

HB

45

# Alaska State Legislature

HOUSE OF REPRESENTATIVES



REPRESENTATIVE FRAN ULMER

## MEMORANDUM

January 30, 1991

TO: Rep. David Finkelstein, Chair  
House Labor and Commerce Committee

FROM: Rep. Fran Ulmer

RE: HB 45, re mammography screening

The following is a list\* of those states which currently require insurance coverage for mammography screening:

Washington  
California  
Arizona  
Nevada  
Colorado  
New Mexico  
Texas  
Oklahoma  
Kansas  
North Dakota  
Minnesota  
Wisconsin  
Iowa  
Florida

Missouri  
Illinois  
Kentucky  
Tennessee  
West Virginia  
Virginia  
Pennsylvania  
New York  
Massachusetts  
New Hampshire  
Maine  
Rhode Island  
Connecticut

The largest, most populous states of the nation are included in this list. They have concluded that requiring insurance coverage for mammography screening is an effective means of promoting the use of this cost effective, preventive procedure.

\*This information provided by the American Cancer Society.

District 4B — Juneau  
P.O. Box V • Juneau, Alaska 99811-3100 • (907) 465-4947



Recycled Paper

## BREAST CANCER EARLY DETECTION FACT SHEET

### Incidence

Leading cause of premature death in American women  
1 in 9 women develop breast cancer  
1988: 135,000 new cases in the U.S.; 42,000 deaths  
75% of breast cancers occur in women over age 50  
40% of breast cancers occur in women over age 65

### Early Detection Benefits

Mammography and physical exam detect 95% of breast cancers  
Mammography most effective means to detect breast cancer in the curable stage  
Over 90% of breast cancers detected early survive vs 60% whose tumors have spread vs 16% of late detection cancers

### Compliance

15%-20% of eligible women have annual mammograms

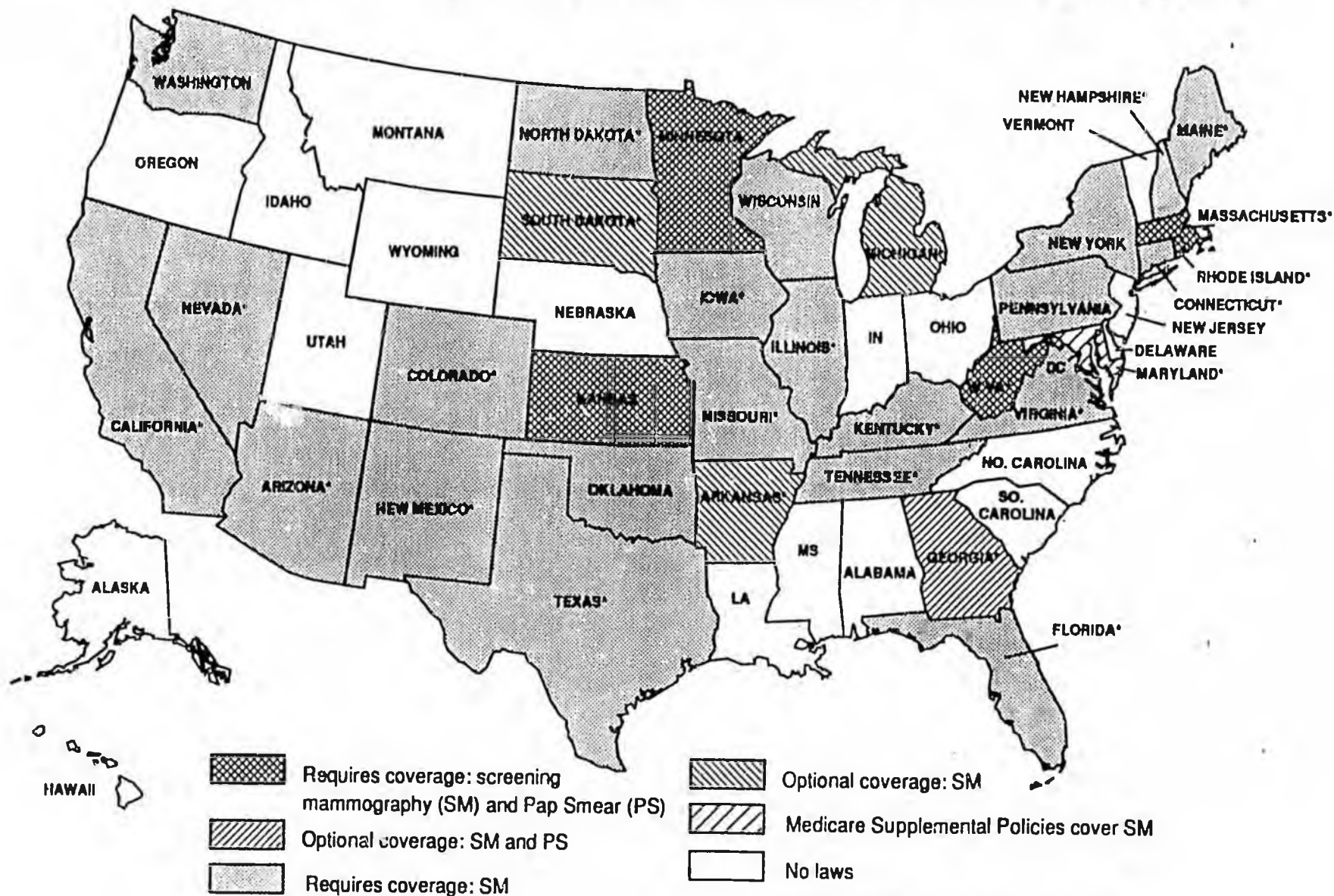
### Costs

Early detection, breast cancer cured = \$12,000 - \$18,000  
No early detection, cancer results in death = \$60,000  
**Medical cost saving from early detection = \$200 million**  
Additional productivity cost (individual, financial, societal)  
per woman = \$9,000  
national total = \$400 million  
**Total annual cost saving, national = \$600 million**

### Barriers

Cost -- National avg = \$100-\$200 per mammogram  
Fear of results  
Fear of radiation - mammogram produces less radiation than a dental X-ray

# State Insurance Laws: Cancer Early Detection Tests



\*States with ACS Screening Guidelines

*Arch Times 1-25-91*

# Breast cancer risk up

ASSOCIATED PRESS

NEW YORK — The average American woman runs a one-in-nine risk of developing breast cancer during her lifetime, an increase over the previous estimate, the American Cancer Society said Thursday.

The increase reflects rising breast cancer rates and the fact that women are living longer, the society said.

About 175,000 American women will get breast cancer this year, and 44,500 women will die from the disease, the society said in releasing its annual projections.

"Every American woman should consider herself at risk," Dr. Clark Heath, the society's vice president for epidemiology and statistics, said in a statement.

The society had projected a 1-in-10 risk since 1987, based on data from the early 1980s. The new estimate is based on federal figures for 1987, the latest available, said cancer society statistician Catherine Boring.

Edward Sondik, the National Cancer Institute's deputy director of the division of cancer prevention and control, noted that the change means going from a risk of 10 percent to one of 11 percent.

*Additional Back-up.*

# Alaska State Legislature

HOUSE OF REPRESENTATIVES

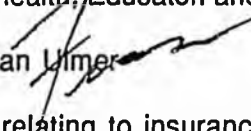


REPRESENTATIVE FRAN ULMER

## MEMORANDUM

February 19, 1991

TO: Rep. Pat Carney, Co-chair  
Rep. Georgianna Lincoln, Co-chair  
House Health, Education and Social Services Committee

FROM: Rep. Fran Ulmer 

RE: HB 45, relating to insurance coverage for mammograms

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HB 45 requires health insurance carriers in Alaska to provide coverage for mammography screening in every policy which includes mastectomies and related procedures, including Medicaid. Mammography screening has proven to be the most effective means of detecting breast cancer in its curable stage.

The bill includes:

- (a) a definition of "low-dose mammography"
- (b) frequency standards for mammography screening (recommended by the American Cancer Society)
- (c) provision for standard co-payment and deductibles
- (d) placement of mammography screening on Medicaid funding priority list.

Industry cost estimates (provided by Aetna) indicate that the per person cost for state employees to have this benefit will be, at maximum, no more than \$1.50 per month. That figure represents 0.4% of the monthly premium. This percentage (0.4%) should be the cost of this benefit in policies from other providers as well.

Twenty-seven other states currently require some type of mammography screening coverage (see map attached). The experience of those states has shown that over 90% of women whose breast cancer is detected early survive. The medical cost saving from early detection is estimated to be, for the nation, approximately \$200 million. That cost, coupled with the saving of lives which would otherwise be lost, recommends that Alaska take action to make mammography screening a routine procedure for every woman of appropriate age.

This bill was requested by the American Cancer Society and is supported by the Hospital and Nursing Home Association, the Alaska Hospital Council, and the Juneau Commission on Aging.

District 4B — Juneau

P.O. Box V • Juneau, Alaska 99811-3100 • (907) 465-4947



Recycled Paper

Sponsor Statement

February 4, 1991

The Honorable David Finkelstein  
Chairman  
House Labor and Commerce Committee  
Alaska State Legislature  
P.O. Box V  
Juneau, AK 99811-3100

Dear Mr. Chairman:

Re: House Bill 45 (Mammogram Screening)

During your committee's January 29 hearing on House Bill (HB) 45, I was asked to determine if the State could obtain costs for breast cancer related treatment and benefits paid through the current State active employee insurance plan. Through the Division of Retirement and Benefits, I have been provided the enclosed inpatient cost and utilization figures from our present carrier (Aetna), for 1990. Unfortunately, outpatient costs associated with breast cancer are an unusual event and figures are not easily retrievable; Aetna "estimates" perhaps another \$1,400 per admittance and will advise us later if they find that estimate unsupportable.

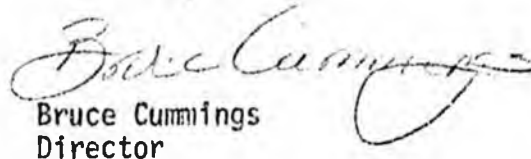
The short version is that there were nine (9) admissions for our active employee groups (all branches of State government), with \$60,733 submitted expenses and \$57,303 paid in benefits. If we add in another \$1,400 per admit for outpatient costs, the total benefits paid were \$69,903 (\$57,303 + \$12,600 [\$1,400 x 9]). Parenthetically, the State would have paid \$41,580 in health insurance premiums for these employees in 1990 if each were employed for the full year ( $\$385/\text{mo.} \times 12 \times 9 = \$41,580$ ).

Since this bill left your committee before I could provide the requested information, I am taking the liberty of copying the Health, Education and Social Services Committee with the same information; no doubt, the question will arise.

February 4, 1991

Thank you for the opportunity to present my testimony and your professional reception of it.

Sincerely,

  
Bruce Cummings  
Director

BC/mme

15/8D2/020402-1

Enclosures

cc: The Honorable Pat Carney  
The Honorable Georgianna Lincoln  
Co-Chairpersons  
House Health, Education and  
Social Services Committee  
Alaska State Legislature  
P.O. Box V  
Juneau, AK 99811-3100

The Honorable Fran Ulmer  
Alaska State Representative  
P.O. Box V  
Juneau, AK 99811-3100

Millett Keller  
Commissioner  
Department of Administration

bcc: Gary Bader  
Director  
Division of Retirement and Benefits  
Department of Administration

HB 45 File

STATE OF ALABKA  
INPATIENT COST AND UTILIZATION ASSOCIATED  
WITH BREAST CANCER  
ACTIVE GROUP ONLY

CALENDAR YEAR 1990

NUMBER OF ADMISSIONS	9
NUMBER OF BED DAYS	24
TOTAL SUBMITTED EXPENSES	\$60,735
TOTAL COVERED EXPENSES	\$59,941
TOTAL BENEFITS PAYABLE*	\$57,303
AVG. BENEFIT PER ADMIT	\$4,367
AV.G BENEFIT PER DAY	\$2,368

\* Benefits Payable is defined as the regular benefits payable after plan provisions, i.e., deductible and coinsurance, but before coordination of benefits.

To : All Alaska State Legislators

From: American Cancer Society  
Veva Becker - Fairbanks/Interior Unit  
Interior Public Education Chairman  
4137 Rosebud Lane  
Fairbanks, Alaska 99709

Date: February 19, 1991

Subject: HB # 45 - Mammograms/Insurance  
Resolution to provide appropriate medical screening care and follow-up assistance of the women of Alaska, uninsured or under-insured victims of breast cancer.

Whereas, many doctors refuse to treat patients who are covered only my medicare,

Whereas, medicare part A is costly.

Whereas, medicare does not provide long term care in home or in nursing home if you have incurable breast cancer.

Whereas, many women cannot afford annual check-ups or diagnostic tests like "mammograms" or other specialized test because they don't have insurance, medicaid or medicare. (or clinics or doctors will not accept them.)

Whereas, many insurance policies do not cover extended care - nursing homes, convalescent home or in at-home follow-up needed by patient recovering from cancer.


Whereas, family resources can be totally depleted from the long-term treatment necessary to combat cancer.

Whereas, many employers do not provide employee health insurance which leaves workers without comprehensive financial support for medical treatment.

Whereas, women need a doctors permission to get a mammogram, either at the hospital or Breast Cancer Detection Center and insurance is a factor in the decision to visit a doctor.

Whereas, Alaska women need health insurance which is affordable and provides long term provisions for cancer patients care.

Therefore be it resolved - The American Cancer Society, which has prevention and education as one of its main components, encourages the 17th Alaska State Legislature to advance HB 45, which will provide insurance coverage to mammograms, making them available to more Alaskan Women.

