations, benefiting both patients and the state's healthcare system overall.

This legislation will have a positive impact on the most vulnerable populations in North Dakota, including many of the 35,000 individuals served by Community Health Centers each year, many of whom face financial barriers to care. By eliminating the financial obstacles to diagnostic and supplemental breast screenings, HB1283 will lead to earlier diagnosis, better health outcomes, and lower overall healthcare costs in the long run.

We strongly urge the Committee to support HB1283, as it represents a critical step forward in improving breast cancer detection and treatment for North Dakotans.

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Phone: (605) 275-2423 | Phone: (701) 221-9824
www.communityhealthcare.net

Community HealthCare Association of the Dakotas

Thank you for your time and consideration.

Sincerely,

Shelly Ten Napel, CEO
Community HealthCare Association of the Dakotas

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Testimony in Support of HB 1283

Senate Industry and Business Committee

Senator Jeff Bart, Chair

March 18, 2025

Chair Barta and honorable members of the Senate Industry and Business Committee,

My name is Kim Kuhlmann and I am asking you to recommend a do pass on HB 1283, which would eliminate cost sharing for diagnostic breast imaging in the early detection of cancer.

Between 40-50% of women in the U.S., including myself, have dense breast tissue. Dense breast tissue is hard to see through on a mammogram and makes it more difficult to determine what's dense breast tissue and what's breast cancer with a mammogram alone. Dense breast tissue also means you are at a higher risk for having breast cancer. Additional tests such as ultrasound and MRI make it easier to detect breast cancer in dense breasts and other patients who are at high-risk.. As I recently discovered, these additional tests result in patients paying out of pocket.

In December 2024, I went in for a mammogram and received a call that I needed to follow up with a second mammogram and ultrasound. One of my first questions was if the procedure would be covered by my insurance. It took me four hours of going back and forth between the provider and my insurance company to determine that the procedure codes were covered by insurance, but the insurance company only pays for one breast screening per year. Both procedures would be my responsibility to pay and I was given an estimate of close to $1,000 for the two procedures. I wouldn't know until the day of the second mammogram if they would need to also do an ultrasound.

The technology for screenings, especially for those of us who have dense breast tissue, has improved greatly but the payments for these new screening options have not kept up. I'm fortunate that I make enough to pay for these screenings out of pocket at this time, but there are those whose life circumstances mean these additional screenings will cost too much, they will delay finishing the screening process, and could result in more costly cancer treatment with a late stage diagnosis.

We have the technology to detect cancer early when the treatment options cost less. We should encourage women to get FULLY screened by reducing as many barriers as we can to early detection.

While this bill only applies to NDPERS at this time, I hope that you will support HB 1283 to start the process of eliminating cost-sharing for all preventative breast cancer screenings for North Dakota women.

Thank you

Kim Kuhlmann
Bismarck, ND 58503
701-320-0493

House Bill 1283
North Dakota Senate Industry and Business Committee
March 18, 2025

To: Chair Barta and Members of the Senate Industry and Business Committee,

My name is Kelly Buettner-Schmidt, and I am here in support of HB 1283. Thank you for the opportunity to share with you today about my work with the American Cancer Society Cancer Action Network (ACS CAN), my personal experience with cancer, and why affordable screening is important.

Background

I am a volunteer advocate for the ACS CAN and have collaborated with the ACS since the mid-1990s. I believe in the ACS and trust their work to prevent deaths from cancer and support those who do have cancer. The ACS CAN is an advocacy organization working for effective public policies. My work as a PHN included policy advocacy actions primarily related to tobacco prevention. My PhD is in nursing with a focus on health policy. As you know, policies can affect so many lives. As a nurse, and with other nurses and doctors, we often can care for one patient at a time, but policy can impact the lives of thousands of people at a time. The ACS CAN is making fighting cancer affordable for everyone.

Personal

My large extended family includes 18 aunts and uncles, in addition to the aunts and uncles I have through their marriages. I have more than 50 first cousins. Cancer is part of our family's health history, with deaths from cancers of the breast, blood, throat, and more. My aunt died young from breast cancer. One of my dearest friends recently had a double mastectomy after a breast cancer diagnosis, at the age of 60.

Why is Screening for Breast Cancer Important

Breast cancer typically has no symptoms when it is small and easily treated, which is why screening is so important. Fortunately, early detection through screening improves survival by detecting cancer early when treatment is more effective. However, a mammogram alone cannot confirm a cancer diagnosis and is only the initial step in the early detection of breast cancer.

Diagnostic / Ongoing Screening

Follow-up diagnostic screenings help women who need more than a mammogram to determine if they have cancer. Follow-up diagnostic screenings are often needed for abnormal results or high-risk points. This may include an MRI or a higher-level diagnostic mammogram. These frequently involve significant out-of-pocket expenses, hundreds to thousands of dollars, including co-pays, co-insurance, and deductibles. These cost barriers may prevent many individuals from going forward with the screening. This is especially true among people with limited incomes, for whom these costs can be a significant portion of their income. This can lead to delayed or missed breast cancer screenings and delays in follow-up tests. Any delays can impact a person's survival.

I cannot imagine having a positive mammogram and then not having the dollars to pay for the diagnostic screening. Really screening should not be thought of as a single test, it is more of a continuum of testing to determine if a person has cancer. The costs of all screening procedures, including the diagnostic mammogram and MRIs, should be covered without costing the patients and making them decide between groceries and other bills and diagnosis of cancer. We should make fighting cancer affordable for everyone.

I strongly encourage you to support HB 1283 to increase access to medically necessary diagnostic and supplemental breast imaging by eliminating cost sharing.

Thank you for your time.
Kelly Buettner-Schmidt, PhD, RN
ACS CAN Volunteer

Senate Industry and Business Committee

HB 1283

March 18, 2025

Chairman Barta and Committee Members, I'm Courtney Koebele and I serve as executive director of the North Dakota Medical Association. The North Dakota Medical Association is the professional membership organization for North Dakota physicians, residents, and medical students.

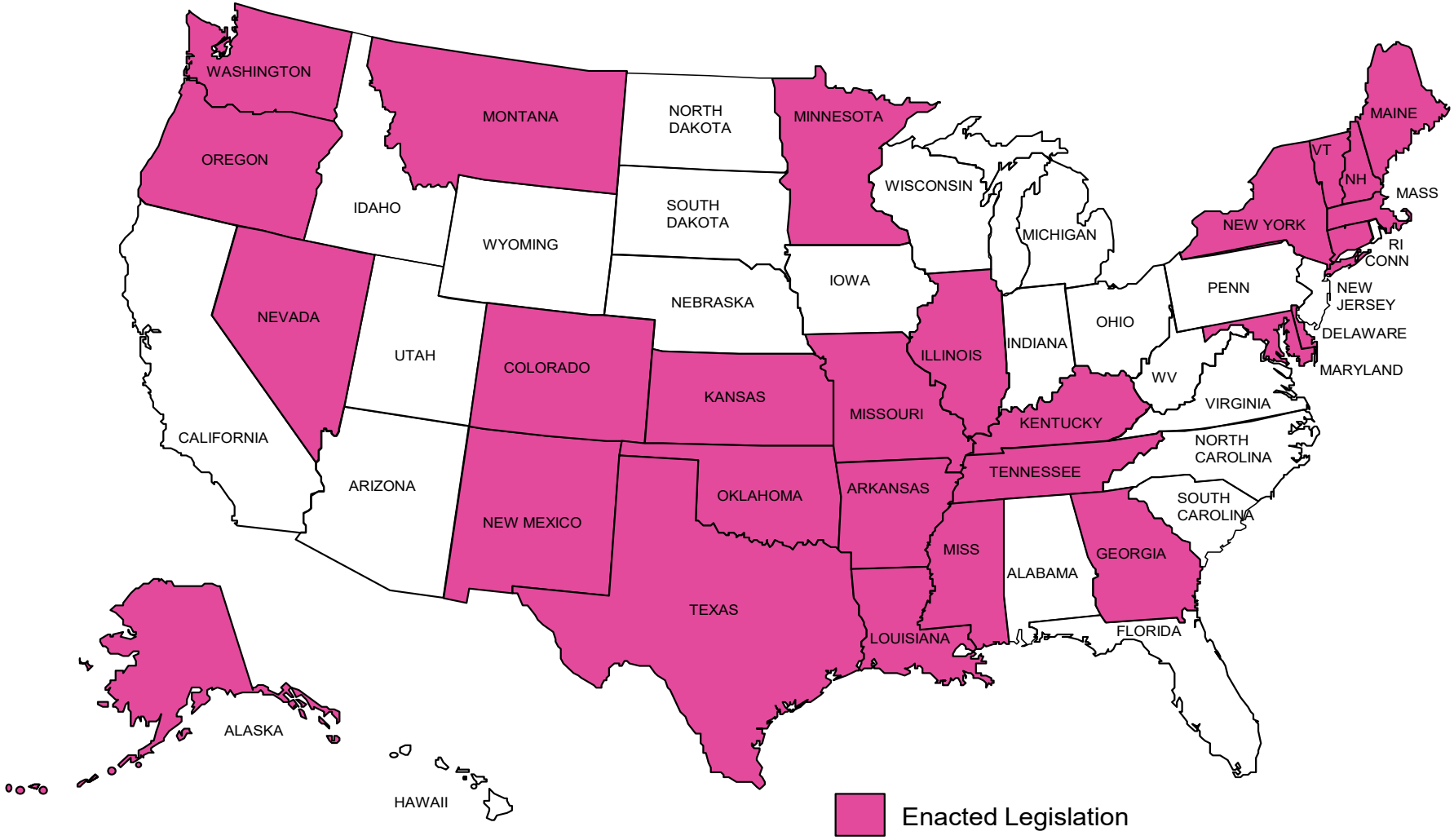
NDMA supports HB 1283. NDMA is committed to advocating on behalf of patients, to give them a better health care system, and on behalf of physicians, to help them provide the best care possible. NDMA strongly supports requiring coverage as defined in the bill, with zero cost-sharing as part of a patient's annual preventive breast cancer screening. As we know, regular and comprehensive mammograms contribute to the early detection of breast cancer, improving treatment outcomes and survival rates, reducing healthcare costs associated with advanced-stage cancer treatments, and ultimately saving lives. By requiring coverage for diagnostic imaging, North Dakota will provide clarity and assurance to patients who may forego screenings due to high out-of-pocket costs.

