

SB

78

ALASKA STATE LEGISLATURE



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Session:

State Capitol
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SENATOR LYDA GREEN
SENATE DISTRICT G

SPONSOR STATEMENT

SB 78

“An Act relating to an optional group of persons eligible for medical assistance who require treatment for breast and cervical cancer; relating to cost sharing by those recipients under the medical assistance program; providing for an effective date.”

Senate Bill 78, the Breast and Cervical Cancer program, removes the sunset provision of the 2001 legislation and continues treatment for women who have been participating in this program and for women who will be diagnosed in the future.

This bill gives authority to the Department of Health and Social Services to impose allowable cost sharing under federal authority for the breast and cervical cancer category. The State would then be able to work with the Federal government by submitting an amended state plan. It also provides for the implementation of a system by which these funds are collected.

I urge your support and swift passage of Senate Bill 78.

Breast & Cervical Cancer Screening Facts

The Breast and Cervical Cancer Mortality Prevention Act of 1990, authorized the Centers for Disease Control and Prevention (CDC) to fund breast and cervical cancer screening service for low-income women. The National Breast and Cervical Cancer Early Detection Program (NBCCEDP) provides:

- Breast and cervical cancer screening services to low income or un/underinsured women.
- Diagnostic medical follow-up, case management services and assurances for medical treatment.
- Public information and education programs to increase the use of screening services.
- Education to health professionals to improve the screening process.
- Quality monitoring of the screening process.
- Surveillance and epidemiological systems.
- Linkages with key partners.

In Alaska, there are five federally funded NBCCEDP grantees:

- Alaska Dept. of Health & Social Services' Breast and Cervical Health Check (BCHC) program;
- Southcentral Foundation (SCF);
- Southeast Alaska Regional Health Corporation (SEARHC);
- Yukon Kuskokwim Health Corporation (YKHC); and
- Arctic Slope Native Association (ASNA).



Together these programs provide services to nearly 18,000 Alaskan women annually.

Breast & Cervical Health Check (BCHC) is the State of Alaska Department of Health and Social Service's breast and cervical cancer screening program. In operation since March 1995, BCHC services are now available numerous communities statewide. BCHC works closely with tribal corporation colleagues to provide a network of coverage for native and non-native women throughout the State.

BCHC has screened more than 14,000 women since 1995. Seventy cases of breast cancer, 13 cases of cervical cancer, and 446 cases of pre-cancerous cervical disease have been detected among women enrolled in BCHC.

Alaska Native women receive NBCCEDP screening services from four tribal health programs:

- Arctic Slope Native Association (ASNA)
- Southcentral Foundation (SCF)
- Southeast Alaska Regional Health Corporation (SEARHC)
- Yukon/Kuskokwim Health Corporation (YKHC)

The four tribal health programs have screened more than 17,000 women since 1995.

The Burden of Cancer in Alaska

Breast & Cervical Cancer Occurrence (1996 – 1999)				
	1996	1997	1998	1999
Breast Cancer	265	287	326	294
Cervical Cancer	27	27	31	18

State of Alaska, Cancer Registry Data 2003

Breast & Cervical Cancer Mortality (1996 – 1999)				
	1996	1997	1998	1999
Breast Cancer	53	41	49	43
Cervical Cancer	6	4	5	6

State of Alaska, Cancer Registry Data 2003

Breast & Cervical Cancer Treatment in Alaska

The U.S. Congress enacted the Breast & Cervical Cancer Treatment Act in 2000, with very strong bipartisan support. In response to this, the Alaska State Legislature passed legislation allowing women enrolled in CDC funded programs and diagnosed with cancer to access Medicaid funds for cancer treatment.

Who is eligible for "Breast and Cervical" Medicaid?

To qualify for "Breast and Cervical" Medicaid, a woman must be:

- an enrolled client in one of the 5 CDC funded programs in Alaska (BCHC, SCF, SEARHC, YKHC, ASNA) prior to being diagnosed;
- diagnosed by a clinician in one of the 5 CDC programs;
- a resident of the US and have a Social Security Number;
- a resident of Alaska;
- age 18 - 64; and,
- have no creditable medical coverage

How long will each patient's Medicaid coverage last?