Signed:   
American Cancer Society  
By: Veva Becker, Interior Education Chairman



# NEA-ALASKA

AFFILIATED WITH THE NATIONAL EDUCATION ASSOCIATION

### ANCHORAGE REGIONAL OFFICE

1411 W. 33RD AVENUE  
ANCHORAGE, ALASKA 99503  
(907) 274-0536  
FAX: (907) 274-0551

### JUNEAU OFFICE

105 MUNICIPAL WAY, SUITE 302  
JUNEAU, ALASKA 99801  
(907) 586-3090  
FAX: (907) 586-2744

### FAIRBANKS REGIONAL OFFICE

2118 CUSHMAN STREET  
FAIRBANKS, ALASKA 99701  
(907) 456-4435  
FAX: (907) 456-2159

February 28, 1991

To: **Representatives Carney and Lincoln, Co-Chairs  
Members, House HESS Committee**

Re: **HB 45: "An Act relating to insurance coverage for mammograms;  
requiring the medical assistance program to cover mammograms; and  
reordering the priorities granted to services covered under the medical  
assistance program."**

NEA-Alaska strongly supports and encourages your favorable consideration of HB 45.

Provision for the mandatory coverage of mammography screening under all health insurance programs is in the public interest since it will clearly enhance the probability of early detection of breast cancer.

In the long term, effective preventative health measures represent substantial cost savings to individuals and to society as well. Since early detection is less expensive than extended care treatment this legislation has significant potential for meaningful health care cost containment.

It is our belief that any increase in premium costs will be easily off-set in the long term savings to health insurance programs.

Thank you for your consideration of our position.

Respectfully submitted,

Bob Manners  
Executive Director

Don Oberg  
President

cc: **Representative Ulmer**

NEA Position Paper 2/28/91



Alaska Independent  
Insurance Agents & Brokers, Inc.

March 1, 1991

Representative Fran Ulmer  
Alaska State Legislature  
P.O. Box V  
Juneau, Alaska 99811-3100

Dear Fran:

I would like to thank you for meeting with Bud Jaeger and myself last week in your office.

As I mentioned to your aide, following our meeting with you, our Board of Directors reconsidered our position on HB45 / SB117 regarding mandatory mammogram legislation. Our association is now in support of your legislation and will assist your efforts any way that we can. I appreciate the detailed information you provided us with, which allowed us the necessary information to reconsider the issue.

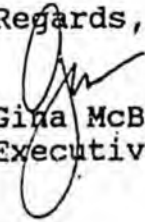
As we discussed, we are following many of the health insurance issues, and are willing to provide any assistance we can.

One of our main concerns, as we mentioned, is the uninsured-underinsured motorists issue, which passed last year's session under HB429. We are actively working with Representative Donley to propose an amendment that is acceptable to the industry.

Also, we are in support of HB107, which will allow Umialik Insurance, one of the few domestic insurers in the state, sufficient time to meet the new capital and surplus requirements.

If there are any other issues that we can be of assistance, please give me a call. Our association consists of 50 independent insurance agencies located throughout the state. We feel we can be of assistance to the legislature in regards to providing information on the insurance industry in Alaska.

Regards,

  
Gina McBride  
Executive Director

Letters of Support

1989 ACCIDENT & HEALTH MARKET SHARE  
GROUP

RANK	COMPANY NAME	PERCENT OF MARKET	DIRECT PREMIUMS WRITTEN
1	AETNA LIFE INS CO	66.81	124,729
2	NEW YORK LIFE INS CO	4.20	7,849
3	PRINCIPAL MUTUAL LIFE INS CO	2.87	5,360
4	LINCOLN NATIONAL LIFE INS CO	2.23	4,168
5	WESTERN LIFE INS CO	1.89	3,533
6	TRAVELERS INS CO LIFE DEPT	1.86	3,465
7	GREAT WEST LIFE ASSURANCE CO	1.82	3,395
8	PRUDENTIAL INS CO OF AMERICA	1.70	3,172
9	DELTA SERVICE PLANS INS CO	1.56	2,905
10	GUARDIAN LIFE INS CO OF AMERICA	1.29	2,410
11	CONTINENTAL ASSURANCE CO	1.28	2,380
12	UNITED OF OMAHA LIFE INS CO	1.23	2,288
13	HOME LIFE INS CO	.93	1,730
14	MUTUAL BENEFIT LIFE INS CO	.90	1,675
15	PROVIDENT LIFE & ACCIDENT INS CO	.73	1,372
16	UNION LABOR LIFE INS CO	.62	1,158
17	NATIONAL AMERICAN LIFE INS CO OF PA	.54	1,008
18	STANDARD INS CO	.51	960
19	AMERICAN CHAMBERS LIFE INS CO	.45	838
20	NORTH AMERICAN LIFE & CAS	.39	724
TOTAL FOR TOP 20 RANKED INSURERS		93.81	175,137
TOTAL FOR ALL 140 INSURERS WRITING THIS LINE		99.95	186,687

1989 ALASKA HOSPITAL AND MEDICAL SERVICE CORPORATIONS

INSURER	PREMIUMS EARNED (\$000)				CLAIMS INCURRED (\$000)					Number of Subscribers
	Group	Nongroup	Medicare	TOTAL	All Medical Surgical/ Hospital	Dental	Vision	Other	TOTAL	
Blue Cross of Washington and Alaska	63,666	5,355	370	69,391	51,956	6,531	1,555	682	60,724	72,212
Alaska Vision Services, Inc.	221	0	0	221	0	0	0	208	208	13,691
<b>TOTAL</b>	<b>63,887</b>	<b>5,355</b>	<b>370</b>	<b>69,612</b>	<b>51,956</b>	<b>6,531</b>	<b>1,555</b>	<b>890</b>	<b>60,932</b>	<b>85,903</b>

30

# BARTLETT MEMORIAL HOSPITAL

3280 HOSPITAL DRIVE • JUNEAU, ALASKA 99801 • TELEPHONE (907) 581-2611

Representative Fran Ulmer  
State of Alaska  
House of Representatives  
P. O. Box V  
Capitol Building, RM 421  
Juneau, AK 99811

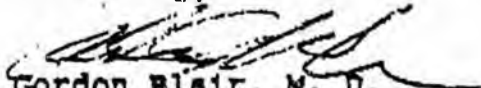
Dear Representative Ulmer:

We have reviewed House Bill Number 45 (An Act relating to insurance coverage for Mammograms). Section 4 of the Bill addresses "Priority for Medical Assistance". In reviewing the listing of services, it seems that there are some which relate to saving or prolonging of life and some that could be said to relate more to matters of comfort or convenience. Clearly items that prevent death should be viewed as more important in this prioritization.

With the high cure rates associated with early detection and treatment of breast cancer, we feel that screening mammography should be placed on a "priority" listing high enough that elimination due to funding shortfalls would be unlikely. Many opinions could be brought forth as to exactly where screening mammography should be placed in the listing. We feel that it is adequately placed in the Bill as proposed (#7). If there is a willingness to move it from this ranking we feel strongly that it should be given a higher number (eliminated later in the event of a shortfall) rather than a lower number (eliminated sooner in the event of a shortfall).

Thank you for efforts to make this important procedure available to more of the women of the state. Please let us know if we can be of assistance. If you have questions, please contact us.

Sincerely,

  
Gordon Blair, M. D.  
Radiologist

# Alaska State Legislature



## REPRESENTATIVE FRAN ULMER M E M O R A N D U M March 1, 1991

TO: Rep. Bettye Davis, Chair  
HESS Subcommittee on HB 45, re mammography screening

FROM: Rep. Fran Ulmer

RE: HB 45, relating to mammography screening

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The subcommittee on HB 45 discussed three issues at the meeting on 2/28/91 which required further research. This memorandum summarizes the work of my staff on those issues:

### 1. Mandated benefit vs Mandated offering

**Question:** Will the increase in prevention of breast cancer (resulting from a mandated benefit) be great enough to offset the increase in premium cost (\$12 - \$18 annual premium increase)?

There is general agreement among professionals in both the health insurance industry and the medical profession that mammography screening is a cost effective procedure. The President of the American Cancer Society in Alaska testified that the medical cost of treating terminal breast cancer is approximately \$60,000, compared to \$6000 for a mastectomy which occurs early. Approximately 175 Alaska women will develop breast cancer in 1991; 90% of that group could survive with early screening and detection, resulting in a significant cost savings.

**Question:** Will the additional premium cost of \$12-\$18 per year cause some persons to drop insurance coverage entirely?

Each benefit included in a health insurance policy increases the cost of the policy. One representative from a health insurance company testified that mammography screening could be the "straw that breaks the camel's back." By itself, mammography screening is a low-cost, highly effective procedure; as an addition to the list of other mandated benefits it is objectionable because the increase in cost may price insurance premiums out of the range of the average consumer causing her to lose coverage entirely. However, because mammography screening is so cost-effective, the Alaska Association of Independent Insurance Agents has chosen to support HB 45, including the mandated benefit provision. The Association does not believe that the slight increase in premium cost will provide a financial barrier to consumers. Aetna estimates that mammography

screening will increase the cost of insurance for state employees less than one-half of one percent (.04%); this percentage of premium cost should be consistent for other carriers as well. This percentage is insignificant, both to the consumer, to the employer, and to the insurance industry, especially compared to the medical/insurance cost savings which will result from utilization of the procedure.

**Question:** Would it be desirable to include mammography screening as a mandated offering for a year or two and then phase-in mammography as a mandated benefit?

Attached you will find a list of the top 20 health insurance providers operating within Alaska. A review of the operations of the companies which cover the majority of the Alaska market (over 80%) reveals that all of them operate in states which currently mandate mammography screening as a benefit to be covered in insurance policies. Each company thus has the experience necessary to be able to implement HB 45 readily within their Alaska operations.

From discussions with the Division of Insurance, we have learned that it probably would not be advisable to phase-in a mandatory benefit after a year or two of mandated offering. Costs associated with mammography screening are related to the degree to which the procedure is utilized; greater utilization should yield lower costs. In addition, costs resulting from a mandated offering could very well be higher because there would be greater adverse selection; those purchasing this benefit as an "offering" are more likely to be in a higher risk category. Thus it is more cost effective, both for the industry and the consumer, to purchase mammography screening as a mandated benefit than as a mandated offering.

## 2. Medicaid Priority List

Attached you will find opinions regarding the appropriate placement of mammography screening on the priority list from the American Cancer Society, and the Alaska Hospital Society. In addition, the American Medical Association has offered an oral opinion on the priority placement.

**American Medical Association:** recommends that mammography screening be placed between the items currently listed as #9 (medical supplies and equipment) and #10 (clinic services). The AMA feels that mammography screening should have a **higher priority** than its current placement indicates. AMA representative Rick Urion will be available to testify at Tuesday's hearing on the bill.

**Alaska Hospital Council** (letter from Gordon Blair, Bartlett Hospital): recommends that mammography screening **either** remain in current placement (#7) or receive **higher** placement on the priority list. The Council argues that since mammography screening is a life saving procedure, it should be placed high enough to ensure that it will still be funded in the event of funding shortfalls.

**American Cancer Society:** recommends that mammography screening remain in current placement on the priority list. As a life saving measure, mammography should be high enough to avoid elimination in the event of budget shortfalls.

The conclusion of professionals in the field is that mammography screening must be placed at #7 or higher on the list because it is a cost-effective life saving procedure. Elimination of mammography screening due to funding shortfalls would soon result in increased Medicaid costs for surgical procedures which could have been avoided if screening had been available.

### 3. Importance of Prevention

**Question:** If prevention is the key to saving both lives and medical costs, does HB 45 go far enough to ensure that prevention of breast cancer does occur?

The American Cancer Society has identified two primary barriers to utilization of mammography screening: cost, and fear of results. HB 45 addresses the issue of cost.

Although the bill does not address the problem of fear or lack of knowledge, the committee might want to amend the bill to include a state sponsored educational program regarding the importance of regular mammograms for women (and men) in the appropriate age groups. A similar educational program on the effects of fetal alcohol syndrome is now being implemented by the state as a result of a bill I sponsored in the last legislature. The total cost for that program was \$12,000.

### COSTS FOR ROUTINE MAMMOGRAMS

JUNEAU -	\$100	(Bartlett Memorial)
KETCHIKAN -	\$190.80	(Ketchikan General)
ANCHORAGE -	\$135	(Humana Hospital)
FAIRBANKS -	\$121	(Fairbanks Memorial)
NOME -	\$110	(Norton Sound Hospital)
BETHEL -	\$168	(Bethel Family Clinic)
SITKA -	Service available 6/1/91; costs not determined	
Service not available: Barrow Kotzebue		

HOUSE COMMITTEE REPORT

3-6-91

(7)

Date Referred: February 4, 1991

FURTHER REFERRALS:

Finance

Date of Committee Action: 3-5-91

The HEALTH, EDUCATION AND SOCIAL SERVICES Committee considered:

HB 45

HOUSE BILL NO. 45

INSURANCE COVERAGE FOR MAMMOGRAMS

"An Act relating to insurance coverage for mammograms; requiring the medical assistance program to cover mammograms; and reordering the priorities granted to services covered under the medical assistance program."