Many studies have been published related to disparities and delays in breast cancer care. Delays in care were found to be higher for women with Medicaid or no insurance,

and women living in economically disadvantaged zip codes. The delays in care are partially related to insurance coverage and the cost of follow-up testing. Delays lead to decreased survival. Patients with breast cancer treatment delays of 3 months or more have 12% lower 5-year survival than those with shorter delays and longer delays are associated with more advanced stages. Low-income breast cancer patients have 5-year relative survival rates that are 9% lower than higher income patients. When breast cancer is small and does not involve regional lymph nodes, it is easier and less expensive to treat, with fewer complications and better long-term survival. Helping women to have access to diagnostic testing will improve patient experience and outcomes and decrease overall health care costs.

Thank you for the opportunity to address this committee. I would be happy to answer any questions.

Diagnostic/Supplemental Breast Imaging Enacted Legislation



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HB 1283
Industry and Business
March 18, 2025

Chairman Barta and Members of Industry and Business,

Breast cancer is the number one diagnosed cancer, the most expensive to treat, and remains the second leading cause of death among women in North Dakota. According to the North Dakota Department of Health, nearly 1 in 8 women will be diagnosed with breast cancer in their lifetime. The two greatest risk factors for breast cancer are being a woman and getting older, two factors we can't prevent.

HB 1283 is a bill to expand medically necessary breast screening tests, such as ultrasound and breast MRI at no cost share. Currently, an initial screening (a mammogram), which is utilized for average-risk women is at no cost share.

This legislation ensures that the 10% of patients who need follow-up breast screening after a mammogram and 15% of women who are high risk with a personal or family medical history of breast cancer are not forced to forego medically necessary screenings due to high out-of-pocket costs. One study found that the out-of-pocket costs for follow-up screening image tests can average $234 for a diagnostic mammogram and $1,021 for a breast MRI.

These financial barriers prevent many individuals from accessing the full benefits of early detection, limiting the effectiveness of breast cancer screening and ultimately costing more in treatment. House Bill 1283 proposes to eliminate these out-of-pocket costs and the financial burdens they present and provide the full benefits of early detection and effectiveness of breast cancer screenings for employees on the NDPERS health insurance plan.

HB 1283 is not a mandate in coverage, the breast screening tests defined in the bill are included in the ND Essential Health Benefits Benchmark Plan, therefore health insurance plans including PERS cover the diagnostic and supplemental breast screening tests listed in HB 1283, **this is a cost-share bill**.

According to PERS, the bill would have an estimated increase in premium of .5%, or four million dollars in the 2025-2027 biennium. Nineteen states out of 28 that have passed similar legislation did not have fiscal notes and nine had less than ND's FN. MT passed this legislation in 2023 and the largest insurer in the state shared there would be an increased cost of .001% in the commercial market and

their self-insured state employee plan already covers diagnostic and supplemental breast screenings at no cost share. I believe early detection will ultimately save money and it will save lives.

It is imperative that we take measures to reduce the overall costs to the health care system, ensuring breast cancer is detected at the earliest possible stage helps to eliminate the exorbitant treatment costs associated with a later-stage diagnosis. Early detection results in better outcomes, cost savings, and fewer treatments and reduces the chance of dying from the disease.

North Dakota Medicaid covers diagnostic and supplemental imaging at no cost share. North Dakota Women's Way Program is a federal/state program that provides mammograms, diagnostic, and supplemental screenings to income-eligible women who are underinsured (covering deductible, copays, etc.) or not insured.

Please support House Bill 1283 and vote yes for this life-saving bill and save ND taxpayers money.

Bobbie Will
Policy and Advocacy Manager
Susan G. Komen
701-202-5840
bwill@komen.org

Diagnostic and Supplemental Breast Imaging

Fact Sheet – HB 1283

Early detection of breast cancer reduces the chance of dying from the disease. While millions have coverage for screening mammography without cost sharing, individuals at a higher risk of breast cancer or those requiring follow-up imaging due to an abnormal screening mammogram result are subject to hundreds to thousands of dollars in cost sharing.

DIAGNOSTIC AND SUPPLEMENTAL BREAST IMAGING

- Early detection of breast cancer is not possible without the medically necessary diagnostic follow-up or supplemental imaging required to rule out breast cancer or confirm the need for a biopsy.
- A recent study published in Radiology found that 1 in 5 patients said they would not go in for recommended follow-up imaging if they had to pay a deductible.
- The same study noted that 18% of patients shared they would skip the initial screening mammogram if they knew they would have to pay a deductible for the follow-up testing.
- Out-of-pocket costs are particularly burdensome for high-risk individuals, including those previously diagnosed with breast cancer, as diagnostic and supplemental tests are recommended rather than traditional screening.
- Eliminating out-of-pocket costs for diagnostic and supplemental imaging would improve access and likely result in more patients receiving an earlier diagnosis.

WHY DIAGNOSTIC AND SUPPLEMENTAL BREAST IMAGING AT NO COST SHARE

- In 2025 alone, more than 640 individuals will be diagnosed with breast cancer and more than 70 will die of the disease in North Dakota.
- Despite significant advancements in breast cancer screening and diagnosis over the past 30 years, disparities persist across some demographics. Evidence shows women who live in rural areas, who may have limited access to health care, are less likely to get their recommended breast imaging than women who live in urban areas.
- Studies show that individuals facing high out-of-pocket costs associated with diagnostic and supplemental imaging are less likely to have the recommended follow-up imaging. This can mean that the person will delay care until the cancer has spread to other parts of the body making it more deadly and much costlier to treat.
- According to the National Cancer Institute's Financial Burden of Cancer report, breast cancer has the highest treatment cost of any cancer.
- It is imperative that we take measures to reduce the overall costs to the health care system, ensuring breast cancer is detected at the earliest possible stage helps to eliminate the exorbitant treatment costs associated with a later-stage diagnosis.

Susan G. Komen encourages legislators to support HB 1283 which will increase access to medically necessary diagnostic and supplemental breast imaging by eliminating burdensome patient cost-sharing.

Contact: Bobbie Will bwill@komen.org (701)202-5840

DIAGNOSTIC AND SUPPLEMENTAL BREAST IMAGING FISCAL NOTE – PREMIUM INCREASES

			States with no fiscal notes or reports show no premium increase.	
			Alaska, Arkansas, Colorado, Connecticut, Delaware, Georgia, Illinois, Maine, Minnesota, Mississippi, Missouri, Montana, Nevada, New Hampshire, New Mexico, New York, Pennsylvania, Texas, Vermont	**19 States with no Fiscal Impact**
			States with a fiscal note or reports show a premium increase.	
State	**Year**	**Bill Status**	**Fiscal Analysis Premium Increase**	**Link**
CA	2022	Not passed	Among DMHC-regulated plans, CHBRP estimates that post mandate, premiums will **increase by $0.5343 per member per month** (PMPM) for large-group plans. Among small-group and individual DMHC plans, premiums will increase by an **estimated $0.6719 PMPM and $1.0437 PMPM**, respectively. Among CDI regulated policies, CHBRP estimates that post mandate, premiums will increase **by $0.6114 PMPM for large-group policies**. Among small-group and individual CDI policies, premiums will increase by an estimated **$0.9243 PMPM and $0.9364 PMPM, respectively.**	CHBRP Fiscal Analysis
KS	2024	Passed	The Department of Administration estimates enactment of the bill would increase expenditures to the State Employee Health Benefits Program by $75,477 in FY 2025 ($150,954 annually X 50.0 percent of the calendar year). For FY 2026, the agency assumes the growth in medical costs will be approximately 5.5 percent, resulting in increased expenditures totaling approximately $159,257.	KS Division of the Budget
KY	2024	Passed	Our estimated increase in premiums for health benefit plans, not including state employee plans. is approximately **$0.00 to $0.57 per member per month (PMPM)**. This represents an **increase of approximately 0.0% to 0.1%**	Fiscal Note
LA	2019	Passed	**PMPM totaling $0.04-$0.06;** Based upon the aforementioned assumptions, the estimated annual cost increases for insurance providers associated with claims are as follows: FY 21 - **$138,600 (550K members * $0.04 PMPM * 6 months * 1.05) - $207,900 (550K members * $0.06 PMPM * 6 months * 1.05)**	Fiscal Note

Bobbie Will-bwill@komen.org-701-202-5840

MA	2022	Passed	Requiring coverage for diagnostic examinations for breast cancer would result in an average annual increase, over five years, to the typical **member's monthly health insurance premium of between $0.19 and$0.33 per member per month (PMPM**), or **between 0.03% and 0.06% of premium.**	CHIA Fiscal Report
MD	2022	Passed	The total cost PMPM is $0.33 on a cost basis. Assuming an 85% loss ratio, this translates to a $0.39 premium increase or 0.06% of the total. *This effect is small in comparison to the increased utilization of diagnostic screening because only one to two in 1,000 screening mammograms will result in a diagnosis of breast **cancer at an estimated savings of $15,000 per detected cancer. The net savings is $0.02 on a cost basis.**	MHCC Study
NC	2023	In progress	The projection assumes a 6.5% annual claims growth trend for medical claims, a 10.0% trend for pharmacy claims, a 7.0% trend for pharmacy rebates, benefit provisions and member-paid premiums as adopted by the Board for 2023, **and 4% employer premium increases in FY 2023-24.**	Actuarial Note
OK	2023	Passed	Aon, estimates the **annual cost impact to be $1.3 million, which is less than 0.25% increase in total premium cost.**	Fiscal Analysis
OR	2023	Passed	Based on input provided by PEBB's and OEBB's actuaries, OHA estimates that premiums for **plans offered by both Boards will increase by an average of 0.9% under the measure.** For PEBB, this increase would result in additional costs of **$862,793 in 2023-25, and $1,150,391 in 2025-27. For OEBB, the premium increase would result in additional costs of $582,469 in 2023-25, and $1,553,251 in 2025-27.**	Fiscal Note
TN	2023	Passed	Such legislation will result in an increase in the cost of health insurance premiums to cover the patient's share of the cost of procedures and treatments covered by plans. It is estimated that the increase to each individual's total premium will be less than one percent.	TN General Assembly
WA	2023	Passed	No fiscal impact, changes that require inclusion of this health care benefit in qualified health plans offered in the Exchange marketplace are not expected to require significant operational or Healthplanfinder system changes. There is an administrative fee.	Fiscal Note Summary

Bobbie Will-bwill@komen.org-701-202-5840

Community HealthCare Association of the Dakotas

Testimony
House Bill No. 1567
Senate Human Services Committee
Senator Judy Lee, Chair
March 18, 2025

Chair Lee, Vice Chair Weston and honorable members of the Senate Human Services Committee:

I am Kim Kuhlmann, the Policy and Partnership Manager in North Dakota for Community HealthCare Association of the Dakotas (CHAD). On behalf of CHAD and our member health centers, I am here today to support House Bill 1567.