Until completion of treatment is determined by the woman's private health care provider.

What treatment services are covered?

Only clinically proven medical or surgical cancer treatments are covered. Such treatments typically include: surgery, chemotherapy or radiation therapy.

Medicaid coverage would end when:

- a woman turns 65 (and becomes Medicare eligible);
- she is no longer a state resident;
- she obtains creditable medical coverage; or
- she is no longer eligible for services from one of the screening and diagnostic programs.

FY02 Statistics on Treatment

- From July 2001 through June 2002, Medicaid paid treatment costs for 44 women with breast or cervical cancer, or a pre-cancerous cervical condition.
- The total cost to the State of Alaska was \$174,838.
- Federal funding paid \$411,279 of the \$586,118 total.
- The State of Alaska does not cover any costs for treatment of Alaska Native or Native American women under this special category of Medicaid. One hundred percent of IHS beneficiary treatment costs are paid for with federal dollars.

FY03 Treatment Projections

An estimated 69 women will qualify and need breast cancer treatment in FY03. Eleven women will need treatment for cervical cancer and 102 for pre-cancerous cervical conditions.

Sec. 47.07.020. Eligible persons.

(a) All residents of the state for whom the Social Security Act requires Medicaid coverage are eligible to receive medical assistance under 42 U.S.C. 1396 - 1396p (Title XIX, Social Security Act).

(b) In addition to the persons specified in (a) of this section, the following optional groups of persons for whom the state may claim federal financial participation are eligible for medical assistance:

Sec. 47.07.042. Recipient cost-sharing.

(a) Except as provided in (b) - (d) of this section, the state plan developed under AS 47.07.040 shall impose deductible, coinsurance, and copayment requirements on persons eligible for assistance under this chapter to the maximum extent allowed under federal law and regulations. The plan must provide that health care providers shall collect the allowable charge. The department shall reduce payments to each provider by the amount of the allowable charge. A provider may not deny services because a recipient is unable to share costs, but an inability to share costs imposed under this section does not relieve the recipient of liability for the costs.

(b) The state plan developed under AS 47.07.040 shall impose a copayment requirement for inpatient hospital services in an amount that is the lesser of

- (1) \$50 a day, up to a maximum of \$200 per discharge; or
- (2) the maximum allowed under federal law and regulations.

(c) If the department has clear and compelling reason to believe that application of the maximum allowable charges under (a) of this section to a specific service would not reduce state expenditures or would generate savings to the state that are insignificant in relation to the total cost containment possible,

then the department may waive the charges otherwise required under (a) of this section as to that specific service.

(d) In addition to the requirements established under (a) and (b) of this section, the department may require premiums or cost-sharing contributions from recipients who are eligible for benefits under AS 47.07.020(b)(13) and whose household income is between 150 and 200 percent of the federal poverty guideline. If the department requires premiums or cost-sharing contributions under this subsection, the department

(1) shall adopt in regulation a sliding scale for those premiums or contributions based on household income;

(2) may not exceed the maximums allowed under federal law; and

(3) shall implement a system by which the department or its designee collects those premiums or contributions

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[TITLE 42](#) > [CHAPTER 6A](#) > [SUBCHAPTER XIII](#) > [Sec. 300k.](#)

[Next](#)

Sec. 300k. - Establishment of program of grants to States

(a) In general

The Secretary, **acting** through the Director of the Centers for Disease Control and **Prevention**, may make grants to States on the basis of an established competitive review process for the purpose of carrying out programs -

(1)

to screen women for **breast** and cervical **cancer** as a preventive health measure;

(2)

to provide appropriate referrals for medical treatment of women screened pursuant to paragraph (1) and to ensure, to the extent practicable, the provision of appropriate follow-up services and support services such as case management;

(3)

to develop and disseminate public information and education programs for the detection and control of **breast** and cervical **cancer**;

(4)

to improve the education, training, and skills of health professionals (including allied health professionals) in the detection and control of **breast** and cervical **cancer**;

(5)

to establish mechanisms through which the States can monitor the quality of screening procedures for **breast** and cervical **cancer**, including the interpretation

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of such procedures; and

(6)

to evaluate activities conducted under paragraphs (1) through (5) through appropriate surveillance or program-monitoring activities.