RECOMMENDATIONS:

be replaced with [ ] the same title

[ ] a new title

[ ] have attached amendments(s)

[x] do pass

[ ] do not pass

[ ] no recommendations

[ ] individual recommendations

[ ] additional referral to the \_\_\_\_\_ Committee

ADOPTS: \_\_\_\_\_ letter of Intent

ATTACHES NEW FISCAL NOTE(S): (Dept)

APPROVES PREVIOUS: (Dept/Date)

[ ] fiscal impact \_\_\_\_\_ (2) [x] fiscal note(s) DHSS, DOA 2/4/91

[ ] zero fiscal note \_\_\_\_\_ [x] zero fiscal note(s) DCED 2/4/91

SIGNING DO PASS:

SIGNING OTHER RECOMMENDATIONS:

	Check appropriate column:	Do Not Pass	No Rec	Amend
<i>[Signature]</i> LINCOLN				
<i>[Signature]</i> CARNEY				
Beatty Davis	J. G. Gonzales Gonzales		x	
Cheri Davis	Mark Hanley Hanley			x
	Mary Miller			x

*[Signature]* LINCOLN

# FISCAL NOTE

**STATE OF ALASKA**  
**1991 LEGISLATIVE SESSION**

BILL NO. HB 45

Revision Date: 2/21/91  
 Title: An Act relating to insurance coverage  
mammograms.  
 Sponsor: Ulmer, et al.  
 Requester: \_\_\_\_\_

Department Affected: All agencies  
 BRJ: \_\_\_\_\_  
 Components: \_\_\_\_\_  
 COMPONENT SERIAL NO.

**EXPENDITURES/REVENUES: (Thousands of Dollars)**

OPERATING	FY 92	FY 93	FY 94	FY 95	FY 96	FY 97
Personal Services	1,593.0	1,593.0	1,593.0	1,593.0	1,593.0	1,593.0
Travel	0.0	0.0	0.0	0.0	0.0	0.0
Contractual	0.0	0.0	0.0	0.0	0.0	0.0
Supplies	0.0	0.0	0.0	0.0	0.0	0.0
Equipment	0.0	0.0	0.0	0.0	0.0	0.0
Land & Structures	0.0	0.0	0.0	0.0	0.0	0.0
Grants, Claims	0.0	0.0	0.0	0.0	0.0	0.0
Miscellaneous	0.0	0.0	0.0	0.0	0.0	0.0
<b>TOTAL OPERATING</b>	<b>1,593.0</b>	<b>1,593.0</b>	<b>1,593.0</b>	<b>1,593.0</b>	<b>1,593.0</b>	<b>1,593.0</b>
<b>CAPITAL</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>
<b>REVENUE</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>

**FUNDING: (Thousands of Dollars)**

General Funds	1440.1	1440.1	1440.1	1440.1	1440.1	1440.1
Federal Funds	73.3	73.3	73.3	73.3	73.3	73.3
Other	79.6	79.6	79.6	79.6	79.6	79.6
<b>TOTAL</b>	<b>1593.0</b>	<b>1593.0</b>	<b>1593.0</b>	<b>1593.0</b>	<b>1593.0</b>	<b>1593.0</b>

**POSITIONS:**

Full-Time	0	0	0	0	0	0
Part-Time	0	0	0	0	0	0
Temporary	0	0	0	0	0	0

Estimate of current year impact: None

**ANALYSIS: (attach a separate page if necessary)**  
 Costs for political subdivisions and school districts throughout the State will increase an estimate of \$1,812,038. See attached analysis for details.

Prepared By: Gary M. Bader, Director *Gary M. Bader* Phone: 465-4470  
 Division: Retirement and Benefits Date: 2/21/91

Approved By Commissioner: \_\_\_\_\_ Date: \_\_\_\_\_  
 Agency: Administration

Distribution (by preparer): Legislative Finance, Legislative Sponsor, Requestor, OMB, Impacted Agency(ies)

House Bill 45  
Analysis of Financial Impact on  
Mandatory Coverage of Mammograms  
Prepared by the Division of Retirement and Benefits  
Department of Administration  
February 21, 1991  
Page 2 of 3

This bill will not result in additional operations cost for the Division of Retirement and Benefits. The estimated cost of \$1,593,117 to all agencies the State shown on the attached fiscal note is the result of two components: active State employees and contributions to the retirement funds for retirees.

The bill is estimated to result in an increase of \$1.50 per month per active State employee. It is also estimated to result in a .24% in the PERS contribution rate for the State and a .21% increase in the TRS contribution rate for State.

The total estimated cost to the State is calculated as follows:

Active State Employees

The increase of \$1.50 per month per employee times the number of State employees (15,000) times 12 months equals	\$ 270,000
---	------------

Retirement Fund Contributions

The change in the PERS employer contribution rate for the State (.24%) times the estimated FY 92 PERS salaries (\$545,579,183) equals	\$1,309,390
---	-------------

The change in the TRS employer contribution rate for the State (.21%) times the estimated FY 92 TRS salaries (\$6,537,114) equals	\$ 13,727
---	-----------

<b>TOTAL COST TO STATE</b>	<b>\$1,593,117</b>
----------------------------	--------------------

In addition to the State costs outlined above, there will also be additional costs for political subdivisions and school districts throughout the state. The total estimated cost for these entities is calculated as follows:

Active Political Subdivision and School

District Employees

The increase of \$1.50 per month per  
employee times the number of  
employees(1200) times 12 months equals \$ 21,600

Retirement Fund Contributions

The change in the PERS employer  
contribution rate for Political Subdivisions  
(.24%) times the estimated FY 92 salaries  
(\$109,599,379) equals \$983,038

The change in the TRS employer  
contribution rate for school districts (.21%)  
times the estimated FY 92 salaries  
(\$384,476,586) equals \$807,400

TOTAL COST TO  
POLITICAL SUBDIVISION AND SCHOOL  
DISTRICTS \$1,812,038

**STATE OF ALASKA**  
**1991 LEGISLATIVE SESSION**

**BILL NO.** HB No 45

Revision Date: 1/28/91 Department Affected: Health and Social Svcs

Title: An Act Relating to Insurance Coverage for Mammograms Medical Assistance  
for Mammograms Component: Medicaid non-facility

Sponsor: ULMGR

Requestor: \_\_\_\_\_

COMPONENT SERIAL NO. 

	2	2	9
--	---	---	---

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY 92	FY 93	FY 94	FY 95	FY 96	FY 97
PERSONAL SERVICES	0	0	0	0	0	0
TRAVEL	0	0	0	0	0	0
CONTRACTUAL	0	0	0	0	0	0
SUPPLIES	0	0	0	0	0	0
EQUIPMENT	0	0	0	0	0	0
LAND & STRUCTURES	0	0	0	0	0	0
GRANTS, CLAIMS	10.0	11.5	13.2	15.1	17.3	19.8
MISCELLANEOUS	0	0	0	0	0	0
<b>TOTAL OPERATING</b>	<b>10.0</b>	<b>11.5</b>	<b>13.2</b>	<b>15.1</b>	<b>17.3</b>	<b>19.8</b>

<b>CAPITAL</b>	0	0	0	0	0	0
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<b>REVENUE</b>	0	0	0	0	0	0
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FUNDING: (Thousands of Dollars)

GENERAL FUND	5.0	5.7	6.6	7.5	8.6	9.9
FEDERAL FUNDS	5.0	5.8	6.6	7.6	8.7	9.9
OTHER	0	0	0	0	0	0
<b>TOTAL</b>	<b>10.0</b>	<b>11.5</b>	<b>13.2</b>	<b>15.1</b>	<b>17.3</b>	<b>19.8</b>

POSITIONS:

FULL-TIME	0	0	0	0	0	0
PART-TIME	0	0	0	0	0	0
TEMPORARY	0	0	0	0	0	0

Estimate of current year impact: \_\_\_\_\_

ANALYSIS: (Attach a separate page if necessary.)

See attached analysis

Prepared By: Kimberly B. Busch Phone: 465-3355

Division: Medical Assistance Date: 1-29-91

Approved by Commissioner: [Signature]

Agency: HEALTH AND SOCIAL SERVICES Date: 1/29/91

Distribution (by preparer): Legislative Finance, Legislative Sponsor, Requestor, OMB, & Impacted Agency(ies).

## HB 45

Currently, Medicaid reimburses enrolled providers for diagnostic mammograms furnished to eligible recipients. Of more than 14,000 mammograms in Alaska in 1990, approximately 400 were provided for Medicaid-eligible women over 35. Each mammogram costs, on average, \$100.

If HB 45 were passed, we do not anticipate any substantial increase in the use of mammograms for screening, in part because radiologists report they do not commonly recommend screening mammograms. We estimate that HB 45 would not add more than 100 new mammograms to Medicaid during FY92, at a total new cost of \$10,000 (100 X \$100 = \$10,000). Funding for this service is 50% Federal, 50% State General Funds.

Costs for FY93 and future years assume a total annual increase of 14.6%, which consists of an increase of 6% in the number of recipients eligible for mammograms, an annual increase of 4% in the rate at which eligible persons will use this service, and an annual increase (typical of past years) of 4.6% in the costs per screening.

No allowance has been made in this estimate for the costs of periodic mammograms for Medicaid-eligible persons (primarily those who are over 65) who receive Medicare benefits. Recent Federal legislation made screening mammograms a Medicare-covered service, and existing Federal law requires Medicaid to pay any Medicare deductibles or co-insurance costs incurred by anyone who participates in both programs.

The department views section 2 of HB 45 as setting only minimum coverage limits, not maximum limits, and that anyone with the appropriate familial and/or personal history may receive payment for any number of mammograms that are medically justified. The Division of Medical Assistance will incur costs in processing claims for this new service and in retrospectively examining these claims to insure that the service was medically necessary, appropriate, and not excessive. However, these costs are anticipated to be so minor as to be absorbed within normal program appropriations and without adding new staff.

# FISCAL NOTE

**STATE OF ALASKA**  
**1991 LEGISLATIVE SESSION**

BILL NO. HB 45

Revision Date: \_\_\_\_\_  
 Title: An Act relating to insurance coverage  
mammograms.  
 Sponsor: Ulmer, et al.  
 Requester: \_\_\_\_\_

Department Affected: All agencies  
 BFU: \_\_\_\_\_  
 Components: \_\_\_\_\_  
 COMPONENT SERIAL NO.

**EXPENDITURES/REVENUES: (Thousands of Dollars)**

OPERATING	FY 92	FY 93	FY 94	FY 95	FY 96	FY 97
Personal Services	270.0	270.0	270.0	270.0	270.0	270.0
Travel	0.0	0.0	0.0	0.0	0.0	0.0
Contractual	0.0	0.0	0.0	0.0	0.0	0.0
Supplies	0.0	0.0	0.0	0.0	0.0	0.0
Equipment	0.0	0.0	0.0	0.0	0.0	0.0
Land & Structures	0.0	0.0	0.0	0.0	0.0	0.0
Grants, Claims	0.0	0.0	0.0	0.0	0.0	0.0
Miscellaneous	0.0	0.0	0.0	0.0	0.0	0.0
<b>TOTAL OPERATING</b>	<b>270.0</b>	<b>270.0</b>	<b>270.0</b>	<b>270.0</b>	<b>270.0</b>	<b>270.0</b>
<b>CAPITAL</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>
<b>REVENUE</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>

**FUNDING: (Thousands of Dollars)**

General Funds	244.1	244.1	244.1	244.1	244.1	244.1
Federal Funds	12.4	12.4	12.4	12.4	12.4	12.4
Other	13.5	13.5	13.5	13.5	13.5	13.5
<b>TOTAL</b>	<b>270.0</b>	<b>270.0</b>	<b>270.0</b>	<b>270.0</b>	<b>270.0</b>	<b>270.0</b>

**POSITIONS:**

Full-Time	0	0	0	0	0	0
Part-Time	0	0	0	0	0	0
Temporary	0	0	0	0	0	0

Estimate of current year impact: None

ANALYSIS: (attach a separate page if necessary)  
 See attached.

Prepared By: Gary M. Bader, Director *Gary M. Bader* Phone: 465-4470  
 Division: Retirement and Benefits Date: \_\_\_\_\_  
 Approved By Commissioner: *Milton Valer* Date: 11/24/90  
 Agency: Administration

Distribution (by preparer): Legislative Finance, Legislative Sponsor, Requestor, OMB, Impacted Agency(ies)

House Bill 45  
Analysis of Financial Impact on  
Mandatory Coverage of Mammograms  
Prepared by the Division of Retirement and Benefits  
Department of Administration  
January 28, 1991  
Page 2 of 2

This bill will not result in additional operations cost for the Division of Retirement and Benefits.

The bill is estimated to increase the monthly health premium by \$1.50 per employee. This equates to an annual increase of \$270,000.

$$[\$1.50 \times 15,000 \text{ employees} \times 12 \text{ months} = \$270,000]$$

There will be an equivalent cost to school districts and participating political subdivisions and to the retirement funds. Future costs are assumed to remain level but will be determined by the plan's claim experience.

STATE OF ALASKA  
1991 LEGISLATIVE SESSION

BILL NO. HB 45

Revision Date: 1/21/91 Department Affected: Commerce & Economic Dev  
 Title: An Act relating to insurance coverage for mammograms . . . . BRU: Insurance  
 Sponsor: Ulmer, Brown, et al. Component: Operations  
 Requestor: \_\_\_\_\_ COMPONENT SERIAL NO. 

0	3	5	4
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Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY 92	FY 93	FY 94	FY 95	FY 96	FY 97
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	0	0	0	0	0	0

CAPITAL	0	0	0	0	0	0
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REVENUE	0	0	0	0	0	0
---------	---	---	---	---	---	---

FUNDING: (Thousands of Dollars)

GENERAL FUND						
FEDERAL FUNDS						
OTHER						
TOTAL	0	0	0	0	0	0

POSITIONS:

FULL-TIME	0	0	0	0	0	0
PART-TIME						
TEMPORARY						

Estimate of current year impact: \_\_\_\_\_

ANALYSIS: (Attach a separate page if necessary.)

No fiscal impact on the division.

