SUBJECT: Providing treatment for breast and cervical cancer under Medicaid

COMMITTEE: Public Health — committee substitute recommended

VOTE: 6 ayes — Gray, Coleman, Capelo, Glaze, Maxey, Uresti

0 nays

2 present, not voting — Delisi, Wohlgemuth

1 absent — Glaze

WITNESSES: For —Susan Ghertner, Breast Cancer Resource Center of Austin and National Breast Cancer Coalition; Terri Jones, WINGS and Methodist Healthcare Ministries; *Registered but did not testify:* Laura Balla and Kelly Headrick, American Cancer Society; Larry Cernosek, The Rose; Anne Dunkelberg, Center for Public Policy Priorities; Patricia Kolodzey, Texas Hospital Association; Lisa McGiffert, Consumers Union; Maria Rankins, Sisters Network; Hannah Riddering, Texas National Organization for Women; Linda Rushing, Texas Conference of Catholic Health Facilities; John Umphress, Texas Association of Public and Nonprofit Hospitals; Jenny Young, Texas Medical Association; *(On committee substitute:)* Marc Samuels, U.S. Oncology and Texas Academy of Internal Medicine

Against — None

On — Judy Denton and David Freeland, Texas Department of Human Services; *Registered but did not testify:* Ron Gernsbacher and Margaret Mendez, Texas Department of Health

BACKGROUND: The federal Breast and Cervical Cancer Prevention and Treatment Act of 2000 provides enhanced matching funds to states that provide Medicaid to uninsured women under age 65 who have breast or cervical cancer identified through the Centers for Disease Control and Prevention's (CDC) National Breast and Cervical Cancer Early Detection Program (NBCCEDP). Diagnoses can include precancerous conditions and early-stage cancer. States also can create presumptive eligibility for this program to ensure that

treatment begins as early as possible. Presumptive eligibility allows enrollees to receive benefits while their applications are being processed, as long as they likely satisfy the eligibility requirements.

The NBCCEDP provides funding for breast and cervical cancer screening services, which include breast examination, mammograms, Pap tests, pelvic exams, and diagnostic services such as surgical consultations and biopsies. It provides no funding for treatment. For states to participate in this screening program, they must give priority to low-income women.

The new federal law creates a new optional category of Medicaid-eligible people. Women who would be eligible under this program must have been screened for breast or cervical cancer by the NBCCEDP and found to need treatment and must be under age 65 and not otherwise insured. The state cannot impose Medicaid income or resource limitations for applicants under this program. Women have continuous eligibility until the treatment for breast or cervical cancer is completed or other eligibility criteria (such as the age limit) no longer apply. Medicaid coverage provided under this program is full coverage, not limited to the treatment associated with the cancer.

The federal matching rate, or Federal Medical Assistance Percentage (FMAP), for this program is equivalent to the state's FMAP for the Children's Health Insurance Program (CHIP). In fiscal 2002, Texas' estimated FMAP for Medicaid is 60.57 percent, and the estimated FMAP for CHIP is 72.14 percent.

DIGEST:

CSHB 101 would direct the Texas Department of Human Services (DHS) to provide Medicaid benefits to people who need treatment for breast or cervical cancer and are eligible for assistance under the federal Breast and Cervical Cancer Prevention and Treatment Act of 2000.

People who applied for Medicaid under this program would, to the extent allowed by federal law, be exempt from the personal interview portion of the application process and would be enrolled continuously while receiving treatment. CSHB 101 also would direct DHS to develop a presumptive eligibility certification for this program and to simplify the process by which medical assistance providers are enrolled.

CSHB 101 would direct DHS to seek any necessary federal waivers or authorizations needed to implement the bill's provisions. The agency could delay implementation until the federal waivers or authorization was granted.

The bill would take effect September 1, 2001.

SUPPORTERS SAY:

CSHB 101 would save lives by providing treatment for breast and cervical cancer. State and federal programs screen low-income and uninsured women for these diseases but do not provide treatment when they find cancer. The program required by this bill would create a continuum of health services from screening through treatment.

This bill would maximize the state's Medicaid funding. Because the program carries the CHIP FMAP, the state would receive more federal money to insure these women than for traditional Medicaid enrollees.

CSHB 101 would take advantage of the presumptive eligibility option to ensure that women received treatment as soon as possible. If the state does not have presumptive eligibility, then women entering Medicaid through this program could be sicker than if they received treatment from the start, which would be unfavorable from the standpoint of costs.

OPPONENTS SAY:

CSHB 101 would increase Texas' Medicaid caseload, which should give the Legislature pause in an environment of rising costs and utilization. Medicaid caseloads have been higher than expected in fiscal 2000-01, in part because of past legislation to keep eligible individuals in Medicaid. Because of this, the state has spent $600 million more than appropriated for Medicaid. Given that costs are projected to continue to rise in the coming biennium, the state should be cautious about adding populations to those eligible for services.

This bill would provide Medicaid coverage for some women who already have insurance. The requirement that women not be otherwise insured would not prohibit women with health insurance that does not cover treatment for breast or cervical cancer from being eligible. For example, if a woman had a preexisting condition that precluded coverage for breast or cervical cancer under her health insurance, she would be eligible for Medicaid, assuming that she met the other eligibility criteria.

OTHER OPPONENTS SAY:

CSHB 101 should require cost sharing to reduce the cost of this program. Medicaid allows limited cost sharing in the form of nominal deductibles or coinsurance payments. These funds can be used to offset total federal and state expenditures. This type of funding arrangement allows individuals to participate in their health care and reduces the association with welfare.

The Legislature also should consider alternatives to general revenue for the state match. The Arkansas legislature is considering creating a health-care trust fund through a cigarette tax that would be disbursed as the state match for this type of program.

NOTES:

Both the House- and Senate-approved versions SB 1 by Ellis, the general appropriations bill for fiscal 2002-03, include a contingency rider for this legislation in the Article 11 “wish list.”

The committee substitute added the provisions for continuous eligibility, simplification of enrollment, presumptive eligibility, and personal interview exemption.

The companion bill, SB 532 by Nelson, which is identical to HB 101 as filed, passed the Senate on April 26 by voice vote and was reported favorably, as substituted, by the House Public Health Committee on May 2, making it eligible to be considered in lieu of HB 101.