(b) Grant and contract authority of States

(1) In general

A State receiving a grant under subsection (a) of this section may, subject to paragraphs (2) and (3), expend the grant to carry out the purpose described in such subsection through grants to public and nonprofit private entities and through contracts with public and private entities.

(2) Certain applications

If a nonprofit private entity and a private entity that is not a nonprofit entity both submit applications to a State to receive an award of a grant or contract pursuant to paragraph (1), the State may give priority to the application submitted by the nonprofit private entity in any case in which the State determines that the quality of such application is equivalent to the quality of the application submitted by the other private entity.

(3) Payments for screenings

The amount paid by a State to an entity under this subsection for a screening procedure under subsection (a) (1) of this section may not exceed the amount that would be paid under part B of title XVIII of the Social Security Act (42 U.S.C. 1395j et seq.) if payment were made under such part for furnishing the procedure to a woman enrolled under such part.

(c) Special consideration for certain States

In making grants under subsection (a) of this section to States whose initial grants under such subsection are made for fiscal year 1995 or any subsequent fiscal year, the Secretary shall give special consideration to any State whose proposal for carrying out programs under such subsection -

(1)

has been approved through a process of peer review;
and

(2)

is made with respect to geographic areas in which there is -

(A)

a substantial rate of mortality from **breast** or **cervical cancer**; or

(B)

a substantial incidence of either of such **cancers**.

(d) Coordinating committee regarding year 2000 health objectives

The Secretary, **acting** through the Director of the Centers for Disease Control and **Prevention**, shall establish a committee to coordinate the activities of the agencies of the Public Health Service (and other appropriate Federal agencies) that are carried out toward achieving the objectives established by the Secretary for reductions in the rate of mortality from **breast** and **cervical cancer** in the United States by the year 2000. Such committee shall be comprised of Federal officers or employees designated by the heads of the agencies involved to serve on the committee as representatives of the agencies, and such representatives from other public or private entities as the Secretary determines to be appropriate

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Sec. 1396r-1b. - Presumptive eligibility for certain breast or cervical cancer patients

(a) State option

A State plan approved under section 1396a of this title may provide for making medical assistance available to an individual described in section 1396a(aa) of this title (relating to certain **breast or cervical cancer** patients) during a presumptive **eligibility** period.

(h) Definitions

For purposes of this section:

(1) Presumptive eligibility period

The term "presumptive **eligibility** period" means, with respect to an individual described in subsection (a) of this section, the period that -

(A)

begins with the date on which a qualified entity determines, on the basis of preliminary information, that the individual is described in section 1396a(aa) of this title; and

(B)

ends with (and includes) the earlier of -

(i)

the day on which a determination is made with respect to the **eligibility** of such individual for services under the State plan; or

(ii)

in the case of such an individual who does not file an application by the last day of the month following the month during which the entity makes the determination referred to in subparagraph (A), such last day.

(2) Qualified entity

(A) In general

Subject to subparagraph (B), the term "qualified entity" means any entity that -

(i)

is **eligible** for payments under a State plan approved under this subchapter; and

(ii)

is determined by the State agency to be capable of making determinations of the type described in paragraph (1)(A).

(B) Regulations

The Secretary may issue regulations further limiting those entities that may become qualified entities in order to prevent fraud and abuse and for other reasons.

(C) Rule of construction

Nothing in this paragraph shall be construed as preventing a State from limiting the classes of entities that may become qualified entities, consistent with any limitations imposed under subparagraph (B).

(c) Administration

(1) In general

The State agency shall provide qualified entities with -

(A)

such forms as are necessary for an application to be made by an individual described in subsection (a) of this section for medical assistance under the State plan; and

(B)

information on how to assist such individuals in completing and filing such forms.

(2) Notification requirements

A qualified entity that determines under subsection (b)(1)(A) of this section that an individual described in subsection (a) of this section is presumptively **eligible** for medical assistance under a State plan shall -

(A)

notify the State agency of the determination within 5 working days after the date on which determination is made; and

(B)

inform such individual at the time the determination is made that an application for medical assistance under the State plan is required to be made by not later than the last day of the month following the month during which the determination is made.