In my position at CHAD, I also facilitate the North Dakota Oral Health Coalition, which has over sixty member organizations who are working collaboratively to address access to oral health care in North Dakota, especially for underserved populations.

CHAD is a non-profit membership organization that serves as the Primary Care Association for North Dakota and South Dakota, supporting community health centers across both states in their efforts to provide health care to underserved and low-income populations. The heath centers we represent have locations in both urban and rural communities.

Community health centers (CHCs) are non-profit, community-based primary care clinics that serve all individuals, regardless of their insurance status or ability to pay. The community health center integrated care model includes primary care, mental health and substance use treatment, dental care, pharmacy services, and a range of case management services that can include help with transportation, finding community resources, or assistance with insurance and financial enrollments.

North Dakota is home to five community health center organizations that provide comprehensive, integrated care to more than 36,000 individuals at 22 locations in 20 communities across the state. Sixteen percent of those patients are uninsured and about 40 percent earn incomes below the federal poverty level. Three health centers in North Dakota provide dental care at eight locations, with a new urgent dental clinic that just opened in Ray in February. Health centers served 11,912 dental patients with over 25,000 visits in 2023.

Community HealthCare Association of the Dakotas

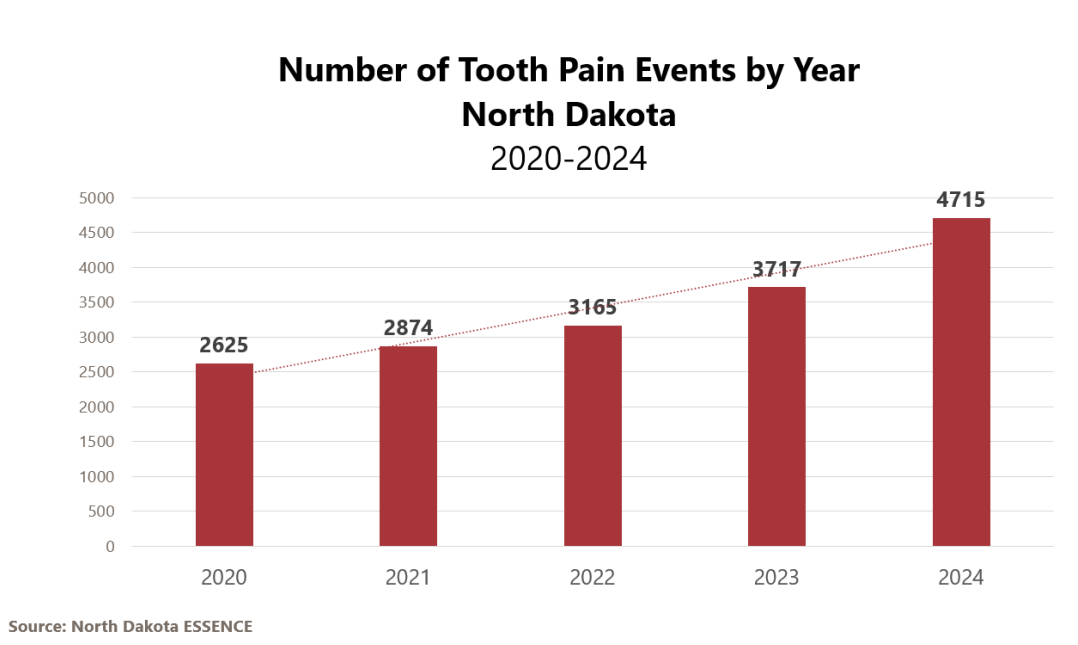
North Dakota is Facing an Oral Health Crisis

North Dakota is facing an oral health crisis, and it is impacting children, adults, and the aging population. These are just a few statistics which illustrate the unmet dental needs in our state:

- One of every two kindergarteners have experienced tooth decay;
- More than half of adults who are Indigenous reported no dental visit in the past 5 or more years;
- Nearly 1 in 3 adults who are not Indigenous reported no dental visit in the past 5 or more years; and
- 1 in 4 long term care residents in our state have untreated tooth decay.

We know that oral health impacts a variety of chronic disease outcomes, including diabetes, heart disease, and respiratory disease. In North Dakota, over twice as many adults with diabetes have lost 6 or more teeth due to tooth decay or gum disease compared to those without diabetes. According to the Centers for Disease Control, treating gum disease significantly improves blood sugar level among people with diabetes. Access to routine preventive dental care is a much less costly – and more healthy – way to help manage associated chronic diseases.

According to the North Dakota Department of Health and Human Services ESSENCE data, our state has seen a significant rise in the number of emergency room and urgent care clinic visits related to tooth pain over the last 5 years. From 2020 to 2024, the number of tooth pain related visits, including visits to emergency rooms, primary care clinics, and urgent care, increased from 2,625 to 4,715, nearly doubling in just 5 years. (See chart on next page).



These oral health related emergencies are costing the healthcare system, the Medicaid program, and patients additional money in emergency visits. And they don't even include the additional costs of the complications for patients with heart disease and diabetes that is caused by poor oral health. In addition, individuals who report dental care affordability concerns miss more hours of work for unplanned dental care. Better oral health results in better overall health outcomes, improved productivity, and leads to better quality of life.

Coverage and Workforce Challenges at Health Centers

Let me share how the coverage numbers shape up for North Dakota health centers. Currently around 40 percent of our patients are Medicaid beneficiaries, and those covered by Medicaid Expansion have no dental coverage. 13 percent are served by Medicare (which lacks dental coverage), 16 percent are uninsured, and 31 percent have private insurance coverage. When put together, that adds up nearly half of those we see lacking dental coverage. This makes it difficult to pay competitive wages and build our dental programs enough to meet community needs.

The North Dakota Department of Health and Human Services reports that only 44 percent of the need for dental providers across the state is being met. North Dakota has 20 counties that are geographical dental care health professional shortage areas (HPSAs) and two counties that are considered low-income population dental HPSAs. Geographical shortage areas means a shortage

of providers within a defined geographic area. The low-income population indicates there is a sub-population of individuals living in a defined geography that has insufficient access to care. These designations indicate a gap between the healthcare needs of the population and the available resources. Rural citizens, patients with urgent dental care needs, and patients with Medicaid coverage are more adversely affected by a dental provider shortages.

Given that health centers serve underserved populations and communities where there are likely to be even fewer providers than the state average, that gap looms large. Mara Jiran, CEO of Spectra Health, one of the state's community health centers that provides dental care, says, "Every week, hundreds of people attempt to schedule dental visits at our clinic. The demand far outweighs our current capacity." This is a challenge we hear from other health centers providing dental care as well.

Health centers are continuously looking for opportunities to innovate and expand access to dental care, and we would welcome the opportunity to collaborate and provide information for a legislative study on this topic. We were glad to see that HB 1567 includes consideration of the expansion or promotion of programs that offer support for on-the-job training and apprenticeships for dental assistants. At CHAD, we have developed an on-the-job training toolkit for health centers to offer dental assistant apprenticeships and are finding this to be a promising model for bringing homegrown talent into a dental career path. Further studying the application of this model in North Dakota, and resources needed to enable its success, would be incredibly valuable.

In Ray, Northland Health Centers just opened an urgent care dental clinic in February. At this time they will only be operating two days a week and only for emergency dental services because they cannot find a full time dentist. The long-term hope is to expand the care being provided at that location. The Ray clinic is the result of a multi-year, multi-partner collaborative project team committed to establishing a new dental clinic to address disparities for low-income, uninsured, or Medicaid-eligible individuals in the northwest region of the state. This area is one of the largest areas with lack of dental access in the state. The clinic will be sustained as part of Northland Health Centers operations in Ray.

Dental Student Rotations & Recruitment

The study originally included an appropriation of $97,000 for supporting dental student rotations

and dental student recruitment in North Dakota. The bill was amended in the House to remove the appropriation, but I would like to share the information we provided on those programs.

Currently, North Dakota does not have a dental school. In an effort to address dental workforce shortages, the North Dakota Department of Health and Human Services Oral Health Program (OHP) is helping to offset some costs associated with hosting dental student rotations, currently at two non-profit organizations in North Dakota. These sites are working cooperatively with dental schools from surrounding states to provide fourth year dental student rotations.

Dr. Jacki Nord, a dentist at Family HealthCare in Fargo, submitted testimony in the House Human Services Committee about the program she oversees at Family HealthCare including the costs associated with hosting students. Tammy King also shared information about the dental student rotations at Bridging the Dental Gap in Bismarck and the dental student recruitment trips taking place, the next one is coming up in April. These organizations provide valuable experiences in public health dentistry for dental students and bringing dental students to North Dakota.

The impact of this program is two-fold. During their rotations, dental students provide additional services and help reduce wait times for patients seeking preventive care. In other words, they help to address immediate needs. In addition, these rotations expose dental students to career paths within North Dakota, with some students choosing to begin their career in North Dakota.
We would appreciate your support for additional funding to sustain these programs and possibly expand to additional sites. Again, one of the biggest challenges to expanding the program is the additional staff needed to administer the programs.

Conclusion

Today, I've shared about the significant barriers to oral health care in the state. While we are proud of the ways that CHAD and community health centers and are partners are creatively working to address the limited rural oral health infrastructure and the limited options for our lower-income neighbors in need, we remain deeply concerned by the level of unmet need that persists. A legislative management study of oral health care could identify ways to strengthen an oral health system in which we are facing a real crisis in access to care. CHAD and our member health centers would welcome the opportunity to provide information and collaborate throughout the study, and we can also serve as a liaison by inviting members of the Oral Health Coalition to participate.

Community HealthCare Association of the Dakotas

I ask for your support on behalf of our member health centers to recommend a do pass on HB 1567 to provide for a legislative management study of dental care in North Dakota. I am happy to answer any questions you have. Thank you!

Kim Kuhlmann
Policy and Partnership Manager, ND
Community HealthCare Association of the Dakotas (CHAD)

Chair Barta, members of the Senate Industry and Business Committee, for the record my name is Ben Hanson, I'm the government relations director for the American Cancer Society Cancer Action Network. I'm here today to testify in favor of HB 1283.

Wanted to level set here, obviously everyone knows what breast cancer is here and likely many committee members have personal stories of families members who have had to deal with it. Wanted to just share some information:

1 in 8 women will be diagnosed with breast cancer in their lifetimes.

1 in 43 will die of the disease.

And, finally, here in North Dakota, In 2025, approximately 640 women will be diagnosed with breast cancer and an estimated 70 lives will be lost to the disease in our state.