Prepared By: Joan Brown, Administrative Officer Phone: 465-2597  
 Division: Insurance Date: 1/24/91

Approved by Commissioner: Glenn A. Olds  
 Agency: Department of Commerce & Economic Development Date: \_\_\_\_\_

Distribution (by preparer): Legislative Finance, Legislative Sponsor, Requestor, OMB, & Impacted Agency(ies).



**Alaska State Legislature**  
**House of Representatives**  
 COMMITTEE ON HEALTH, EDUCATION  
 AND SOCIAL SERVICES

**DATE:** March 5, 1991

**PLACE:** Capitol Room 106

**SUBJECT OF MEETING:**  
 HB 45 INSURANCE COVERAGE OF MAMMOGRAMS

NAME	REPRESENTING	BUSINESS/PERSONAL MAILING ADDRESS	ZIP	(H) PHONE	(W) PHONE	DO YOU WANT TO TESTIFY?	WHAT SUBJECT/ WHICH BILL?
✓ Willie Anderson	NEA-AK	105 Municipal Way 302 TILZALL	801		6-3090	<input checked="" type="radio"/> N	HB 45
✓ Dave Walsh	Div of INS ADMIN/	Pouch D Box CR	801		465-2515	<input checked="" type="radio"/> N	HB 45
✓ Mike Coughlin	RET. BENEFIT.	99811		463-3522	465-4471	<input checked="" type="radio"/> N	HB 45
						Y N	
						Y N	
						Y N	
						Y N	
						Y N	
						Y N	
						Y N	
						Y N	

# HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

DATE 2/21/91

JOINT \_\_\_\_\_

TAPE # 12

JOINT \_\_\_\_\_

TIME CALLED TO ORDER 8:35 am/pm

TIME ADJOURNED 10:00A

ROLL CALL:	PRES	ABST	TIME ARRVD	JOINT MEMBERS PRESENT:
Rep. Patrick Carney	✓			
Rep. Georgiana Lincoln	✓			
Rep. Bettye Davis	✓			
Rep. Cheri Davis	✓			came in late. @ 8:30A
Rep. John Gonzales	✓			
Rep. Mark Hanley	✓			
Rep. Mary Miller	✓			

**AGENDA:**

BILL NO.	SHORT TITLE	ACTION TAKEN
*HB 45	Insurance Coverage for Mammograms	
*HB 24	HIV Testing for Sex Offenders	

**OTHER:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**SPECIAL ANNOUNCEMENTS:**

## Mandated Benefits In Health Insurance Policies

Gregory Krohm and Mary H. Grossman, *Benefits Quarterly*, Fourth Quarter 1990

"According to a research bulletin prepared by the Health Insurance Association of America, state governments had enacted over 730 mandates by 1989—up from 343 in 1978 (*MB*, 12/15/89, p. 3). As shown in Table 2 (page 10), Blue Cross and Blue Shield data show that the total number of distinct treatment benefit mandates adopted with any frequency is about 12. The total number of provider mandates is about the same. There are relatively few mandates relating to special populations. The 10 most common mandates account for over 300 of the 730 mandates listed by HIAA.

Almost any benefit added to a health insurance policy increases the cost of the policy. Only those benefits that clearly serve as substitutes for more costly services or treatment actually would decrease costs. Few mandates, however, increase costs significantly.

There have been several state-level studies of the costs of mandated benefits. Table 3 (page 10) summarizes cost data from the studies that have been conducted.

Opponents of mandated benefits frequently point to the exemption from mandates as a primary reason for employers to decide to self-fund their health benefit plans. If that is the case, one would expect to find that self-funded plans provide less coverage for state-imposed mandates than do insured plans.

Continued

### Mandated Benefits (continued)

To determine whether this was the case in Wisconsin, insurers that act as administrators for self-funded plans were surveyed, as were third-party administrators and benefit consultants.

The survey showed that, in 1989, the mandates included in the study

**Almost any benefit increases the cost of the policy. Few mandates increase costs significantly.**

accounted on average for 10.2 percent of the total medical benefits paid for administrative services—only business and 7.9 percent for insured plans. This indicates that self-funded plans provide at least as many of the mandated benefits as insured plans and in some cases provide more generous coverage." MB

Table 2. Health benefit mandates adopted by more than five states, 1989.

	Number of states enacting mandate
<b>Treatment mandates</b>	
Alcoholism	40
Mental health	27
Mammography	25
Drug abuse	22
Maternity	20
Home health	17
Breast reconstruction	11
Ambulatory surgery	8
Hospice	7
In-vitro fertilization	6
Cleft lip and palate	6
Temporomandibular joint disease	6
<b>Provider mandates</b>	
Chiropractors	39
Psychologists	38
Dentists	30
Optometrists	31
Podiatrists	26
Nurse midwives	23
Social workers	16
Nurse practitioners	14
Osteopaths	11
Psychiatric nurses	9
Nurses	8
Nurse anesthetists	7
Physical therapists	6
Speech/hearing therapists	6
<b>Special populations</b>	
Newborns	48
Mentally/physically handicapped dependents	34
Adopted children	15
Preventive care for children	10
Noncustodial children	7
Dependent students	6

Source: Blue Cross and Blue Shield Association; Krohm and Grossman, 1990

Table 3. Percent of claim dollars attributable to state mandated benefits, by state.

	Iowa (1987)	Maine (1988)	Maryland (HIAA) <sup>1</sup> (1984)	Maryland BC/BS (1984)	Wisconsin (1989)
Mental health	3.7%	2.6%	6.5%	6.5%	4.8%
Alcoholism and drug abuse	1.7	1.3	( <sup>2</sup> )	0.8	( <sup>2</sup> )
Other mandates	(Not significant)	(No data)	5.1	3.8	2.3
Total	5.4	3.9	11.6	11.1	7.1

<sup>1</sup> The Maryland HIAA data are based on a percentage of premium. The others are based on a percentage of claim dollars.

<sup>2</sup> Included in mental health

Source: Blue Cross and Blue Shield Association; Krohm and Grossman, 1990

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*
* DELIVER TO: LMSCHES
*
* ORIGINAL
* SENT: 02/21/91 TIME: 11:22
* FROM: LTCCFBX
* SUBJECT: 91-02-092,FS,HB45,24;2-21
* PRINT DATE: 02/21/91 TIME: 11:22
*
*****

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SUBJECT LINE TO READ: TC NO.;PL/FS;SHORT SUBJECT;DATE

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T/C NO: 91-02-092
DATE: FEBRUARY 21, 1991
SPONSOR: HOUSE HESS
SUBJECT: HB 45; HB 24
MODERATOR: FRAN
SITE: FAIRBANKS

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FINAL STATS

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*****
TESTIFIED

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NAME/REPRESENTING	ADDRESS	PHONE	BILL NO.
1. BONNIE MCCORQUODALE,	P.O. BOX 71248,FBX,99707	452-5222	HB24
2. VEVA BECKER,	4139 ROSEBUD LN.,FBX,99709	479-6968	HB45
3. MARGARET GRAY,	311 SLATER ST.,FBX,99701	452-3788	HB45
4. MARK TUMED,	1324 SUMMIT DR.,FBX,99712	457-6818	HB24
5. TRISH NEUBERT,	1969 SWALLOW DR.,FBX,99709	479-6538	HB45
6. DORIS LOENING,	665 10TH,FBX,99701	452-4039	HB45

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*****
OBSERVED

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NAME/REPRESENTING	ADDRESS	PHONE	BILL NO.
1. BEVERLY MCCLENDON,	P.O. BOX 04397,FBX,99708	455-6639,	HB24
2. LUCY MCCARTHY,	P.O. BOX 00607,FBX,99708	479-2804	HB45
3.			
4.			
5.			

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TESTIFIED: 6
UNABLE: 0
OBSERVED: 2
TOTAL: 8

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START TIME: 8:30 A.M. END TIME: 10:05 A.M.

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HOUSE COMMITTEE REPORT

2-4-91

(7)

Date Referred: January 21, 1991

FURTHER REFERRALS: Health, Education and Social Services

Finance

Date of Committee Action: 1-31-91

The LABOR AND COMMERCE Committee considered:

HB 45

HOUSE BILL NO. 45

INSURANCE COVERAGE FOR MAMMOGRAMS

"An Act relating to insurance coverage for mammograms; requiring the medical assistance program to cover mammograms; and reordering the priorities granted to services covered under the medical assistance program."

RECOMMENDATIONS:

[ ] the same title

be replaced with \_\_\_\_\_ [ ] a new title

[ ] have attached amendments(s)

[x] do pass

[ ] do not pass

[ ] no recommendations

[ ] individual recommendations

[ ] additional referral to the \_\_\_\_\_ Committee

ADOPTS: \_\_\_\_\_ letter of Intent

ATTACHES NEW FISCAL NOTE(S): (Dept)

APPROVES PREVIOUS: (Dept/Date)

(2) [x] fiscal impact (DOA) (DHESS)

[ ] fiscal note(s)

[x] zero fiscal note (DLED)

[ ] zero fiscal note(s)

SIGNING DO PASS:

SIGNING OTHER RECOMMENDATIONS:

	Check appropriate column:	Do Not Pass	No Rec	Amend
Dave Douglas				
Betty Bruckman				
Jim Allen				
John J. Zwick			X	
William P. Pappell				
David M. Finkelstein				

Chairman's Signature: Finkelstein

**HB 45 — RELATED TO MAMMOGRAPHY SCREENING**  
**Sectional Analysis**

**Section 1.(a)** Requires Alaska health insurance providers to include low dose mammography screening in every group and individual policy which covers mastectomies and related procedures.

(b) Establishes frequency standards for mammography screening, as recommended by the American Cancer Society.

(c) Requires that payment for mammograms should be not less favorable than for other radiological examinations and may be subject to standard co-payment and deductible provisions.

(d) States that these requirements are not applicable to supplemental contracts covering a specified disease or other limited benefits.

(e) Definition of "low-dose mammography screening".

**Section 2.** List of statutes that apply to service corporations operating as insurance providers in Alaska; the mammography requirement for insurance providers is included in this list so that the statutes are consistent.

**Section 3.** Includes mammography screening as a service which may be covered by Medicaid funding.

**Section 4.** Places mammography screening on the prioritized list of services which will not be funded if funds are not available.

**Section 5.** States that this act applies to individual and group health insurance policies and to hospital or medical service subscriber contracts entered into or renewed on or after the effective date of the Act.



Medicine

COVER STORIES

# A Puzzling Plague

*What is it about the American way of life that causes breast cancer?*

By CLAUDIA WALLIS



In the bad old days, some 20 years ago, no one had the heart even to talk about it. Breast cancer struck the most evident of a woman's assets, where the motherly and the erotic are joined. And treatment of the disease was a nightmare of pain, dis-

figurement and uncertainty too terrifying to contemplate. A seemingly healthy woman with nothing more than a tiny lump in her breast (and a larger one forming in her throat) could agree to have a biopsy performed and not know whether she would awake from surgery with a small bandage on her breast—or no breast at all.

Much has changed since then. For one

thing, breast cancer is widely discussed. Celebrity after celebrity—a veritable Breast Cancer Hall of Fame—has stepped forward to demystify the disease and soften its stigma, beginning with Shirley Temple Black, Ingrid Bergman and Betty Ford, and more recently including Nancy Reagan and Gloria Steinem. Lessons on cancer detection and the importance of mammo-



**One out of every ten American women will get breast cancer. Of those who do, one out of four will die of it.**

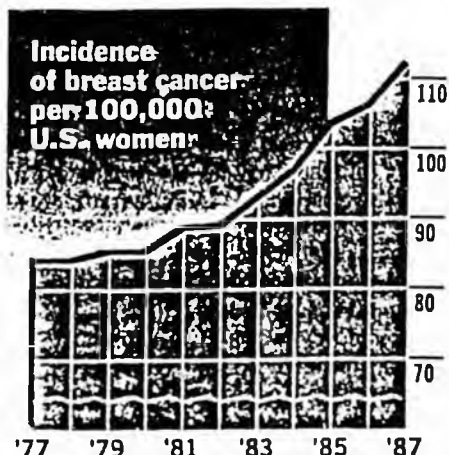
grams are the subject of elaborate public information campaigns.

More important, the surgical and post-surgical options have multiplied. Chastened by better educated and more demanding patients, doctors now wait after a positive biopsy to discuss these options before moving in to amputate. Just last year a consensus meeting convened by the National Institutes of Health formally recommended lumpectomy, the removal of a cancerous lump plus a small amount of surrounding tissue, followed by radiation therapy, as an equally effective alternative to breast removal in many cases. And the success rate for treatment is up—not dramatically, but up. Nowadays, 76.6% of breast-cancer patients survive five years after surgery, and 63% are alive 10 or more years later. In 1970 the five-year survival rate was 68%.

But there is also bad news about breast cancer. The number of cases continues to soar. According to the National Cancer Institute (NCI), the U.S. incidence increased 32% between 1982 and 1987. Only lung can-

cer is rising faster. Cancer is the leading cause of death for women 35 to 50, and breast cancer is the most common malignancy in this age group. All in all, an American woman has a 1-in-10 chance of developing breast cancer over the course of her lifetime, and that risk keeps on rising.

The big question is why. Most experts



TIME Chart. Source: National Cancer Institute. Annual figures are for 1987.

on the disease agree that part of the increase can be attributed to earlier detection of tumors. Some 65% of American women over 40 have had a mammogram, up from about 20% in 1979. The widespread use of this tool, a low-dose X ray of the breasts, has meant that more women are discovering their tumors in the early stages, before a lump can be felt. In past decades, prior to the spread of mammography, such women might have died of other causes before their breast cancer was diagnosed.