(3) Application for medical assistance

In the case of an individual described in subsection (a) of this section who is determined by a qualified entity to be presumptively **eligible** for medical assistance under a State plan, the individual shall apply for medical assistance under such plan by not later than the last day of the month following the month during which the determination is made.

(d) Payment

Notwithstanding any other provision of this subchapter, medical assistance that -

(1)

is furnished to an individual described in subsection (a) of this section -

(A)

during a presumptive **eligibility** period;

(B)

by a ^[1] entity that is **eligible** for payments under the State plan; and

(2)

is included in the care and services covered by the State plan,

shall be treated as medical assistance provided by such plan for purposes of clause (4) of the first sentence of section 1396d(b) of this title



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The National Breast and Cervical Cancer Early Detection Program



Get a free or low-cost mammogram and Pap test.

Go to our [program contacts](#) page or call 1-888-842-6355 (select option 7).

The National Breast and Cervical Cancer Early Detection Program (NBCCEDP) builds the infrastructure for breast and cervical cancer early detection by supporting public and provider education, quality assurance, surveillance, and evaluation activities critical to achieving maximum utilization of the screening, diagnostic and case management services. Funded comprehensive early detection programs provide

- Breast and cervical cancer screening services to women who are low income and to racial/ethnic minorities.
- Appropriate referrals, and when necessary, appropriate diagnostic follow-up, case management and assurances for medical treatment.
- Public information and education programs to increase the use of screening services.
- Education to health professionals to improve the screening process.
- Mechanisms to monitor the quality of the screening process.
- Appropriate surveillance and epidemiological systems.
- Linkages with key partnerships.



- [Conference Overview](#)
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Featured Article
[Invasive Cervical Cancer Incidence Among Hispanic and Non-Hispanic Women — United States, 1992–1999](#)


Breast Cancer and Mammography Information

Cervical Cancer and Pap test Information



"Early detection through screening is our best defense against morbidity and mortality from breast and cervical cancers and precancers. Since 1990, the National Breast and Cervical Cancer Early Detection Program (NBCCEDP) has been working in states, U.S. Territories, and tribal organizations to ensure women with little or no insurance have access to lifesaving cancer screening, diagnostic, and treatment services. As of 2002, the NBCCEDP has provided breast and cervical cancer screening services to more than 1.5 million uninsured and underinsured women."

Julle L. Gerberding, MD, MPH, Director,
Centers for Disease Control and Prevention

 Please note: Some of these publications are available for download only as *.pdf files. These files require Adobe Acrobat Reader in order to be viewed. Please review the information on using and downloading Acrobat Reader software.

Congress established The National Breast and Cervical Cancer Early Detection Program (NBCCEDP) in 1991 by enacting the Breast and Cervical Cancer Mortality Prevention Act of 1990, Public Law 101-354 (PDF-37K). This act authorizes CDC to provide critical breast and cervical cancer screening services to underserved women, including older women, women with low incomes, and women of racial and ethnic minority groups. Reauthorization of the program and changes to the law since its passage are described in the document below.



National Breast and Cervical Cancer Early Detection Program: Authorizing and Related Legislation

Páginas del internet sobre el cáncer en español

- Información sobre el cáncer de seno y la mamografía

Public Law 106-354
106th Congress

An Act

To amend title XIX of the Social Security Act to provide medical assistance for certain women screened and found to have breast or cervical cancer under a federally funded screening program, to amend the Public Health Service Act and the Federal Food, Drug, and Cosmetic Act with respect to surveillance and information concerning the relationship between cervical cancer and the human papillomavirus (HPV), and for other purposes.

Oct. 24, 2000

[H.R. 4386]

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Breast and Cervical Cancer Prevention and Treatment Act of 2000".

Breast Cancer
Prevention and
Treatment Act of
2000.
42 USC 1305
note.

SEC. 2. OPTIONAL MEDICAID COVERAGE OF CERTAIN BREAST OR CERVICAL CANCER PATIENTS.

(a) COVERAGE AS OPTIONAL CATEGORICALLY NEEDY GROUP.—

(1) IN GENERAL.—Section 1902(a)(10)(A)(ii) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(ii)) is amended—

- (A) in subclause (XVI), by striking "or" at the end;
- (B) in subclause (XVII), by adding "or" at the end;

and

(C) by adding at the end the following:

"(XVIII) who are described in subsection (aa) (relating to certain breast or cervical cancer patients);".