Breast cancer is the most common form of cancer in women, and the second deadliest after lung cancer.

And I highlight these devasting statistics to not just to level set but reinforce the public policy that North Dakota already has already established as of 1989 with regards to breast cancer screening. As you can see if you check your online testimony under the submitted documents under my name, during that legislative session North Dakota mandated that mammography be covered at no cost share due to the disease's prevalence. Therefore, this is not a new mandate, Mr. Chair and committee members, but what this bill does is bring into parity the new methods of screening for the same thing: breast cancer detection. Some of you will remember that in 2015 this body moved to require providers to inform women if they have dense breast tissue.

We know that about 40% of women have dense breast tissue and 10% of those have extremely dense breast tissue and that dense breast tissue reduces the effectiveness of mammograms in screening for breast cancer.

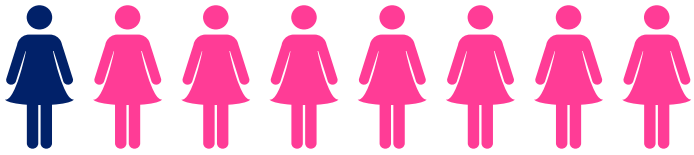
Early Detection Breast Cancer Screening

Breast Cancer & Screening

Breast cancer occurs when cells in breast tissue change and divide uncontrolled, typically resulting in a lump or mass. Most breast cancers begin in the milk glands (lobules) or in the tubes (ducts) that connect milk glands to the nipple. Breast cancer typically has no symptoms when it is small and easily treated, which is why mammography screening is important for early detection. In the U.S., 1 in 8 women will be diagnosed with invasive breast cancer, and 1 in 43 will die from the disease.

Screening mammograms are widely available without cost sharing for individuals starting at age 40, increasing access and utilization. However, mammography alone cannot confirm a cancer diagnosis and is only the initial step in early detection of breast cancer.

Follow-up diagnostic screenings, often required for abnormal results or high-risk patients, frequently involve significant out-of-pocket costs. These financial barriers prevent many individuals from accessing the full benefits of early detection, limiting the effectiveness of breast cancer screening.



1 in 8 women will be diagnosed with breast cancer in their lifetime.

Breast Cancer in North Dakota

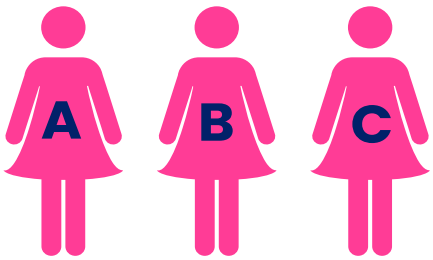
Breast cancer continues to be the most commonly diagnosed cancer among women and is the second leading cause of cancer-related deaths among women in the U.S. In 2025, approximately 640 women will be diagnosed with breast cancer and an estimated 70 lives will be lost to the disease in North Dakota.

Early detection, through screening, significantly improves survival rates by identifying cancer at an earlier, more treatable stage, underscoring the importance of accessible breast cancer screenings.

Variations in Out-of-Pocket Costs for Breast Cancer Screening

Understanding Screening Needs & Costs

Patients A, B, and C all work at the same organization, share the same health insurance plan, and prioritize their breast health by utilizing preventive care benefits. Despite their shared circumstances, they face significant differences in out-of-pocket costs for follow-up breast cancer screenings.



Patient A undergoes an annual preventive screening mammogram, which yields a normal result. Patient A incurs no out-of-pocket expenses, as this service is fully covered under the insurance plan's preventive care benefits. Their physician advises routine screening again next year.

Patient B also completes an annual screening mammogram. However, an abnormal finding necessitates a follow-up diagnostic screening, such as diagnostic mammography, breast ultrasound, or breast MRI. Patient B is required to pay out-of-pocket for this medically necessary screening and is forced to delay the procedure due to the high cost, increasing the risk that a potential breast cancer diagnosis could be made at a later, more advanced stage, when treatment is less effective and significantly more expensive.

Patient C is identified as high-risk for breast cancer based on National Comprehensive Cancer Network (NCCN) Guidelines. Their annual screening requires advanced imaging, such as a breast MRI or ultrasound, instead of a standard mammogram. However, these advanced screenings are not fully covered as part of the plan's preventive care benefits, leaving Patient C responsible for significant out-of-pocket costs. The results of their screening are normal, but they may delay screening next year because of the cost they incurred.

American Cancer Society Cancer Action Network
fightcancer.org

ACS CAN Supports Eliminating Cost Sharing for Breast Cancer Screening and Follow-up Tests

Despite the effectiveness of breast cancer screening, the full benefit of screening has not been achieved because barriers, like cost, still exist. Research shows that required cost sharing – including co-pays, co-insurance, and deductibles – can be a significant barrier for individuals who need preventive services.[1,2] This is especially true among people with limited incomes, for whom these payments can represent a significant percentage of their income.

Out-of-pocket costs for individuals can lead to delayed or missed breast cancer screenings including delays in follow-up tests that are needed after an abnormal initial screening. Any delays in testing or missed screenings can ultimately impact a person's survival. One study showed that even a 3-month delay in follow-up breast cancer screening tests can lead to later stage diagnosis and less favorable outcomes and less life years gained.[3]

Removing cost sharing for preventive services has proven to increase the use of those services. For example, following the removal of cost sharing for preventive services in Medicare, there was a statistically significant uptake in mammography screenings among Medicare enrollees.[4]

The Importance of Screening

In the U.S., breast cancer is the most diagnosed cancer and the second leading cause of cancer death among women. More than 297,000 women will be diagnosed and 43,000 will die from breast cancer in 2023.[8] Despite a lower incidence rate, Black women have a 40% higher mortality rate than White women. Fortunately, early detection of cancer through screening can improve survival and reduce mortality by detecting cancer at an early stage when treatment is more effective.

Current Insurance Coverage & Cost Requirements

Federal law requires all ACA-compliant private insurance plans to cover recommended breast cancer screening services starting at age 40 without cost sharing, thereby making it easier for individuals– especially individuals with limited incomes – to access these important services. This provision of the

[1] The Clinical Practice Guideline Treating Tobacco Use and Dependence 2008 Update Panel, Liaisons, and Staff. (2008). A Clinical Practice Guideline for Treating Tobacco Use and Dependence: 2008 Update: A U.S. Public Health Service Report. *American Journal of Preventive Medicine*, *35*(2), 158–176. http://doi.org/10.1016/j.amepre.2008.04.009
[2] Han X, Robin Yabroff K, Guy GP, Zheng Z, Jemal A. Has recommended preventive service use increased after elimination of cost-sharing as part of the Affordable Care Act in the United States? Prev Med. 2015 Sep;78:85-91. doi: 10.1016/j.ypmed.2015.07.012.
[3] Rutter CM, Kim JJ, Meester RGS, Sprague BL, Burger EA, Zauber AG, Ergun MA, Campos NG, Doubeni CA, Trentham-Dietz A, Sy S, Alagoz O, Stout N, Lansdorp-Vogelaar I, Corley DA, Tosteson ANA. Effect of Time to Diagnostic Testing for Breast, Cervical, and Colorectal Cancer Screening Abnormalities on Screening Efficacy: A Modeling Study. Cancer Epidemiol Biomarkers Prev. 2018 Feb;27(2):158-164. doi: 10.1158/1055-9965.EPI-17-0378. Epub 2017 Nov 17. PMID: 29150480; PMCID: PMC5809257.
[4] Cooper GS, et al. Changes in Receipt of Cancer Screening in Medicare Beneficiaries Following the Affordable Care Act JNCI J Natl Cancer Inst (2016) 108 (5): djv374 doi:10.1093/jnci/djv374

federal law has increased access and utilization of these life-saving services.[5] Some states have also enacted mandates that require plans to cover breast cancer screening beginning at age 40, but these laws do not often address patient cost.

However, in the absence of federal or state laws that define insurance benefits for screening, payers are determining what does or does not constitute a no-cost preventive service. This has led to individuals being charged when additional screening tests are recommended after an abnormal screening or if supplemental screening is recommended, such as when they are above average risk.

For a person being screened for breast cancer, this can include a charge for an imaging test after an initial abnormal mammogram. One study found that the out-of-pocket costs for follow-up screening image tests can average $234 for a diagnostic mammogram and $1,021 for a breast MRI.[6] Another study found women were less likely to undergo follow-up screening tests as the costs of those tests increased.[7] The costs associated with follow-up testing as part of screening undermines the progress of screening in reducing death from breast cancer, leaving people unscreened for cancer and having the potential to delay a diagnosis of cancer.

ACS CAN Position

ACS' "Position Statement on the Elimination of Patient Cost-Sharing Associated with Cancer Screening and Follow-up Testing[8]" states that screening is a "continuum of testing rather than a single recommended screening test, and that irrespective of individual risk, screening is a process that includes a recommended screening test and all follow-up tests described as diagnostic and judged to be integral and necessary to resolve the question of whether an adult undergoing screening has cancer." The statement makes clear that these "tests should be covered without any patient cost-sharing."

ACS CAN supports comprehensive insurance coverage and the elimination of cost sharing by all payers for recommended breast cancer screening and follow-up testing for asymptomatic individuals, regardless of risk.

[5] Office of Health Policy: Assistant Secretary for Planning and Evaluation, Access to Preventive Services without Cost-Sharing: Evidence from the Affordable Care Act, U.S. Dep't of Health and Hum. Serv., at 8 (Jan. 11, 2022), https://aspe.hhs.gov/sites/default/files/documents/786fa55a84e7e3833961933124d70dd2/preventive-services-ib-2022.pdf
[6] Susan G Komen & Martec. Understanding Cost & Coverage Issues with Diagnostic Breast Imaging. January 2019.
[7] Hughes DR, Espinoza W, Fein S, Rula EY, McGinty G. Patient Cost-Sharing and Utilization of Breast Cancer Diagnostic Imaging by Patients Undergoing Subsequent Testing After a Screening Mammogram. JAMA Netw Open. 2023;6(3):e234893. doi:10.1001/jamanetworkopen.2023.4893
[8] American Cancer Society. Cancer Facts & Figures 2023. Atlanta: American Cancer Society; 2023.
[8] American Cancer Society. Position Statement on the Elimination of Patient Cost-Sharing Associated with Cancer Screening and Follow-up Tests. 2023. Accessed October 20, 2023. https://www.cancer.org/health-care-professionals/american-cancer-society-prevention-early-detection-guidelines/overview/acs-position-on-cost-sharing-for-screening-and-follow-up.html

CHAPTER 367

HOUSE BILL NO. 1391
(Representatives J. DeMers, Myrdal, Kelly)
(Senators Heinrich, Nalewaja, Mushik)

MAMMOGRAM INSURANCE COVERAGE

AN ACT to create and enact a new section to chapter 26.1-36 and a new section to chapter 54-52.1 of the North Dakota Century Code, relating to health insurance coverage for mammogram examinations.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. A new section to chapter 26.1-36 of the 1987 Supplement to the North Dakota Century Code is hereby created and enacted to read as follows:

Health insurance policy and health service contract - Mammogram examination coverage.