Nonetheless, most investigators of the epidemic believe early detection is only part of the story. They look at the fact that breast cancer is far less common in other parts of the world and conclude, ominously, that the answer lies in some facet of the American life-style. "Something in our environment is contributing," contends Dr. Marc Lippman of Georgetown University.

Study after study has explored the possibilities. Could it be the birth control pill? Probably not, since dozens of investigations into that question have produced a quag-

## Medicine



The ouch factor: a good mammogram is uncomfortable

*Two out of three older women fail to get checked regularly.*

mire of contradictions. How about smoking? Again, there is no clear connection. Alcohol? Drinking seems to raise the risk of the disease slightly, but the association is too weak to account for America's prodigious rate. What about the widespread use of estrogen therapy following menopause? Studies show only a mildly elevated risk. And while food additives and even lack of sunlight have come under suspicion, there is little evidence to convict them.

### THE FAT FACTOR

Instead, many researchers around the world are pointing to another component of the Western way of life: a diet rich in fat. Researchers have known for more than 40 years that high-fat diets promote the growth of mammary tumors in laboratory animals. They have also observed that the varying rates of breast cancer in various countries correlate neatly with the amount of fat in a nation's diet. The U.S., Britain and the Netherlands, which have some of the world's richest diets, also have among the highest breast-cancer rates. Meanwhile, in countries such as Japan, Singapore and Romania, where the diet is very lean, the incidence of breast cancer is one-sixth to one-half the U.S. rate.

On the theory that genetic factors might be responsible for such national variations, researchers have looked at immigrant groups. They have found that

when Japanese move to the U.S., or Italians to Australia, their previously low breast-cancer mortality rate rises to match the higher rate of their adopted country within a generation or two, as diet and lifestyle change. "The results are too consistent to believe that the association is indirect," says Maureen Henderson, an epidemiologist at the Fred Hutchinson Cancer Research Center in Seattle. When it comes to the breast cancer-fat connection, she says flatly, "I'm sure of it."

Japanese researchers are also convinced. Breast cancer is one of the fastest-growing diseases among Japanese women, with the incidence up 58% between 1975 and 1985. "The largest factor behind the sharp rise is the Westernization of eating habits," says Dr. Akira Eboshida, chief deputy director of the Health and Welfare Ministry's Disease Control Division. "We are eating more animal fat and less fiber." Cancer of the breast is not the only ailment rising with the larding of the Japanese diet. Heart disease is also surging, as is cancer of the colon, ovaries and prostate. All have been linked to a high-fat diet. On the other hand, stomach cancer, historically the most common cancer in Japan, is falling as the nation moves away from its traditional diet of salty, pickled and smoked foods. "If the current trend continues," predicts Eboshida, "breast cancer will replace stomach cancer as the No. 1 killer of Japanese women in the next century."



A color-enhanced mammogram shows a white spot of cancer

*The technique reveals pinpoint tumors undetectable by touch.*

Despite such evidence, not everyone shares the conviction that fat is the villain. Critics of this theory point out that statistical correlations are not the same as proving cause and effect. Many researchers argue that there are probably several lifestyle factors rather than a single culprit. "The high rates are not due to one bad habit, but to our whole way of life," says Mary-Claire King, a cancer geneticist at the University of California, Berkeley.

According to Dr. Walter Willett at the Harvard School of Public Health, overall calories may play a larger role than fat: Americans may simply be eating too well. Willett points out that breast-cancer rates tend to be highest in prosperous countries where people are well nourished. In such lands of plenty, girls begin to menstruate at an earlier age, women tend to have their children later in life and menopause also comes later. Late menopause (after 50), delayed childbearing (after 30) and early onset of menstruation (before 12) are all acknowledged "risk factors" for breast cancer. For older women, obesity also increases the risk of the disease. King notes that better education and job opportunities for women have furthered the trend toward postponed motherhood and childlessness (also a risk factor). "All the things that cause women to be healthy, well-educated and have careers put them at risk for breast cancer."

Critics of the fat theory also point to

several studies that seem to refute it, including a survey by Willett of 90,000 nurses from 34 to 59. Though the diets ranged from 32% fat content to about 44% (the U.S. average is 42%), the Harvard researcher could find no correlation between fat intake and the incidence of breast tumors. One problem with Willett's study: many researchers believe that dietary fat must be more radically reduced, to about 20% of total calories, to affect the occurrence of breast cancer.

The proof, of course, is in the pudding, or in this case, not eating any. Unfortunately, researchers seeking conclusive evidence of the effects of a very low-fat diet have had little success in obtaining funds. One concern is cost. Another is that women participating in such trials would have trouble adhering to the drastic regimen, which would mean very limited amounts of meat, dairy products and oils of any kind.

To show that it can be done, Henderson in Seattle completed a three-year pilot study, funded by the National Institutes of Health, of 2,000 postmenopausal women who were painstakingly taught how to follow a 20% fat diet. "We give them a Ph.D. in fat," she explains. Her hope was that the pilot would lead to NIH funding of a 10-year effort with 24,000 women. No such luck. A competing proposal for a similar study that would cost \$107 million was on the verge of being financed when an NCI advisory panel decided last month to put it on hold—a crushing disappointment for many researchers.

## THE ESTROGEN CONNECTION

If fat does figure in the development of breast cancer, just what role does it play? No one in the research community believes that too many thick shakes and fries can in themselves cause normal, well-behaved cells to mutate into unruly malignant ones. In fact, no one has the faintest notion what causes the initial genetic changes to occur. "In lung cancer we have a reasonable idea that the major cause is cigarette smoking," says Dr. Philip Leder, chairman of Harvard's department of genetics. "In skin cancer we understand that the major cause is ultraviolet light, which is absorbed by DNA and causes it to break. But with breast cancer we don't have any idea what the precipitating factors are."

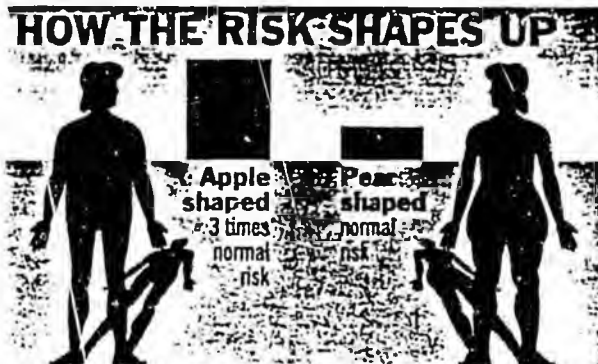
Doctors have long been convinced that some people are genetically predisposed to develop breast cancer. A woman whose mother or sister had the disease before menopause has five to six times the usual risk of developing it. If either one had the

disease in both breasts, then the woman's risk is five to 10 times the norm.

Though scientists do not know how breast cancer begins, they do have some ideas about how it progresses. The female hormone estrogen, which is produced in the ovaries and causes a young girl's breasts to develop, also plays an unmistakable role in promoting the growth of tumor cells. Why do childlessness, late menopause, early onset of menstruation and delayed childbearing all increase the risk of breast cancer? One likely explanation is that all involve a prolonged, uninterrupted

overall levels of estrogen and especially large amounts of the "biologically active" form. Equally significant, endocrinologist David Rose of the Naylor Dana Institute in Valhalla, N.Y., has found that when women switch to a very low-fat diet (20% of total calories), their estrogen levels quickly drop by 20%. Advocates of the dietary-fat theory regard this observation as a crucial bit of supporting evidence. Given estrogen's established role in promoting breast cancer, the fact that fatty foods directly affect estrogen levels means that, as Maureen Henderson puts it, "it's biologically rational that fat can influence cancer."

Considering all the fuss over fish oil and polyunsaturates in the world of heart disease, one might wonder if the type of fat consumed makes any difference. "The data are very confusing on this," admits Rose. Some researchers believe that certain fats are more villainous than others with respect to cancer, but Henderson and others say all fat should be reduced. Drastically.



Obese women who carry excess weight on their upper bodies (apple shaped) are at three times the average risk of getting breast cancer, possibly because they have unusually high levels of certain estrogens. Overweight women who are pear shaped have no increased risk. Apple-shaped women are also more susceptible to heart disease and diabetes.

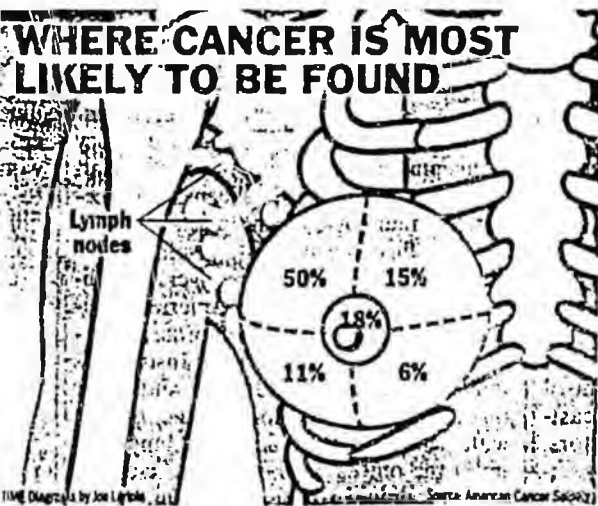
## THE MAMMOGRAM MUDDLE

Until the government decides to fund a long-term dietary study and until the work is completed, the value of an ultralow-fat diet in preventing breast cancer will remain open to question. For women 40 or older, however, there is one bit of medical counsel that has almost unanimous approval: Get a mammogram. Now. And do it regularly.

Consider these facts. By the time a breast tumor is large enough to be felt as a lump, it is generally more than 1 cm (0.4 in.) in diameter and contains several billion cancer cells, some of which may have broken loose, circulated through the bloodstream and begun to infiltrate other organs. A mammogram can detect pinpoint tumors that are less than 0.5 cm (0.2 in.) across, often well before the process of metastasis has started. This is not to say that a manual exam by a doctor or the woman herself is a waste of time. Such exams can sometimes turn up tumors missed by X rays. But the early-detection capability of mammography clearly saves lives. A 1987 study found that for women whose tumors were discovered early by mammograms, the five-year survival rate was about 82%, as opposed to 60% for a control group.

And if that is not incentive enough, early detection through mammography can sometimes bring another bonus: surgery that spares the breast. A small, early tumor can often be removed with a lumpectomy procedure rather than a mastectomy.

Why, then, aren't American women running en masse to the mammographer's

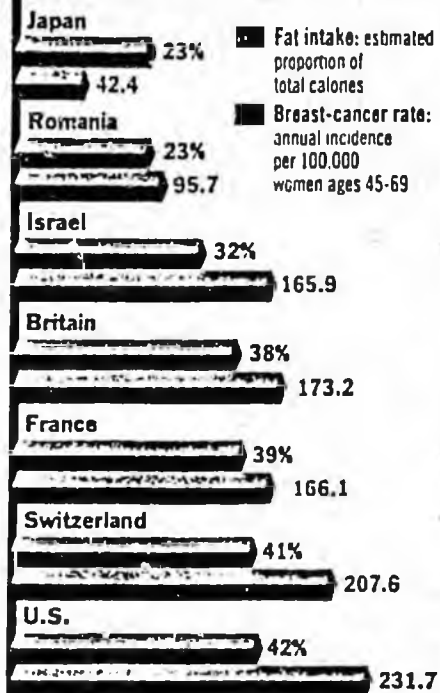


presence of high levels of estrogen in the bloodstream. Doctors have also noticed that women whose ovaries were removed before age 40 rarely get breast cancer.

Researchers focusing on the role of fat in the development of cancer have been particularly intrigued by the estrogen connection. Biologists have long known that estrogen is produced not only in the ovaries but also in fat cells. Obese women have higher levels of estrogen than thin ones—a probable factor in their greater risk of breast cancer after menopause.

But it has been only in the past five years that researchers have found a link between estrogen levels and fat in the diet. Women who eat lots of hamburgers, thick shakes and other fatty foods have higher

## DANGER IN THE DIET



An intriguing link with eating habits: a Seattle woman, participating in a study on cancer prevention, prepares a special low-fat meal

office? Why do less than a third of women over 40 have mammograms every one to two years, as experts recommend? One reason may be lingering fears about radiation exposure. Nowadays, however, mammography doses are about one-tenth of what they were 20 years ago—less than one receives from cosmic rays on an airplane flight. A more significant factor, says Dr. Sarah Fox, a UCLA professor of family medicine, is "that physicians aren't making the recommendations." Doctors often feel that mammograms are unnecessary for women who are not in a high-risk category. "Sometimes they'll say, 'You've had a couple of children and you've got no family history, so relax,'" explains Dr. Robert Smith of the Centers for Disease Control in Atlanta. Yet three out of four breast-cancer victims have no known risk factors, says Smith. No woman over 40 should consider herself safe. And certainly her doctor should know better.

The cost of mammograms may also discourage women. Insurance frequently fails to cover the \$50 to \$200 procedure. Medicare just began paying for it this year. Public hospitals do not always offer such screening, and some state Medicaid programs have refused to provide reimbursements, which helps explain why breast cancer is often diagnosed too late among the poor. For black women in particular, the five-year survival rate is only 64%, in contrast to 77% for white women.

Adding to the confusion on mammography is the unfortunate fact that medicine's powerful professional societies cannot agree on what to recommend. The American Cancer Society urges a mammogram every one or two years for women be-

tween ages 40 and 49, and annually thereafter. The American College of Physicians disagrees, claiming that a mammogram is not "cost-effective" for women under 50, since only 20% of malignancies occur in these women.