1. An insurance company, nonprofit health service corporation, or health maintenance organization may not deliver, issue, execute, or renew any health insurance policy, health service contract, or evidence of coverage on an individual, group, blanket, franchise, or association basis unless the policy, contract, or evidence of coverage provides benefits, of the same type offered under the policy or contract for illnesses, for health services to any person covered under the policy or contract for:

   a. One baseline mammogram examination for each woman who is at least thirty-five but less than forty years of age.

   b. One mammogram examination every two years or more frequently if ordered by a physician for women who are at least forty but less than fifty years of age.

   c. One mammogram examination every year for women age fifty and over.

2. This section does not apply to individually guaranteed renewable supplemental specified disease, long-term care, or other limited benefit policies.

SECTION 2. A new section to chapter 54-52.1 of the North Dakota Century Code is hereby created and enacted to read as follows:

Insurance to cover mammogram examinations. The board shall provide medical benefits coverage under either a contract for insurance pursuant to section 54-52.1-04 or under a self-insurance plan pursuant to section 54-52.1-04.2 for:

1. One baseline mammogram examination for each woman who is at least thirty-five but less than forty years of age.

2. One mammogram examination every two years or more frequently if ordered by a physician for women who are at least forty but less than fifty years of age.

3. One mammogram examination every year for women age fifty and over.

Approved March 22, 1989
Filed March 23, 1989

01/19	House	COMMITTEE HEARING 01/27 10:30	
02/03	House	Reported back, do pass, placed on calendar y 011 n 001	HJ 515
02/08	House	Second reading, passed, yeas 091 nays 003	HJ 597
02/10	Senate	Received from House	SJ 531
		Introduced, first reading, referred NATURAL RESOURCES	SJ 560
02/23	Senate	COMMITTEE HEARING 03/03 9:30	
03/17	Senate	Reported back amended, amendment poc y 006 n 000	SJ1198
03/20	Senate	Amendment adopted, placed on calendar	SJ1209
03/22	Senate	Second reading, passed as amended, yeas 045 nays 000	SJ1304
03/27	House	Returned to House (12)	HJ1636
04/03	House	Concurred	HJ1837
		Second reading, passed as amended, yeas 096 nays 010	HJ1837
		Enrolled	HJ1901
04/05	House	Signed by Speaker	HJ1938
04/06	Senate	Signed by President	SJ1637
04/07	House	Sent to Governor	HJ1987
04/12	House	Signed by Governor 0410	HJ2177
04/13	House	Filed with Secretary of State 0411	

HB 1388

Rep. Shockman, Marks

A BILL for an Act to amend and reenact sections 61-04.1-08, 61-04.1-12, 61-04.1-33, 61-04.1-34, 61-04.1-35, and 61-04.1-38 of the North Dakota Century Code, relating to the powers and duties of the state atmospheric resource board, license and permit exemptions, bid requirements, performance and bid bond requirements, and the receipt and expenditure of funds by the board; to repeal sections 61-04.1-01, 61-04.1-02, 61-04.1-09, 61-04.1-10, 61-04.1-20, 61-04.1-21, 61-04.1-22, and 61-04.1-39 of the North Dakota Century Code, relating to state sovereignty over moisture, policy and purpose, research and development programs, creation of operating districts and district operations advisory committees, suspension of operations, and county appropriations.

01/16	House	Introduced, first reading, referred NATURAL RESOURCES	HJ 196
01/25	House	Request return from committee	HJ 341
		Rereferred to AGRICULTURE	HJ 341
02/02	House	COMMITTEE HEARING 02/09 9:00	
02/10	House	Reported back, do not pass, placed on calendar y 008 n 006	HJ 676
02/17	House	Second reading, failed to pass, yeas 021 nays 083	HJ 887

HB 1389

Rep. Myrdal, Goetz

A BILL for an Act to amend and reenact section 15-47-06 of the North Dakota Century Code, relating to recounts in school district elections.

01/16	House	Introduced, first reading, referred EDUCATION	HJ 197
01/18	House	COMMITTEE HEARING 01/23 9:30	
01/24	House	Reported back, do pass, placed on calendar y 015 n 000	HJ 337
01/25	House	Second reading, passed, yeas 104 nays 000	HJ 349
01/27	Senate	Received from House	SJ 321
		Introduced, first reading, referred EDUCATION	SJ 342
02/16	Senate	COMMITTEE HEARING 02/22 10:00	
03/10	Senate	Reported back amended, amendment poc y 008 n 000	SJ1078
03/13	Senate	Amendment adopted, placed on calendar	SJ1089
03/15	Senate	Second reading, passed as amended, yeas 051 nays 000	SJ1140
03/17	House	Returned to House (12)	HJ1499
04/03	House	Concurred	HJ1837
		Second reading, passed as amended, yeas 106 nays 000	HJ1837
		Enrolled	HJ1901
04/05	House	Signed by Speaker	HJ1938
04/06	Senate	Signed by President	SJ1637
04/07	House	Sent to Governor	HJ1987
04/12	House	Signed by Governor 0410	HJ2177
05/03	House	Filed with Secretary of State 0411	

HB 1390

Rep. Halmrast
Sen. Satrom

A BILL for an Act to create and enact a new section to chapter 15-38.2, relating to documentation of material in teachers' personnel files.

01/16	House	Introduced, first reading, referred EDUCATION	HJ 197
01/18	House	COMMITTEE HEARING 01/24 9:00	
02/02	House	Reported back amended, amendment poc y 012 n 004	HJ 484
02/03	House	Amendment adopted, placed on calendar	HJ 492
02/06	House	Second reading, passed as amended, yeas 069 nays 036	HJ 531
02/08	Senate	Received from House	SJ 489
		Introduced, first reading, referred EDUCATION	SJ 506
03/03	Senate	COMMITTEE HEARING 03/06 9:45	
03/15	Senate	Reported back amended, do not pass, y 006 n 002	SJ1143
03/17	Senate	Amendment adopted, placed on calendar	SJ1175
03/20	Senate	Second reading, failed to pass, yeas 006 nays 043	SJ1211

HB 1391

Rep. J.DeMers, Myrdal, Kelly
Sen. Heinrich, Nalewaja, Mushik

A BILL for an Act to create and enact a new section to chapter 26.1-36 and a new section to chapter 54-52.1 of the North Dakota Century Code, relating to health insurance coverage for mammogram examinations.

01/16	House	Introduced, first reading, referred INDUSTRY, BUSINESS AND LABOR	HJ 197

01/25	House	COMMITTEE HEARING 02/01 10:15	
02/03	House	Reported back amended, amendment poc y 015 n 000	HJ 515
02/06	House	Amendment adopted, placed on calendar	HJ 525
02/07	House	Second reading, passed as amended, yeas 103 nays 002	HJ 558
02/09	Senate	Received from House	SJ 507
		Introduced, first reading, referred INDUSTRY, BUSINESS AND LABOR	SJ 528
03/01	Senate	Request return from committee	SJ 934
		Rereferred to STATE AND FEDERAL GOVERNMENT	SJ 934
03/02	Senate	COMMITTEE HEARING 03/07 2:45	
03/08	Senate	Reported back, do pass, placed on calendar y 006 n 000	SJ1026
03/10	Senate	Second reading, passed, yeas 051 nays 000	SJ1058
03/14	House	Returned to House	HJ1413
		Enrolled	HJ1452
03/15	House	Signed by Speaker	HJ1453
03/16	Senate	Signed by President	SJ1150
03/20	House	Sent to Governor	HJ1515
03/23	House	Signed by Governor 0322	HJ1611
03/29	House	Filed with Secretary of State 0323	

HB 1392

Rep. Urlacher, Goetz, Wald
Sen. Krauter, Maixner

A BILL for an Act to create a new section to chapter 61-24.3 of the North Dakota Century Code, relating to the distribution of water through the southwest pipeline project.

01/16	House	Introduced, first reading, referred NATURAL RESOURCES	HJ 197
01/19	House	COMMITTEE HEARING 01/26 11:00	
01/27	House	Reported back, do pass, placed on calendar y 013 n 000	HJ 392
01/31	House	Second reading, passed, yeas 105 nays 000	HJ 425
02/02	Senate	Received from House	SJ 397
		Introduced, first reading, referred NATURAL RESOURCES	SJ 412
02/13	Senate	Committee hearing 03/02 10:30	
03/06	Senate	Reported back, do pass, placed on calendar y 006 n 000	SJ1004
03/09	Senate	Second reading, passed, yeas 050 nays 000	SJ1040
03/13	House	Returned to House	HJ1392
		Enrolled	HJ1411
03/15	House	Signed by Speaker	HJ1433
03/16	Senate	Signed by President	SJ1151
03/20	House	Sent to Governor	HJ1515
03/23	House	Signed by Governor 0321	HJ1611
03/29	House	Filed with Secretary of State 0323	

HB 1393

Rep. Knell, Gunsch
Sen. Keller

A BILL for an Act to amend and reenact section 11-15-08 of the North Dakota Century Code, relating to commissions collected by sheriff in certain proceedings.

01/16	House	Introduced, first reading, referred JUDICIARY	HJ 197
01/25	House	COMMITTEE HEARING 01/31 10:30	
02/01	House	Reported back amended, amendment poc y 014 n 000	HJ 464
02/02	House	Amendment adopted, placed on calendar	HJ 470
02/03	House	Second reading, passed as amended, yeas 103 nays 000	HJ 496
02/07	Senate	Received from House	SJ 465
		Introduced, first reading, referred JUDICIARY	SJ 486
02/23	Senate	COMMITTEE HEARING 03/01 3:30	
03/02	Senate	Reported back, do pass, placed on calendar y 005 n 000	SJ 961
03/06	Senate	Second reading, passed, yeas 051 nays 000	SJ1001
03/08	House	Returned to House	HJ1307
		Enrolled	HJ1337
03/10	House	Signed by Speaker	HJ1381
03/13	Senate	Signed by President	SJ1084
03/14	House	Sent to Governor	HJ1411
03/15	House	Signed by Governor 0314	HJ1433
03/16	House	Filed with Secretary of State 0315	

HB 1394

Rep. Sorensen

A BILL for an Act to create and enact a new section to chapter 40-01 and a new subsection to section 40-05-01 of the North Dakota Century Code, relating to an organization of city governments.

01/16	House	Introduced, first reading, referred POLITICAL SUBDIVISIONS	HJ 197
01/19	House	COMMITTEE HEARING 01/27 10:45	
02/03	House	Reported back, do pass, placed on calendar y 013 n 000	HJ 515
02/08	House	Second reading, passed, yeas 095 nays 000	HJ 597
02/10	Senate	Received from House	SJ 531
		Introduced, first reading, referred POLITICAL SUBDIVISIONS	SJ 560
02/16	Senate	COMMITTEE HEARING 02/23 10:30	
03/01	Senate	Reported back, do pass, placed on calendar y 005 n 000	SJ 939
03/03	Senate	Second reading, passed, yeas 048 nays 000	SJ 981
03/07	House	Returned to House	HJ1297
		Enrolled	HJ1307
03/09	House	Signed by Speaker	HJ1338
03/10	Senate	Signed by President	SJ1053
03/13	House	Sent to Governor	HJ1389
03/15	House	Signed by Governor 0314	HJ1433
03/16	House	Filed with Secretary of State 0315	

HB 1395

Rep. Tollefson, Wald

1989 HOUSE INDUSTRY, BUSINESS AND LABOR

HB 1391

1989 HOUSE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. HB 1391

House Committee on Industry, Business & Labor

Subcommittee on _____ Identify or check where appropriate

Conference Committee _____

Hearing Date 2-1-89

Tape Number 3 /Side A X Side B _____ Meter # 2312

Committee clerk signature Marsha Smith

Minutes:

HB 1289 Relating to reimbursement of erroneous overdraft service charges.

The Industry, Business and Labor Committee met at 10:15 in the Peace Garden Room with 17 members present and none absent.

Proponents

Rep. Judy DeMers, District 17 & 18, Grand Forks: Presented prepared testimony. See copy attached. Supports amendments by Tom Smith except for the Medicare supplement. This is important.

Rep. Rosemarie Myrdal, District 11: Am interested in the advancements of preventive medicine that are being developed and this a kind of health care cost containment measure. Encourages women to use it and it emphasizes the importance of using this kind of diagnostic tool to avoid advanced cases of cancer.

Michael Unhjem, Blue Cross and Blue Shield: We oppose any sort of mandate but we instituted the identical benefit schedule that you see in this legislation in January, 1987. We are pleased with it and for that reason we have no opposition to the bill.

Rep. Tish Kelly, District 21: Is the co-sponsor of the bill and glad that we have the backing of Blue Cross and Blue Shield. Could be cost saving measure.

Opponents

Tom Smith, Health Insurance Association of America: We support the concept but that decision should be left to individual company. This bill addresses all health insurance policies.

(Tom Smith testimony continued)

If full range then this type of coverage should be under these policies. There are specialty contracts that may offer cancer only coverage and specified diseases. Presented amendments. See copy attached.

Earl Pomeroy, Commissioner of Insurance: Is for the bill but opposed to the amendments of Tom Smith's with regard to the limited benefit policy. People obtain coverage over and above their major medical coverage for this particular condition. It doesn't seem right to write a cancer policy and cover mammograms. This bill is cost effective and should not increase premiums and good to get early detection.

Hearing closed.

COMMITTEE ACTION 2-1-89 HB 1391 Tape 4 Side A

Rep. Dorso moved to accept the amendments of Tom Smith but to take out Medicare Supplement, seconded by Rep. Lang. The motion carried on a vote of 15 ayes, 0 nays, and 2 absent. Rep. Oban moved a DO PASS AS AMENDED, seconded by Rep. Gerl. The motion carried on a vote of 15 ayes, 0 nays and 2 absent. Rep. Oban will carry the bill on the floor.

COMMITTEE CLERK
MARSHA SMITH

JAN 18 1988

(Return in triplicate) **FISCAL NOTE**

Bill/Resolution No.: HB 1391 Amendment to: _____

Requested by: Legislative Council Date of Receipt: 1/18/89

Please estimate the fiscal impact of the above measure for:

|X| State general or special funds |___| Counties |___| Cities

In the following space note the fiscal effect in dollars of this measure:

Narrative:

The bill requires that insurance plans cover certain mammogram examinations. This benefit will be included in the state's group health insurance plan and its cost is reflected in the premiums included in state agency budgets.

State Fiscal Effect:

1989-90		1990-91		Biennium Total	
General Fund	Special Funds	General Fund	Special Funds	General Fund	Special Funds
-0-	-0-	-0-	-0-	-0-	-0-

County and City Fiscal Effect:

1989-90		1990-91		Biennium Total	
Counties	Cities	Counties	Cities	Counties	Cities

If additional space is needed, attach a supplemental sheet.

Signed Alan Person

Typed Name Alan Person

Date Prepared: 1/18/89

Department Public Emp. Ret. Sys.

1989 HOUSE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION No. HB 1391

House Committee on INDUSTRY, BUSINESS & LABOR

Subcommittee on _____ Identify or check where appropriate

Conference Committee _____

Date of Hearing 2-1-89 Date of Action 2-1-89

Action Taken Amendments of Judy DeMars except medical case Sustained

Motion Made By Rep. Dorso Seconded By Rep. Lang

Representatives	Yes	No	Representatives	Yes	No
Whalen, Chairman	✓		Tokach	✓	
Dorso, Vice Chrm.	✓		Tollefson	✓	
Enget	✓		Vander Vorst	✓	
Frey		A			
Gerhardt	✓				
Gerl	✓				
Haugland		A			
Lang	✓				
Larson	✓				
Oban	✓				
Shide	✓				
Skjerven	✓				
Soukup	✓				
Starke	✓				

Total 15 (Yes) 0 (No)

Absent 2

Floor Assignment _____

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

1989 HOUSE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION No. HB 1391

House Committee on INDUSTRY, BUSINESS & LABOR

Subcommittee on _____

Conference Committee _____

Identify or check where appropriate

Date of Hearing 2-1-89 Date of Action 2-1-89

Action Taken Do Pass As Amended

Motion Made By Rep. Oban Seconded By Rep. Gerl

Representatives	Yes	No	Representatives	Yes	No
Whalen, Chairman	✓		Tokach	✓	
Dorso, Vice Chrm.	✓		Tollefson	✓	
Enget	✓		Vander Vorst	✓	
Frey		A			
Gerhardt	✓				
Gerl	✓				
Haugland		A			
Lang	✓				
Larson	✓				
Oban	✓				
Shide	✓				
Skjerven	✓				
Soukup	✓				
Starke	✓				

Total 15 (Yes) 0 (No)

Absent 2

Floor Assignment Rep Oban

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

13659

REPORT OF STANDING COMMITTEE

DATE: 2 / 1 / 89 CARRIER: Rep. Oban

(MR~~XXRESIDENT~~/MR. SPEAKER): Your Committee on IBL

to which was (~~are~~) referred HB 1391 has had the same under consideration and recommends by a vote of 15 YEAS, 0 NAYS, 2 ABSENT AND NOT VOTING that the same

( ) (DO PASS) (DO NOT PASS)
(and BE PLACED ON THE CONSENT CALENDAR)

( ) BE PLACED ON THE (CONSENT) CALENDAR
(WITHOUT RECOMMENDATION)

(X) BE AMENDED AS FOLLOWS and when so amended, recommends the same
(DO PASS/DO NOT PASS):

( ) and be rereferred to the Committee on _____

(X) AMENDMENT: (see attached) _____
(LC NUMBER)

( ) (title change and emergency clause added)

( ) (statement of purpose of amendment)

(SEN./REP.) _____, Chairman
Rep. Joe Whalon

****

(X) HB1391 was placed on the 6th order of business on the calendar for the succeeding legislative day.

****

( ) _____ was rereferred to the Committee on _____.

****

(1) LDP, (2) LDP, (3) DESK FILES, (4) DESK REPORTER 89-410 (8/15/88)

90430.0202

9NN
2/2/87

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1391

Page 1, line 9, after the period insert "1."

Page 1, line 17, replace "1." with "a."

Page 1, line 19, replace "2." with "b."

Page 1, line 22, replace "3." with "c."

Page 1, after line 22, insert:

"2. This section does not apply to individually guaranteed renewable supplemental specified disease, long-term care, or other limited benefit policies."

Renumber accordingly

1989 SENATE STATE AND FEDERAL GOVERNMENT

HB 1391

1989 SENATE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. HB 1391

Senate Committee on State and Federal Government

Subcommittee on _____

Conference Committee _____

Identify or check where appropriate

Hearing Date 03-07-89

Tape Number 2 /Side A X Side B _____ Meter # 890

Committee clerk signature _____

Minutes: Chairman D. Meyer opened hearing on HB 1391 and told the committee that Blue Cross/ Blue Shield of ND are in support of the bill. Rep. Judy De Mers testified in favor of the bill. See attached. Sen. Donna Nalewaja, District 45, testified in favor of hte bill. She said with passage of this bill the legislature would be encouraging women of this age bracket to have the exam done. The bill would definitely help to pay costs when the exam is recommended each year. Gene Sandwick, with the NDPEA, stated that they are in favor of the bill. They understand that this is to become available and feels it is an important tool in early detection. In response to a question raised by the committee, the answer was that payment would still be subject to teh deductible of an insurance company depending on what that person's policy stated. Sen. Lodoen moved a DO PASS and the motion was seconded by Sen. Axtman. Upon roll call the vote was 6 to 0 with 1 absent and not voting. **Sen. Lodoen will carry the bill.**

1989 SENATE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION No. HB 1341

Senate Committee on State & Federal Government

Subcommittee on _____ Identify or check where appropriate

Conference Committee _____

Date of Hearing 3-7-89 Date of Action 3-7-89

Action Taken Do Pass

Motion Made By Sen Lodoen Seconded By Sen Axtman

Senators	Yes	No	Senators	Yes	No
Meyer, Dean J.	X		Lodoen, Clayton A.	X	
Kinnoin, Meyer J.	X		David, Ray	X	
Meyer, Walter			Vosper, F. Kent	X	
Axtman, Ben	X				

Total 6 (Yes) 0 (No)

Absent 1

Floor Assignment Sen. Lodoen.