As if matters were not muddled enough, a storm has erupted in recent years over the uneven quality and accuracy of mammograms around the U.S. "Half the states do not have a licensing procedure for radiologic technologists. It could be the office receptionist pushing those buttons," warns Marie Zininger, a quality-control specialist for the American College of Radiology. Another problem, according to the National Cancer Institute, is that General Electric, Philips and other manufacturers have flooded the market with mammography machines. Many wind up in the offices of doctors who lack the proper training in the use and maintenance of these machines. The College of Radiology has responded with a drive, launched in 1989, to examine and certify mammography facilities. It advises patients to choose a high-volume accredited facility. Another sign that a mammogram is up to snuff: the ouch factor. To get a good picture, the mammography machine must compress the breast. "If you're not uncomfortable," says UCLA's Fox, "you're probably getting a bad mammogram."

### A POLITICAL SOLUTION?

In recent years a ground swell of breast-cancer victims, feminists and legislators, inspired by the success of the AIDS lobby in bringing attention and funds to that epidemic, have been pushing for better

regulation of mammography standards, for mandatory insurance coverage of mammograms, and generally for more research into the still mysterious roots of breast cancer. They point out that the U.S. government spends only \$77 million a year investigating ways to prevent the illness, against \$648 billion on heart-disease prevention. Last week Congresswoman Mary Rose Oakar of Ohio sought to redress the shortfall by introducing a bill that would add \$25 million to the NIH budget expressly for basic research on breast cancer. Meanwhile the National Women's Health Network, a lobbying group in Washington, continues to press for federal funding of studies on the effects of diet.

But given the demands on the limited federal research budget, such efforts will probably fail. Perhaps as unfortunate, notes Dr. Geoffrey Howe, a leading researcher on cancer and diet at the University of Toronto, is the fact that "political pressure is the criterion for deciding what scientific research needs to be done."

For patients, the lack of answers and of resources to find them amounts to an all too literal deadlock. "I am scheduled to die because I have metastatic breast cancer," says Elenore Pred, founder of the Breast Cancer Action group in San Francisco. "I'm part of the 44,000 women for whom there is no cure. But I refuse to be written off." Pred is devoting her days to lobbying for more research and better public education on the disease. As the mother of two daughters, she could leave them no healthier legacy. — Reported by J. Madeleine Nash/Chicago and James Willwerth/Los Angeles

# The Rough Road to Recovery

*Options for therapy have multiplied, but making the right choices can be daunting for both doctors and patients*

By CLAUDIA WALLIS

**D** Colleen Fallscheer, a cheerful 40-year-old mother of two from Waterford, Mich., is living proof that breast-cancer therapy is not the horror show it used to be. A little over a year ago, a mammogram revealed a bright malignant spot, no more than 1.5 cm (about 0.6 in.) across, imbedded in the translucent tissue of her left breast. A surgeon recommended a mastectomy, to be followed by chemotherapy. Fallscheer was appalled. She sought a second opinion from David August, a surgical oncologist at the University of Michigan Medical Center, who told her that her tiny malignancy made her an ideal candidate for a lumpectomy, a less drastic procedure.

Last November, in a two-hour operation, Dr. August's team removed the cancer plus a margin of surrounding tissue, leaving Fallscheer with a 5-cm (about 2-in.) scar in an otherwise normal-looking breast. To catch any residual cancer cells, she received six weeks of daily radiation therapy, which produced a light suntan but left no permanent trace. "A lumpectomy plus radiation does not cure more women than mastectomy," says radiation oncologist Allen Lichter of the University of Michigan, "but it creates fewer physical and emotional scars." Fallscheer concurs: "It was only after I saw Dr. August that I felt I wasn't going to die after all."

Ten years ago, lumpectomy would not have been an option for Fallscheer. Since then, studies have shown that when a tumor is small, confined to a single area and readily accessible to the surgeon's scalpel, lump removal plus radiation is no less effective than removing the entire breast. But as Fallscheer's experience shows, not every surgeon is convinced. Nor does every eligible patient choose the lesser operation. Though about 50% of breast-cancer patients are candidates for lumpectomy, only about half of those elect it. Many, including Nancy Reagan, feel safer if the en-



The "caterpillar stage": Crossley, who received high-dose chemotherapy, gets a checkup

tire breast is removed. "For most women, whether or not they lose their pectorals is not the issue," explains University of Chicago surgeon Monica Morrow. "It's whether or not they lose their lives."

Choice of surgery is only the first of many decisions faced by patients and doctors. None are simple, and women sometimes get the impression that there are as many variations in therapy as there are doctors. The key question following surgery, however, is whether the cancer has spread. It is not localized disease in the breast that kills more than 40,000 U.S. women a year, but the dissemination of the cancer to other, more vital organs, usually the brain, the bones, the liver or lungs.

**T**o determine if the deadly process of metastasis has begun, surgeons performing mastectomies and lumpectomies routinely remove 10 to 25 lymph nodes from under the arm near the affected breast and examine these glandular structures for signs of cancer. A woman with "positive" nodes has a 37% to 75% chance of a cancer relapse within five years, depending on the number of affected nodes and the size of the original tumor. In such cases, chemotherapy or hormone therapy will be urged.

The kind of drug treatment depends on many things, including a woman's age and the biology of her tumors. The cancer cells of postmenopausal patients often require the hormone estrogen in order to grow. If lab tests show the presence of estrogen receptors in a tumor (a sign of a good prognosis), therapy with tamoxifen, an estrogen-blocking drug, is usually recommended. It reduces the risk of disease recurrence by approxi-

mately 20%, with relatively mild side effects.

Younger women and those who have no estrogen receptors usually receive combinations of two to five chemotherapy agents, such as Cytosan and methotrexate, over a period of four months to a year. Because these drugs target rapidly dividing cells, they not only destroy cancer cells but also cells in the hair follicles, the lining of the digestive tract and the bone marrow. That produces the dreaded side effects of chemo: hair loss, nausea and a decline in infection-fighting white blood cells. Premature menopause can be another consequence. Even this harsh treatment provides no guarantee of a cure, though in certain groups of patients, it can increase survival rates as much as 40%.

Today, thanks to the widespread use of mammograms, breast tumors are being discovered earlier, before the cancer has spread. Now 60% of patients are "node negative," up from 50% 10 years ago. Increasingly, cancers are being found at a very early, localized stage, known as "in situ carcinoma" (cancer in place).

While early detection vastly improves the chances of a cure, it also raises questions for doctors. No one is certain how much treatment is right for in situ carcinoma. Nor is it easy to determine therapy for patients whose cancer has begun to spread but has not yet affected the lymph nodes. Experience has shown that up to 30% of these node-negative women will develop a recurrence. The question: Which 30%?

Frequently, doctors use a variety of factors to determine which patients are at highest risk. One major consideration: tumor size. "One centimeter [0.4 in.] is considered the major turning point," says Dr.

Larry Norton at Memorial Sloan-Kettering in New York City. "Over 1 cm, and I lean very strongly toward additional treatment." A close look at the tumor cells will provide other clues, says Dr. William McGuire, chief of medical oncology at the University of Texas Health Science Center at San Antonio. Misshapen cell nuclei, abnormal amounts of DNA or an accelerated rate of cell division are all bad signs, suggesting a need for chemotherapy or tamoxifen. Newer tests include examining tumor cells for extra copies of cancer-causing genes or excess amounts of an enzyme called Capthepsin D, which seems to play a role in metastasis. Says McGuire: "Today we know that if you have a low score on all these markers, your chance of recurrence is less than 10%. If you score high, your chance is greater than 50%."

To have the cancer return even after the trauma of surgery and the misery of chemotherapy is the nightmare of every patient. When this happens, the outlook is grim. But in recent years doctors have been experi-

menting with a controversial treatment for advanced and recurring breast cancer that involves massive doses of chemotherapy and a bone-marrow transplant. Annette Crossley, 45, of Glendora, Calif., is hoping it will save her life. Crossley suffered a cancer relapse just a few months after completing a course of treatment that included a mastectomy, chemotherapy and radiation. Given slim odds of survival, she chose to try the new treatment at the University of Chicago Medical Center. Over a five-day period, she received intravenous chemotherapy in four to seven times the usual doses. Because such treatment destroys the bone marrow, healthy marrow was extracted from Crossley's pelvic bone before she began the toxic therapy. After the sessions and some rest, the marrow was re-injected into her body.

Such high-dose therapy is perilous. Until the transplanted marrow replenishes the patient's supply of white blood cells, she is highly vulnerable to infection. Jacob Bitran, Crossley's oncologist, believes that

the procedure is worth the risk. He and his associates have treated 67 advanced breast-cancer patients in this manner over the past four years. Though 11 have died of complications, mostly infections, 16 are in complete remission, seemingly disease free. "That means 1 in every 4 is a long-term survivor," he says. Others are not persuaded. "I am not convinced that we have the benefits to justify the toxicity," says Harvard oncologist I. Craig Henderson, noting that, regardless of treatment, 10% of women with advanced, metastatic disease will be alive after 10 years. Such doubts have led many insurance companies to refuse to pay for the procedure, which typically costs about \$120,000.

For Annette Crossley, cost is not the main concern. Slowly regaining strength, with little hair left on her head, she remains a picture of hope. "This is the caterpillar stage," she says, grinning gamely, "the ugly stage before the butterfly comes out."

—Reported by J. Madeleine Nash/  
Ann Arbor

## Restoring Lost Curves and Confidence

Last November, at the age of 43, Carol Beebe lost her left breast to cancer. But when she awoke from mastectomy surgery at New York City's Columbia-Presbyterian Medical Center and gazed down at her chest, nothing appeared to be missing. Beebe, an IBM employee from Point Pleasant, N.J., had chosen to have a reconstruction of her breast immediately following the mastectomy. In a single operation, plastic surgeons shaped a new breast from Beebe's own abdominal tissue, moving it into place minutes after the general surgeons had removed the diseased breast. The technique spares the patient the anguish of amputation. "Our basic philosophy is that you don't leave the hospital without a breast," explains Plastic and Reconstructive Surgery chairman Norman Hugo, who performed the operation.

Rebuilding the breast after mastectomy has become increasingly popular in recent years: more than 34,000 U.S. women chose some form of reconstruction in 1988, up 71% from 1981, according to the American Society of Plastic and Reconstructive Surgeons. Younger patients are particularly drawn to the procedure, though Hugo has reconstructed breasts for women of all ages and types, including a nun.

The majority of reconstructions are done with implants, small bags that are inserted under the muscle of the chest wall and filled with either silicone gel or saline solution. The inflation must be done gradually over a period of weeks to allow time for the muscle and skin to stretch, a process that can cause discomfort and sometimes lead to infections.

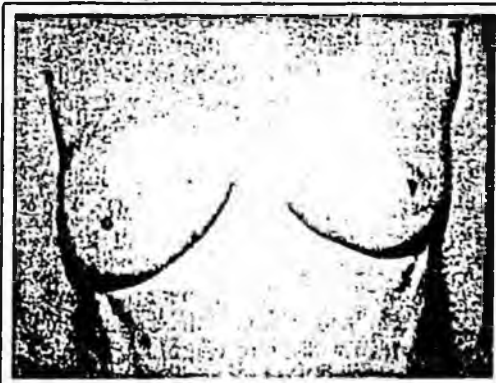
Linda Lehman, 43, a mother of two from Newville, Pa., received two silicone implants last February, three months after undergoing double mastectomies. That summer she went out

and bought a new two-piece swimsuit. "Losing your breasts is a terrible experience," she says. "You mourn the loss. You have the same phantom feelings as when you lose a limb." The implants, she says, have restored her spirit along with her figure. "I wear more revealing clothing than before, and I've never looked better."

Silicone implants are not without drawbacks. Because they sit high on the chest and are compactly curved, the implants most closely reproduce the look of a young woman's breast and can be a poor match for an older patient. They can also make the breast feel hard, interfere with mammography and, on occasion, rupture, causing inflammation if silicone has been used. This spring, as a result of pressure from patient-advocacy groups and members of Congress, the FDA will require implant manufacturers to provide proof of the safety of their products. Still, many surgeons say the risks have been exaggerated.

Reconstruction using a flap of abdominal tissue, as Beebe had, avoids most of the implant problems but is a far more complex operation, lasting upwards of six hours and requiring a longer recovery period.

The plastic surgeon must carve a large, almond-shaped swath from the belly, about 16 cm by 30 cm (6 in. by 12 in.), carefully lifting up the skin, fat and an underlying muscle, without severing the artery that supplies the tissue. The flap is then fashioned into a new breast. A new nipple can be created later by twisting the tissue and tattooing on an areola. For Beebe, there was abdominal pain at first and cramping of the relocated muscle that continued for several weeks following her surgery. But she has no doubt that she made the right choice. "It feels natural and moves naturally," she says. "I don't even feel like I've lost a breast. It's just a little different now."



Breast, left, rebuilt with abdominal tissue

## Tantalizing Clues to a Lethal Legacy

Research into the genetic factors is raising hopes of better screening and treatment

By J. MADELEINE NASH CHICAGO



To most women, the notion of undergoing a mastectomy in order to prevent breast cancer smacks of wild paranoia. But for Maria Burkhardt of Covington, La., the unthinkable slowly became the inevitable. Twenty years ago, an aunt was stricken with the disease. Her mother died from it a decade later. In 1986 Maria's younger sister Jo Ann began fighting for her life. Next her older sister Rose developed an aggressive tumor. Maria consulted a doctor and was told she was "a ticking time bomb." Ominously, her tissues were judged too dense for mammograms to scan reliably.

So last summer, at 47, Maria decided to have both breasts removed. Her own graceful curves were replaced with silicone implants that harbored no trace of her family's lethal legacy. A short time later, Maria received a report that vindicated her decision. A postoperative examination of her breast tissue had found precancerous lesions. "I just broke down and cried," she recalls. "I'd done this knowing I might never know if I'd made the right choice."