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

****
REPORT OF STANDING COMMITTEE
****

DATE: 03/07/89 CARRIER: Sen. Lodoen

(MR. PRESIDENT/~~MR. SPEAKER~~): Your Committee on State & Federal Government to which was (re)referred Engrossed HB 1391 has had the same under consideration and recommends by a vote of 6 YEAS, 0 NAYS, 1 ABSENT AND NOT VOTING that the same

(X) (DO PASS) (~~DO NOT PASS~~)

(~~BE PLACED ON THE CONSENT CALENDAR~~)

( ) BE PLACED ON THE (CONSENT) CALENDAR

(WITHOUT RECOMMENDATION)

( ) BE AMENDED AS FOLLOWS and when so amended, recommends the same

(DO PASS/DO NOT PASS):

( ) and be rereferred to the Committee on _____

( ) AMENDMENT: (see attached) _____.
(LC NUMBER)

( ) (title change and emergency clause added)

( ) (statement of purpose of amendment)

(SEN./~~REP.~~) Dean Meyer, Chairman
Dean Meyer

****

( ) _____ was placed on the _____ order of business on the calendar for the succeeding legislative day.

****

( ) _____ was rereferred to the Committee on _____.

****

(1) LDP, (2) LDP, (3) DESK FILES, (4) DESK REPORTER 89-410 (8/15/88)

1989 TESTIMONY

HB 1391

TESTIMONY - HOUSE BILL 1391

PRESENTED TO THE SENATE STATE AND FEDERAL GOVERNMENT COMMITTEE
BY REPRESENTATIVE JUDY L. DEMERS
MARCH 7, 1989

CHAIRMAN MEYERS AND MEMBERS OF THE SENATE COMMITTEE ON STATE AND FEDERAL GOVERNMENT. FOR THE RECORD, I AM JUDY DEMERS, STATE REPRESENTATIVE FROM DISTRICT 17-18, CONSISTING OF PART OF GRAND FORKS AND THE GRAND FORKS AIR FORCE BASE. I APPEAR BEFORE YOU THIS MORNING AS THE PRIME SPONSOR OF HOUSE BILL 1391.

HOUSE BILL 1391 MANDATES HEALTH INSURANCE COVERAGE FOR MAMMOGRAMS BASED ON THE AMERICAN CANCER SOCIETY RECOMMENDATIONS OF:

-- A BASELINE MAMMOGRAMS EXAM FOR WOMEN 35-40;
-- AN EXAM EVERY OTHER YEAR, DEPENDING ON CANCER RISK FOR WOMEN 40-50 (FAMILY HISTORY, ETC.)
-- A MAMMOGRAM EXAM EVERY YEAR FOR WOMEN AGE 50 AND OVER.

SECTION 1 OF THE BILL MANDATES COVERAGE BY ALL OF THE USUAL INSURERS, WHETHER AN INSURANCE COMPANY, NONPROFIT HEALTH SERVICE CORPORATION, OR A HEALTH MAINTENANCE ORGANIZATION. SECTION 2 AMENDS THE SECTION OF NDCC WHICH DEALS WITH THE NORTH DAKOTA PUBLIC EMPLOYEES SYSTEM SELF-INSURANCE PLAN.

AS OF JANUARY 1, 1987, BLUE CROSS OF NORTH DAKOTA TOOK A PROGRESSIVE STEP IN BEGINNING COVERAGE FOR MAMMOGRAPHY SCREENING. PRIOR TO THAT TIME, BLUE CROSS ONLY WOULD PAY FOR THIS EXAM IF THE PERSONAL PHYSICIAN SUSPECTED A LUMP OR CANCER. BLUE CROSS/BLUE SHIELD IS PLEASED WITH THIS SERVICE AND I AM HOPEFUL THEY WILL TESTIFY IN FAVOR OF HOUSE BILL 1391. ON THE OTHER HAND, THE NDPERS SELF-INSURANCE PLAN DOES NOT COVER MAMMOGRAMS. THEY, HOWEVER, INDICATED PLANS TO ME TO PROVIDE THIS COVERAGE IN THE FUTURE.

AS OF OCTOBER 14, 1988, 13 STATES HAVE MANDATED COVERAGE OF MAMMOGRAPHY SCREENING (ARIZONA, CALIFORNIA, CONNECTICUT, FLORIDA, KANSAS, MINNESOTA, OKLAHOMA, NEW HAMPSHIRE, NEW YORK, RHODE ISLAND,

TEXAS, MARYLAND, AND MASSACHUSETTS). MAMMOGRAPHY IS A FAIRLY SIMPLE, PAINLESS, X-RAY OF THE BREAST WHICH HAS THE CAPABILITY OF EARLY DETECTION OF BREAST CANCER, ONE OF THE LEADING CAUSES OF DEATH AMONG WOMEN. AT THE GRAND FORKS CLINIC, A MAMMOGRAM SCREENING ALONG WITH AN EDUCATIONAL PROGRAM ON BREAST SELF EXAMINATION COSTS $65 (THIS IS NOT EXPENSIVE IN A RELATIVE SENSE).

IT IS A FACT THAT ONE IN TEN WOMEN WILL DEVELOP BREAST CANCER AT SOME TIME IN THEIR LIVES. THE AMERICAN CANCER SOCIETY SAYS WOMEN WHOSE BREAST CANCERS ARE DETECTED EARLY HAVE A FIVE-YEAR SURVIVAL RATE OF 90% OR BETTER. THOSE WITH ADVANCED CASES HAVE A 60% SURVIVAL RATE. IF A LUMP IS DETECTED EARLY, THE ENTIRE BREAST OFTEN DOES NOT HAVE TO BE REMOVED. DETECTING CANCER EARLY, FROM A PRACTICAL STANDPOINT, COSTS THE INSURANCE COMPANY MUCH LESS THAN THE $60,000 TO $70,000 TO TREAT THE CANCER AT A LATER STAGE.

HOUSE BILL 1391 JUST MAKES GOOD SENSE ALL AROUND. IT SHOULD RESULT IN COST SAVINGS, IT IS GOOD PREVENTIVE MEDICINE, IT WILL SAVE MANY WOMEN FROM MUTILATING SURGERY, AND ABOVE ALL, WITH A MAMMOGRAM, A SMALL LUMP IS GOING TO BE FOUND, AND THAT WOMAN IS GOING TO BE ALIVE FIVE YEARS FROM NOW.

THANK YOU. PLEASE GIVE HOUSE BILL 1391 YOUR FAVORABLE CONSIDERATION.

REPRESENTATIVE JUDY DEMERS

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1391

Page 1, line 22, after the second "." insert "This section shall not apply to individually guaranteed renewalable supplemental specified disease, Medicare supplement, long term care or other limited benefit policies."

Renumber accordingly

To: House Industry, Business, and Labor Committee
From: Elise M. Donnelley
Re: House Bill 1391
Date: February 1, 1989

Chairman Whalen and Members of the Committee

This is to support the passage of HB 1391 on behalf of the Aging Network of North Dakota. This bill proposes that health insurance pay for the type of preventive medicine that should help older women by providing early diagnosis and, therefore, treatment of breast cancer. It should not only save lives and years of lingering illness, but is one step toward helping contain the rising costs of health care. The need for preventive health care for older persons is great. The Medicare Program does not address it. Since the vast majority of older persons are women, this bill is of great concern North Dakota's seniors.

We urge this Committee to give HB 1391 a "Do Pass" recommendation.

February 7, 1989

Prepared by the Legislative Council staff

BILL NO.: HB 1391

SUBJECT: Mammogram examinations

CREATES NDCC: New section to Chapter 26.1-36, new section to Chapter 54-52.1

BILL SUMMARY

GENERALLY, THIS BILL:

As amended, requires all health insurance policies to provide coverage for mammogram examinations for women who meet certain age requirements.

Greater North Dakota Chamber

GREATER NORTH DAKOTA CHAMBER
HB 1283
Senate Industry & Business Committee
Chair Jeff Barta
March 18, 2025

Mr. Chairman and members of the Committee, my name is Andrea Pfennig, and I am the Vice President of Government Affairs for the Greater North Dakota Chamber. GNDC is North Dakota's largest statewide business advocacy organization, with membership represented by small and large businesses, local chambers, and trade and industry associations across the state. We stand in **opposition** of House Bill 1283.

In our 2024 ND Economics and Employer Survey of our membership, when asked to name one thing state government could do to help your business, the top answer was to make healthcare more affordable.

Last fall, the Insurance Commissioner approved small group insurance premium increases between 6.3% and 15.3% for the 2025 plan year. Healthcare and prescription drug coverage mandates, when applied to the private sector, increase business burdens and costs. These increases leave employers with hard decisions when it comes to compensation packages. Do they continue offering employer-sponsored health insurance or do they provide cost of living raises to help employees pay for rent and groceries?

The bill's fiscal note validates our cost concerns with an estimated NDPERS premium increase of .5%, or $4,070,000, in the 2025-2027 biennium. If this bill were only applicable to state employees, we would not have an issue. We will be the first to say that employers should have autonomy in developing compensation packages. However, this bill specifically includes a requirement that PERS draft a bill for the next legislative session applying this to the private sector.

As drafted, this could lead to increased costs for businesses by shifting them to the employer. It's important to note that there were 7 other bills that were proposed this session that either would be applied to the private sector or could be applied to the private sector in two years. As introduced, the fiscal notes of those bills totaled over $77.6 million for 2 years for PERS alone. These costs add up, and they don't go away. One of our major health carriers spent over $845 million on health insurance mandates imposed by the North Dakota State Legislature for years 2022-2024.

When considering a healthcare mandate that could be applied to the private sector, we ask that the committee also consider the benefits of a free market economy and the importance of a policy framework that enables that system, and our businesses, to thrive. We hope you will oppose this bill.

701.222.0929 ndchamber@ndchamber.com ndchamber.com PO Box 2639 • Bismarck, ND 58502

HB 1283

Mr. Chairman and members of the Senate Industry Business and Labor Committee.

For the record I am Lisa Meier from District 32 Bismarck.

I'm here in support of HB1283 and glad to be a cosponsor of this legislation.

Breast cancer continues to be the most diagnosed cancer among women and is the second leading cause of cancer-related deaths among women in the U.S. In 2025, approximately 640 women will be diagnosed with breast cancer an estimated 70 lives will be lost to the disease in ND.

Many people cannot afford the out-of-pocket expense for additional screening. When women can't afford additional screening and decide not to do it the result leads to late-stage diagnosis as well as more aggressive and expensive treatments.

This bill will help save lives and large expenses.

Mr. Chairman and committee members, I thank you for your consideration!

Testimony on HB 1283 – March 18, 2025

Senate IB Committee by Rep. Karen Karls, District 35 - Bismarck

This is a bill focused on Women's Health, while also recognizing that approximately 1% of breast cancer cases occur in men. This legislation ensures that essential breast cancer screenings, including follow-up and supplemental imagining, are provided at no cost share for those who need them—regardless of gender.

Currently, initial screening mammograms for average-risk women are covered at no cost share. However, many patients who require follow-up imaging or additional screening due to an abnormal result or high-risk factors (such as personal or family medical history) face significant out-of-pocket costs. This bill ensures that cost is not a barrier to accessing medically necessary breast imaging.

It is important to clarify that this is not an insurance coverage bill-- all breast cancer screening are already included in the Essential Health Benefits plan. HB 1283 specifically eliminates cost-sharing, which often prevents patients from getting the diagnostic care they need.

Cost barriers can lead to delayed diagnosis, more advanced cancer, and even metastatic disease—where cancer spreads beyond the breast, to other parts of the body.

Early detection saves lives, reduces the need for intensive treatments, and lowers overall healthcare costs.

Please support this life-saving bill.

I'd like to introduce my constituent, Bobbie Will, who asked me to sponsor HB1283.

Bobbie serves as the State Policy & Advocacy Manager for Susan G. Komen in MT, ND, SD and WY, and can provide additional insights on the importance of this legislation.

2025 SENATE STANDING COMMITTEE MINUTES

Industry and Business Committee
Fort Union Room, State Capitol

HB 1283
3/24/2025

A bill relating to diagnostic breast examination and supplemental breast examination cost-sharing restrictions; to provide for a report to the legislative assembly; to provide for application; and to provide an expiration date.

3:06 p.m. Chairman Barta opened the hearing.

Members present: Chairman Barta, Vice-Chair Boehm, Senator Klein, Senator Kessel, Senator Enget

Discussion Topics:

- Breakdown of cost analysis
- North Dakota Public Employees Retirement System (NDPERS)
- Fiscal impact and increased premium rates
- Late diagnosis and early recognition cancer treatment costs
- Personal responsibility of copay/deductible

3:06 Chairman Barta updated committee and led discussion of cost sharing to include diagnostics instead of just preventative aspects of breast exams.

3:18 p.m. Senator Kessel moved a Do Not Pass.

3:19 p.m. Senator Boehm seconded the motion.

Senators	Vote
Senator Jeff Barta	N
Senator Keith Boehm	Y
Senator Mark Enget	Y
Senator Greg Kessel	Y
Senator Jerry Klein	Y

Motion passed 4-1-0.

Senator Kessel will carry the bill.

3:21 p.m. Chairman Barta closed the hearing.

Audrey Oswald, Committee Clerk

REPORT OF STANDING COMMITTEE
HB 1283 (25.0075.02000)

Industry and Business Committee (Sen. Barta, Chairman) recommends **DO NOT PASS** (4 YEAS, 1 NAY, 0 ABSENT OR EXCUSED AND NOT VOTING). HB 1283 was placed on the Fourteenth order on the calendar. This bill does not affect workforce development.

2025 SENATE APPROPRIATIONS

HB 1283

2025 SENATE STANDING COMMITTEE MINUTES

Appropriations - Human Resources Division
Harvest Room, State Capitol

HB 1283
4/7/2025

Relating to diagnostic breast examination and supplemental breast examination cost-sharing restrictions to provide for a report to the legislative assembly; to provide for application and to provide an expiration date.

4:04 p.m. Chairman Dever opened the hearing.

Members present: Chairman Dever and Senators Cleary, Davison, Magrum and Mathern.

Discussion Topics:

- Committee Action

4:04 p.m. Representative Karen Karls, District 35, introduced bill and submitted testimony #44740.

4:11 p.m. Senator Cleary moved Do Pass.

4:11 p.m. Senator Mathern seconded the motion.

Senators	Vote
Senator Dick Dever	Y
Senator Sean Cleary	Y
Senator Kyle Davison	A
Senator Jeffrey J. Magrum	N
Senator Tim Mathern	Y

Motion passed 3-1-1.

Senator Mathern will carry the bill.

4:15 p.m. Chairman Dever closed the hearing.

Joan Bares, Committee Clerk

HB1012
4-7-25

Testimony Senate Human Resources Division on HB 1283 – April 7, 2025

by Rep. Karen Karls, District 35 - Bismarck

Thank you for your time this afternoon. I'm Karen Karls, and I represent district 35 which is where you are currently sitting.

House bill 1283 is a bill primarily for Women's Health. Currently, an initial screening (a mammogram), which is utilized for average-risk women, is at no cost share. This legislation ensures that a patient who needs follow-up or supplemental breast imaging, or those at high-risk, based on personal or family medical history, are not forced to forego these medically necessary services due to high out-of-pocket costs. It is a bill to expand screening tests at no cost share, NOT biopsy or any care or treatment, SCREENING ONLY.

This is not considered a healthcare mandate because all breast screening tests are included in the Essential Health Benefits plan, and insurance plans currently, this is a cost-share bill.

Cost is often prohibitive and can lead those in need to skip the necessary screening. Unfortunately, delayed diagnosis can lead to advanced and even metastatic cancer (Metastatic breast cancer is an advanced stage of breast cancer where tumor cells have spread to other parts of the body).

If the cancer spreads beyond the breasts, treatment may be up to ***five times*** more expensive and significantly less successful. Breast cancer ($29.8 Bill) is the most expensive cancer to treat.

An American Cancer Society report shows that the elimination of out-of-pocket cost sharing for follow-up tests could prevent more than 7,500 later-stage diagnoses and ultimately save $11,434 per patient diagnosed with breast cancer and more than $2 billion across all patients over their lifetime.

Early detection results in better outcomes, cost savings and fewer treatments.

It is also important to note that this bill is not just for women. Although rare, breast cancer does occur in men and every year thousands of men are diagnosed with this cancer as well.

Thank you for your time today. Please support this life-saving bill. I would be happy to answer any questions

2025 SENATE STANDING COMMITTEE MINUTES

Appropriations Committee
Harvest Room, State Capitol

HB 1283
4/9/2025

A BILL for an Act to create and enact a new section to chapter 54-52.1 of the North Dakota Century Code, relating to diagnostic breast examination and supplemental breast examination cost-sharing restrictions; to provide for a report to the legislative assembly; to provide for application; and to provide an expiration date.

9:14 a.m. Chairman Bekkedahl opened the hearing.

Members Present: Chairman Bekkedahl, Vice-Chairman Erbele, and Senators Burckhard, Cleary, Conley, Davison, Dever, Dwyer, Magrum, Mathern, Meyer, Schaible, Sickler, Sorvaag, Thomas, Wanzek.

Discussion Topics:

- Cost Benefit Analysis
- Consumer Benefits
- Increased Premiums
- Costs to Citizens

9:15 a.m. Senator Mathern introduced the bill and submitted testimony #44840.

9:18 a.m. Senator Mathern moved a Do Pass.

9:19 a.m. Senator Dever seconded the motion.

Senators	Vote
Senator Brad Bekkedahl	Y
Senator Robert Erbele	N
Senator Randy A. Burckhard	Y
Senator Sean Cleary	Y
Senator Cole Conley	Y
Senator Kyle Davison	N
Senator Dick Dever	Y
Senator Michael Dwyer	Y
Senator Jeffery J. Magrum	N
Senator Tim Mathern	Y
Senator Scott Meyer	Y
Senator Donald Schaible	Y
Senator Jonathan Sickler	N
Senator Ronald Sorvaag	Y
Senator Paul J. Thomas	N
Senator Terry M. Wanzek	Y

Motion Passed 11-5-0.

Senator Mathern will carry the bill.

9:27 a.m. Chairman Bekkedahl adjourned the meeting.

Elizabeth Reiten, Committee Clerk

REPORT OF STANDING COMMITTEE
HB 1283 (25.0075.02000)

Appropriations Committee (Sen. Bekkedahl, Chairman) recommends **DO PASS** (11 YEAS, 5 NAYS, 0 ABSENT OR EXCUSED AND NOT VOTING). HB 1283 was placed on the Fourteenth order on the calendar. This bill does not affect workforce development.

NovaRest
ACTUARIAL CONSULTING

HB 1283
4-9-25
Mathern

I. Evaluation of Proposed Mandated Health Insurance Services

The North Dakota Legislative Council (NDLC) was asked to perform a cost-benefit analysis of Draft Bill 25.0075.02000[1] for the 69th Legislative Assembly pursuant to the North Dakota Century Code (NDCC) 54-03-28. The Draft Bill creates and enacts a new section to 54-52.1 of the NDCC, provides for a report, provides for an application, and provides an expiration date. The Draft Bill, as proposed, states that "the board may not impose a deductible, copayment, coinsurance, or other cost-sharing requirement that causes out-of-pocket costs for a diagnostic breast examination or a supplemental breast examination provided to an individual enrolled under the plan."

NovaRest, Inc., has been contracted as the NDLC's consulting actuary and has prepared the following evaluation of diagnostic and supplemental breast exams with limited cost sharing.

This report includes information from several sources to provide more than one perspective on the proposed mandate and provide an unbiased report. As a result, there may be some conflicting information within the contents. Although we only used sources that we considered credible, we do not offer any opinions regarding whether one source is more credible than another.

NovaRest was asked to provide estimates for the North Dakota Public Employee Retirement System (NDPERS), as well as the impact if the Draft Bill was expanded to the commercial market. We were provided information on four plans administered by NDPERS, 1. Grandfathered PPO/Basic Plan, 2. Non-Grandfathered PPO/Basic Plan, 3. High Deductible Health Plan (HDHP), and 4. Dakota Retiree Plan. For the commercial market we used information from the National Association of Insurance Commissioners Supplemental Health Care Exhibit (SHCE) for individual, small group, and large group markets. Generally, when considering benefits for the individual and small group we considered the Affordable Care Act (ACA) single-risk pool plans, and for large group we considered a sample of plans from the largest three insurers in the North Dakota market.

NovaRest estimates the additional impact of eliminating cost-sharing for diagnostic and supplemental breast exams on health care costs and premiums, which range from 0.2% to 0.5% of premium and $1.10 to $2.40 per member per month (PMPM) for NDPERS. The variation reflects the range of costs associated with breast examinations, the number of breast examinations that would be prescribed, and differences in plan deductibles and cost sharing

If similar language is implemented in the commercial market, we estimate the premium impact to be $0.70 PMPM to $2.30 PMPM, or 0.1% to 0.5% of premium. The variation reflects the range of costs associated with breast examination, the number of breast examinations that would be prescribed, and differences in plan deductibles and cost sharing