Families like Maria Burkhardt's are rare, accounting for a tiny fraction of breast-cancer cases. But the malevolent genes they pass down through the generations are beginning to yield important clues to all breast malignancies. "Cancer," declares celebrated molecular biologist James D. Watson, "is a disease of the DNA," the master molecule that encodes the genetic blueprint for every living cell. Tumors develop as the result of rearrangements in DNA, specifically in the genes that govern cell growth.

In most cases, the changes that lead to breast cancer begin accumulating after birth, perhaps triggered by some set of environmental stresses, whether random cosmic rays or a dietary factor. Some women, however, start out with the genetic deck stacked against them. Like Burkhardt and her sisters, they stand a greater risk of developing breast cancer, in both breasts and at an earlier age, than other women.

Recent months have brought a series of discoveries about the genetic mutations involved in breast cancer. "Information is accumulating at an astounding rate," says University of Utah geneticist Mark Skolnick.



"A ticking time bomb": after her sisters Jo Ann, left, and Rose, right, were stricken with aggressive breast tumors, Maria Burkhardt opted for preventive mastectomies. "Half the people I talked to said I'd be crazy, but it's not worth waiting for cancer."

Changes in at least two types of genes play a role: those that direct cells to grow and divide; and those that issue commands to halt growth. Much of the research has focused on a growth-enhancing gene on chromosome 17, often referred to as the *HER-2/neu* oncogene. An estimated 30% of breast-cancer patients have somehow acquired abnormal quantities of this gene—as many as 50, as opposed to the normal two.

The extra copies are a bad omen. Patients that have them suffer three times the rate of cancer recurrence of other patients, says UCLA oncologist Dr. Dennis Slamon. Such patients, he says, should "absolutely" get further treatment. But one genetic abnormality is not enough to transform healthy, law-abiding breast cells into anarchic tumors. "The genes responsible for this disease are like pieces of a patchwork quilt," says geneticist Mary-Claire King of the University of California, Berkeley. The patchwork pattern may vary from one woman to the next, but each case probably involves five or six separate mutations occurring over a period of years.

Researchers at the Cancer Institute in Tokyo have implicated five genes on four different chromosomes. Dr. Yusuke Nakamura speculates that the loss of a growth-suppressing gene on chromosome 17 may be one of the earliest changes on the road to malignancy. Other groups have also pointed to sites on chromosome 17. Last November a team led by scientists at Mas-

sachusetts General Hospital Cancer Center identified one such gene as the likely cause of Li-Fraumeni syndrome, a rare genetic disorder that increases susceptibility to breast cancer and other malignancies. Since then, King and her colleagues at Berkeley have identified another segment of chromosome 17 that is associated with familial breast cancer. Other researchers, including a group in Strasbourg, France, are unraveling the genetics behind the deadly process of metastasis.

The flood of insights into the genetics of breast cancer will ultimately provide physicians with more effective weapons. This year Dr. Slamon and his colleagues hope to begin clinical trials of a genetically engineered antibody that locks onto the protein made by the *HER-2/neu* oncogene, interfering with its function. This antibody has already been shown to inhibit tumor growth in mice.

Researchers like Berkeley's King dream of diagnostic tools powerful enough to identify abnormal genes in breast cells long before they become fully cancerous. Such tools could begin to lift the burden of uncertainty from women who, like Maria Burkhardt, come from cancer-prone families and wonder if they carry the dreaded trait. Someday, if King has her way, tests for breast-cancer genes could become as commonplace as Pap smears. And then, she says optimistically, "no one need die of breast cancer anymore."

—With reporting by

James Wilberth/Los Angeles

# Screening Mammography: Increasing the Effort toward Breast Cancer Detection

## ABSTRACT

*Mammography is the only modality with the potential for detecting a breast cancer while it is non-palpable and at a stage of high curability. Early detection of breast cancer is important because survival is directly related to tumor size and lymph node status, and prognosis is best for small lesions without axillary node metastasis. Many studies have indicated that screening mammography is tremendously underused. This article focuses on the effectiveness of mammography and the importance of detecting a breast cancer at an early stage. Health care providers have a responsibility to inform their clients about the benefits of mammography. In addition, women need to be taught breast self-examination and undergo regular clinical breast examinations by a health care professional. The American Cancer Society guidelines for screening breast cancer are given.*

Deborah A. Hamwi, R.N., N.P., M.S.N.

The high incidence of breast cancer among women in the United States has made early diagnosis the focus of screening efforts. It is estimated that in 1990 a total of 150,000 women will be diagnosed with breast cancer, and approximately 44,000 will die of this disease.<sup>1</sup> Many advances have been made in early detection and especially in screening mammography, which has been shown to be effective in detecting breast cancer at preclinical stages. However, more than 90 percent of breast cancers are first detected by women themselves.<sup>2</sup> The size of breast cancers detected by this method averages about 2.5 centimeters (approximately one inch), and approximately 50 percent of the women have lymph node involvement at the time of discovery.<sup>3</sup>

Early detection of breast cancer is important because survival is directly related to tumor size and lymph node status, and prognosis is best for small lesions without axillary node metastasis. Small, non-palpable (preclinical) cancers found by screening mammography have a 10-year survival rate of 95 percent and can thus have a major impact.<sup>2,3</sup> When nodes are involved, the survival rate drops to 53 percent or less. Presently, the majority of breast cancers are detected at this stage.<sup>3</sup>

In February 1990 a study sponsored by the

National Cancer Institute and the Jacobs Institute of Women's Health was done to determine whether expanded media coverage, national and local information efforts and screening programs had increased the use of mammography. The survey of 980 women age 40 and older showed that 64 percent had had at least one mammogram, up from 37 percent in 1987. The study also indicated that only 31 percent of the women were following mammography guidelines established by the National Cancer Institute, the American Cancer Society and 11 other medical organizations. Nearly three-fourths of the women 40 years of age or older who had had a mammogram reported that they did so because their doctors recommended it — a finding that was consistent across age, race, income and education categories. Forty-five percent of the women who had never had a mammogram reported that their physicians did not tell them to do so. These women were also more likely to be uncomfortable in asking their physicians for a mammogram if their physicians did not mention it first. It is estimated that breast cancer death rates could be decreased by 30 percent if women received mammograms at recommended intervals.<sup>4</sup>

The American Cancer Society (ACS) recommends a baseline mammogram for all women be-



radiation, such as in the Hiroshima and Nagasaki atomic bomb blasts, multiple fluoroscopies for the treatment of tuberculosis, and X-ray treatment for postpartum mastitis.<sup>12</sup>

However, there appears to be very little increased risk to women exposed to radiation after the age of 40 — the age when mammography is most indicated. The prepubescent breast is sensitive to the carcinogenic effect of radiation, and the breast may become gradually less sensitive to the effects of radiation during adolescence. There are no epidemiologic data demonstrating that routine use of mammography — even repeated mammograms at yearly intervals — is ever associated with an increased risk of breast cancer. In addition, the radiation doses currently used for screening mammography have been significantly reduced from earlier doses to the range of 0.2 rad per breast per examination. Women need to be educated that the dose of radiation from a mammogram is negligible and should not deter them from receiving regular mammograms.<sup>13</sup>

Historically, radiation risk estimates have been taken from studies of women exposed to relatively high doses of radiation such as atomic bomb survivors, patients exposed to multiple fluoroscopic examinations and women treated for postpartum mastitis. These groups received more than 50 rad of radiation and did have an increased incidence of breast cancer. The age at irradiation was identified as a major determinant of risk. Women irradiated when younger than 20

years old had a higher risk of radiation induced breast cancer.<sup>2,12</sup>

It is not known whether very low doses of radiation, such as those used in current mammographic techniques (0.1 to 0.8 rad), can

## Radiologist and Technologist

Competently performing the examination and recognizing the subtle signs of early breast cancer require that the radiologist and

Nearly three-fourths of the women 40 years of age or older who had had a mammogram reported that they did so because their doctors recommended it — a finding that was consistent across age, race, income and education categories.

cause breast cancer. The risk, if it does exist, is so small that it has never been observed but only inferred from the greater incidence of breast cancer seen in women exposed to doses of greater than 50 rad.<sup>2,10,13</sup>

Currently, mammograms are most often produced by a screen-film technique. The average glandular radiation dose for a two view examination is 0.1 to 0.2 rad. There has been considerable improvement over earlier techniques including a significant reduction in radiation dose and considerable improvement in diagnostic image quality.<sup>10,12-13</sup>

technologist be qualified and experienced with mammography. The technologist is responsible for positioning the patient properly so that as much of the breast as possible appears on the film and so that the breast is compressed to as thin a layer as possible. In a population of healthy women age 40 to 74, only 2 percent of the women have a pathological lesion. The radiologist interpreting screening mammograms must be familiar with the wide range of mammographic appearances that are present in normal breasts.<sup>12,14-15</sup>

## Cost of Mammography

In 1986, the American Cancer Society sponsored a community-wide low-cost mammographic screening project. The goal of the ACS campaign was to encourage a long-term reduction in the cost of mammographic screening and increase public and physician awareness of the value of mammographic screening. The project provided mammographic examinations at a cost of \$50 each for 18,264 asymptomatic women ages 35 years and over.<sup>16</sup>

The mean fee for a screening mammography in 1988 was \$111; however, this fee can vary contingent on facilities' volumes and subsidies. Women have reported the high cost of mammography as one reason for not undergoing mammograms at recommended intervals. This can have a major impact on women in low socioeconomic groups who are unable to pay out-of-pocket expenses. In the past, many insurance companies did not authorize payment for routine

## Compression

Adequate compression is an essential factor in reducing the scatter of the X-ray beam, production of a more uniform density of the breast, and preservation of image clarity by prevention of movement. In addition, compression can reduce the radiation dose, since a lesser thickness of breast tissue needs to be penetrated. When the breast tissue is compressed, suspicious lesions are more easily identified.<sup>11-15</sup> The importance of adequate compression should be explained to the patient prior to a mammogram so that she is better able to tolerate the minimal discomfort associated with each exposure. Occasionally, women will experience pain. They should be instructed to communicate discomfort immediately to the technologist. In order to reduce chances of discomfort, mammography should be obtained following the menstrual period when the breasts are least likely to be tender.<sup>3,12,16-15</sup>

**TABLE 1**  
American Cancer Society  
Recommendations  
for Asymptomatic Women

### Women 40 years of age or less:

- Breast self-examination every month.
- Clinical breast examination at least every three years.
- Baseline mammogram between the ages of 35 and 39.

### Women between 40 and 49 years of age:

- Breast self-examination every month.
- Clinical breast examination annually.
- Mammogram every one to two years, depending on risk factors.

### Women age 50 and over:

- Breast self-examination every month.
- Clinical breast examination annually.
- Mammogram annually.

screening purposes. However, insurance coverage for screening mammograms is increasing. As of July 1990, 29 states require insurance companies to provide some level of coverage for mammography. With the coverage provided by insurance companies and the expected increase in procedural volume, compe-

available and easily accessible to all women. More programs that promote the benefits of early breast cancer detection are needed. The American Cancer Society has made a substantial impact in educating and stimulating interest among women about this procedure.

**In a population of healthy women age 40 to 74, only 2 percent of the women have a pathological lesion. The radiologist interpreting screening mammograms must be familiar with the wide range of mammographic appearances that are present in normal breasts.**

tion for patients will hopefully result in lower fees. The availability of low-cost screening for women requires the involvement and cooperation of screening centers, health care professionals and third-party payers.<sup>2,7,16-17</sup>

#### Limitations and Recommendations

Mammography is the only modality with the potential for detecting a breast cancer while it is non-palpable and at a stage of high curability. However, large screening projects have found that 15 to 20 percent of cancers are not detectable on mammograms. It is known that mammography is most limited in the dense breast and is therefore of little diagnostic value in women under age 35. It should be emphasized that neither palpation nor mammography are 100-percent accurate. Therefore, a patient with a suspicious lesion found on clinical examination and a negative mammogram requires further work-up.<sup>2</sup>

#### American College of Radiology Accreditation

Two years ago, the American College of Radiology (ACR) began a voluntary mammography-accredited program to provide quality assurance to consumers through comprehensive assessment of mammography units and facilities. So far, the ACR has accredited more than 770 mammography units in the United States, and 1,500 more units have applied for accreditation. ACR accreditation ensures that a facility has been evaluated by peer radiologists for equipment quality, staff qualifications, quality of the image and the amount of patient exposure to radiation.<sup>18</sup> The American Cancer Society offices have lists of accredited facilities in their areas.

#### Conclusion

Motivation of women to accept the procedure of mammography is an important factor in successful screening. Use of mammography must continue to increase, and women must return for repeat mammograms at recommended intervals. Efforts in this direction must be ongoing and persistent. Special efforts are needed to ensure that older women and women in lower socioeconomic groups receive mammograms. Screening centers must be readily

Breast cancer is a disease that threatens both femininity and life itself. There must be an increased awareness among women and health care professionals that will facilitate early detection and diagnosis. Vital to this process are mammography to detect small, non-palpable cancers, breast self-examination and clinical breast examinations by a health care professional.<sup>16</sup> Application of these guidelines will result in early diagnosis and the saving of many lives.

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About the author: Deborah A. Hamwi, R.N., N.P., M.S.N., is a nurse practitioner in the department of operating room services at the University of California at Irvine Medical Center.

POSITION PAPER

House Bill 45

"An Act relating to insurance coverage for mammograms; requiring the medical assistance program to cover mammograms; and reordering the priorities granted to services covered under the medical assistance program."

The purpose of this bill is to expand coverage for mammography screening under individual or group disability insurance, and under optional services related to state participation in the 50% federally funded Medicaid program.

This legislation would affect both health insurance coverage provided by private carriers and public funding of medical services provided, in Alaska, through the Division of Medical Assistance in the Department of Health and Social Services.

Health and disability insurance coverage provided by the health insurance industry, which would be affected by Sections 1 and 2 of the proposed legislation, is not within the responsibility of DH&SS, so the department does not take a position in regard to this kind of coverage under those programs, except to note the recognized value of mammography screening under today's medical standards.

Medical services available to eligible recipients of Medicaid, as administered in DH&SS by the Division of Medical Assistance, would be addressed by Sections 3 and 4 of the proposed legislation, and would allow the Department to provide mammography screening as an optional medical service to recipients of Medicaid.

The Department endorses periodic mammography screening as a cost-effective preventive health measure, and believes that payment for this service could be added at the low cost of \$10,000 for FY 92 because we expect little increase in the number of referrals from physicians. Currently, Medicaid does pay for diagnostic mammograms when ordered by a physician.

In the interest of maintaining consistency in the Medicaid statutes, we offer the following comments and recommendations.

As a specific medical service, mammography is just one of several thousand CPT-4 codes used universally to bill for medical services, and CPT-4 codes are usually dealt with in regulation rather than singling specific codes out for special treatment in statutory form. The rest of AS 47.07.130 deals with broad categories of services rather than specific CPT-4 codes. Therefore, it would be inconsistent with existing statute to single out this particular CPT-4 code as HB 45 would do in its current form.

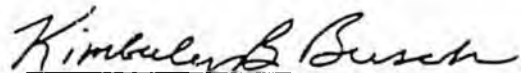
The Department would recommend the following alternative to the present Sections 3 and 4 of the proposed legislation.

In AS 47.07.030(b) we propose changing "low-dose mammography screening" to "adult screening", making an identical change in AS 47.07.035, and defining the proposed term in the existing definitions section, AS 47.07.900, using the definition as stated in the proposed legislation on page 2, lines 14-17.

There is a sensitive issue in the matter of where this new service is to be placed in the priority list of AS 47.07.035. This statute lists the optional services in the order in which they must be suspended or deleted if appropriations are inadequate. Where any service is to be placed on this list is a very subjective matter and invariably arouses strong sentiments among both medical providers and Medicaid recipients. Rather than argue the comparative importance of various medical services, the Department suggests that it may be appropriate to fall back on a principle used by some past legislatures: listing the newest service as first to be suspended. This is defensible on the grounds that the degree to which the public has come to depend on the coverage of any service is, in large measure, a function of how long that services has been covered.

It would therefore be our recommendation that the priority ranking for "adult screening" under AS 47.07.035 be revised to (1).

Recommended by:

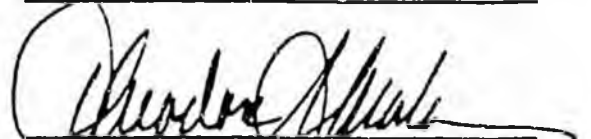


Kimberly B. Busch  
Acting Director  
Div. of Medical Assistance

Date:

1-29-91

Approved by:

  
Theodore A. Maia, MD, MPH  
Commissioner

Date:

29 Jan 1991

ALASKA STATE

# HOSPITAL & NURSING HOME

ASSOCIATION

January 24, 1991

Representative David Finkelstein, Chair  
Labor & Commerce Committee  
House of Representatives  
P. O. Box V  
Juneau, AK 99811

Support: HB 45

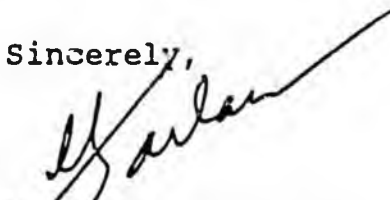
Dear Representative Finkelstein:

The Alaska Hospital & Nursing Home Association would like to lend its support to the passage of HB 45, mandating insurance coverage for mammograms.

Unfortunately I will be out of Juneau on January 29 and will not be able to testify at your Committee hearing on that date.

The bill speaks for itself. It is regretful the Legislature should have to tell either buyers or sellers of health insurance that this type of "preventive" medicine is just good common sense and should be part of an individuals insurance program.

Sincerely,

  
Harlan R. Knudson  
President/CEO

HRK/ma

cc: Members, House Labor & Commerce Committee  
Representative Finkelstein  
Representative Iverson  
Representative Donley  
Representative Bruckman  
Representative Taylor  
Representative Zawacki

✓ Representative Ulmer

# WELLSPRING

A WELLHEALTH CENTER

Mary Lou Follett, RNC, ANP  
Advanced Nurse Practitioner & Counselor

Constance Trollan, RNC, ANP  
Advanced Nurse Practitioner & Counselor

January 26, 1991

Representative Fran Ulmer  
Alaska House of Representatives  
P. O. Box V  
Juneau, Alaska 98211-3100

Dear Representative Ulmer:

Thank you for introducing legislation which will require health insurance carriers in Alaska to provide coverage for mammography screening.

The American Cancer Society states that annually 175,000 new cases and 44,500 deaths will result from breast cancer. This translates into one in nine women in America affected by this disease.

To detect breast cancer in its early, more curable stages, the American Cancer Society recommends breast self-exams every month for women ages 20 and older, a breast exam by a health professional every three years for women ages 20-40, and over 40 years, a clinical exam every year. In addition the American Cancer Society recommends a baseline mammogram for women 35-39 years, a biannual mammogram from 40-49, and an annual mammogram from ages 50 and over.

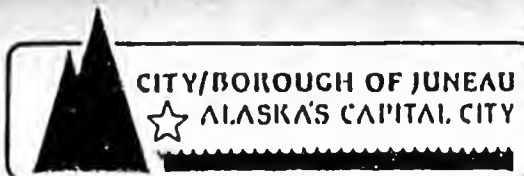
I believe that insurance carriers in Alaska should be required to pay for breast examinations including mammography as delineated by the American Cancer Society. As mammography and radiologist fees are expensive in Alaska, and as these should not be barriers to women seeking adequate women's health care, I suggest that a minimum payment of \$100.00 per woman for mammography be specified in legislation. This will enhance compliance with American Cancer Society guidelines and enable early detection of breast cancer in Alaskan women.

I wholeheartedly support your legislative attempts to require Alaskan insurance carriers to provide coverage.

Sincerely,



Constance Trollan  
Women's Health Care ANP



# LOOKING TO THE FUTURE

1991 ALASKA CONFERENCE ON AGING

JUNEAU COMMISSION ON AGING

COMMUNITY FORUM -- SENIOR CONCERNS

Assembly Chambers  
Juneau, Alaska  
January 26, 1991

## RESOLUTION IN SUPPORT OF HB 45

### RELATING TO MAMMOGRAPHY SCREENING

WHEREAS, breast cancer is the leading cause of premature death in American women; and

WHEREAS, 75% of breast cancers occur in women over age 50, and 40% of breast cancers occur in women over age 65; and

WHEREAS, mammography screening is the most effective means of detecting breast cancer in its curable stage; and

WHEREAS, in over 90% of the breast cancers detected in early stages the patient survives; and

WHEREAS, only 15% - 20% of women who should have a regular mammogram receive one; and

THEREFORE, BE IT RESOLVED, that it is in the interest of senior women to have insurance coverage for mammography screening; and

BE IT FURTHER RESOLVED, that HB 45, relating to insurance coverage for mammography screening, sponsored by Rep. Fran Ulmer, receives the support and endorsement of this organization.

SIGNED

DATE

1-26-91

KAREN S. O'BRIEN

3266 Bluebird Avenue  
Fairbanks, Alaska 99709  
(907) 479-3422

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February 6, 1991

RECEIVED  
FEB 8 - P.M.

Rep. Georgianna Lincoln  
Post Office Box "V"  
Juneau, Alaska 99811

RE: House Bill No. 45

Dear Representative Lincoln:

The Breast Cancer Detection Center in Fairbanks provides an invaluable service for the entire State of Alaska. With the recently proposed cuts, BCDC will be totally eliminated.

Please offer your support for House Bill No. 45 which would enable all individuals to obtain mammograms. Thank you.

Sincerely,



Karen S. O'Brien

# NFIB Alaska

National Federation of  
Independent Business

POSITION PAPER

OF

NATIONAL FEDERATION OF INDEPENDENT BUSINESS  
(NFIB/ALASKA)

TO THE

HOUSE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

ON

HB 45

AN ACT RELATING TO INSURANCE COVERAGE FOR MAMMOGRAMS;  
REQUIRING THE MEDICAL ASSISTANCE PROGRAM TO COVER  
MAMMOGRAMS; AND REORDERING THE PRIORITIES GRANTED  
TO SERVICES COVERED UNDER THE MEDICAL ASSISTANCE PROGRAM.

State Office  
9159 Skywood Lane  
Juneau, AK 99801  
(907) 789-4278



The Guardian of  
Small Business

NFIB/ALASKA POSITION PAPER

Mr. Chairman, members of the Health, Education and Social Services Committee, my name is Resa Jerrel, and I represent the National Federation of Independent Business/Alaska - NFIB/Alaska. Before giving my testimony on HB 45, it might be appropriate to briefly describe NFIB/Alaska and its legislative program.

NFIB/Alaska is comprised of 5400 small and independent business owners statewide.

The legislative agenda of NFIB/Alaska is determined by our ballot. The ballot is our annual poll of our membership on a series of issues deemed critical to small business. A majority vote, of the members in response to the poll, sets our policy and position on legislative issues. We then share the results of our poll with the Legislature and Administration. There is not enough space on the annual poll to place every possible issue to our membership. Therefore, we also use the three previous years ballots as guidance on issues.

The broad issue of mandated benefits is of great concern to our membership. On the 1990 ballot, we polled our members regarding their views on a similar issue, mandated mental/nervous disorders. The ballot results clearly show that small business owners overwhelmingly - 93% - oppose the government imposing such mandates on them. Any employee benefit package should be worked out between the employer and employee.

In recent years there has been an explosion of states passing laws requiring health insurance policies to cover specific diseases and specific health care services. Mandated health insurance benefits cover services ranging from acupuncture to

naturopaths.

Mandated benefits cover everything from life saving techniques to purely cosmetic devices, such as hair transplants in Minnesota. Collective, these mandates have added considerably to the cost of health insurance and they prevent people from buying no-frills insurance at a reasonable price.

We understand the purpose of this legislation is to act as an incentive for people to utilize this screening service. It is doubtful that will occur, because in Juneau a mammogram cost \$100-\$171. Most health insurance policies have a \$250, \$500 or \$1,000 deductibles. A person is still going to have an out of pocket expense of \$100 - \$171 even if their policy covers the x-ray service or they do not even have health insurance.

Our members believe in the freedom of choice in health insurance. This means being able to buy a health insurance policy tailored to individual, family and employee needs. With this in mind, we would offer an ALTERNATIVE to mandating this coverage: have the insurance companies offer this coverage as an option. With the ability to pick and choose a person can purchase it or choose not to purchase it.

We believe the issue is not whether this benefit and other similar benefits should be extended to employees; rather we believe it is instead, should this benefit be mandated by the Legislature.

Mr. Chairman, Members of the Committee, thank you for the opportunity to present our views on this issue.



**Alaska State Legislature**  
**House of Representatives**  
 COMMITTEE ON HEALTH, EDUCATION  
 AND SOCIAL SERVICES

DATE: February 21, 1991

PLACE: Capitol Room 106

**SUBJECT OF MEETING:**  
 HB 45 Insurance Coverage for Mammograms

NAME	REPRESENTING	BUSINESS/PERSONAL MAILING ADDRESS	ZIP	(H) PHONE	(W) PHONE	DO YOU WANT TO TESTIFY?		WHAT SUBJECT/ WHICH BILL?	
						Y	N		
(DO YOU WISH TO TESTIFY?)		(FILL OUT COMPLETELY!)							
JAN YOUNG	American Cancer Society	PO BOX 34337 JUNEAU, AK 99803	99803	789-3146			<input checked="" type="radio"/>	N	HB 45
GORDON LANDES	Div. of Medical Asst.	PO BOX 4-07, JUNEAU 99811	99801	465-775			Y	<input checked="" type="radio"/>	AVAILABLE FOR QUESTIONS HB 45
Jay Frank	State Farm Allstate	One Sealaska Pl Suite 303 JUNEAU AK	99801		6-5912		<input checked="" type="radio"/>	N	HB 45
Dr. Mike Frankie	American Cancer Soc	10301 Diagonal HLU JUNEAU AK	99801	789-0511	789-2910		<input checked="" type="radio"/>	N	HB 45
MIKE COUGHLIN	DIV OF RET/BENEFIT	PO BOX CR JUNO AK 99811		465-4470			Y	<input checked="" type="radio"/>	FOR QUESTIONS IF NEEDED HB 45
DON KOCH	DIV OF INSURANCE	PO BOX D JUNO AK 99811		<del>465-257</del>	465-257		<input checked="" type="radio"/>	N	HB 45
Bruce Brannigan	Admin/ Labor Educ	POC-0220, JUNEAU 99811		<del>789-220</del>	465-2441		<input checked="" type="radio"/>	N	HB 45
Rese Jemel	NFIB	9159 Skyward JUNEAU	99801	789-4278			<input checked="" type="radio"/>	N	HB 45
Gordon Evans	HIAA	318 4th St. JUNEAU	99801	586-3210	same		<input checked="" type="radio"/>	N	HB 45
SHERRIE GOLL	ALASKA WOMEN'S LEAGUE	P.O. Box 22156 JUNO AK	99802		463-6744		<input checked="" type="radio"/>	N	HB 45