(2) GROUP DESCRIBED.—Section 1902 of the Social Security Act (42 U.S.C. 1396a) is amended by adding at the end the following:

"(aa) Individuals described in this subsection are individuals

who—

"(1) are not described in subsection (a)(10)(A)(i);

"(2) have not attained age 65;

"(3) have been screened for breast and cervical cancer under the Centers for Disease Control and Prevention breast and cervical cancer early detection program established under title XV of the Public Health Service Act (42 U.S.C. 300k et seq.) in accordance with the requirements of section 1504 of that Act (42 U.S.C. 300n) and need treatment for breast or cervical cancer; and

"(4) are not otherwise covered under creditable coverage, as defined in section 2701(c) of the Public Health Service Act (42 U.S.C. 300gg(c))."

(3) **LIMITATION ON BENEFITS.**—Section 1902(a)(10) of the Social Security Act (42 U.S.C. 1396a(a)(10)) is amended in the matter following subparagraph (G)—

(A) by striking “and (XIII)” and inserting “(XIII)”; and

(B) by inserting “, and (XIV) the medical assistance made available to an individual described in subsection (aa) who is eligible for medical assistance only because of subparagraph (A)(10)(ii)(XVIII) shall be limited to medical assistance provided during the period in which such an individual requires treatment for breast or cervical cancer” before the semicolon.

(4) **CONFORMING AMENDMENTS.**—Section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)) is amended in the matter preceding paragraph (1)—

(A) in clause (xi), by striking “or” at the end;

(B) in clause (xii), by adding “or” at the end; and

(C) by inserting after clause (xii) the following:

“(xiii) individuals described in section 1902(aa).”

(b) **PRESUMPTIVE ELIGIBILITY.**—

(1) **IN GENERAL.**—Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) is amended by inserting after section 1920A the following:

“**PRESUMPTIVE ELIGIBILITY FOR CERTAIN BREAST OR CERVICAL
CANCER PATIENTS**

“**SEC. 1920B. (a) STATE OPTION.**—A State plan approved under section 1902 may provide for making medical assistance available to an individual described in section 1902(aa) (relating to certain breast or cervical cancer patients) during a presumptive eligibility period.

“(b) **DEFINITIONS.**—For purposes of this section:

“(1) **PRESUMPTIVE ELIGIBILITY PERIOD.**—The term ‘presumptive eligibility period’ means, with respect to an individual described in subsection (a), the period that—

“(A) begins with the date on which a qualified entity determines, on the basis of preliminary information, that the individual is described in section 1902(aa); and

“(B) ends with (and includes) the earlier of—

“(i) the day on which a determination is made with respect to the eligibility of such individual for services under the State plan; or

“(ii) in the case of such an individual who does not file an application by the last day of the month following the month during which the entity makes the determination referred to in subparagraph (A), such last day.

“(2) **QUALIFIED ENTITY.**—

“(A) **IN GENERAL.**—Subject to subparagraph (B), the term ‘qualified entity’ means any entity that—

“(i) is eligible for payments under a State plan approved under this title; and

“(ii) is determined by the State agency to be capable of making determinations of the type described in paragraph (1)(A).

“(B) REGULATIONS.—The Secretary may issue regulations further limiting those entities that may become qualified entities in order to prevent fraud and abuse and for other reasons.

“(C) RULE OF CONSTRUCTION.—Nothing in this paragraph shall be construed as preventing a State from limiting the classes of entities that may become qualified entities, consistent with any limitations imposed under subparagraph (B).

“(c) ADMINISTRATION.—

“(1) IN GENERAL.—The State agency shall provide qualified entities with—

“(A) such forms as are necessary for an application to be made by an individual described in subsection (a) for medical assistance under the State plan; and

“(B) information on how to assist such individuals in completing and filing such forms.

“(2) NOTIFICATION REQUIREMENTS.—A qualified entity that determines under subsection (b)(1)(A) that an individual described in subsection (a) is presumptively eligible for medical assistance under a State plan shall—

“(A) notify the State agency of the determination within 5 working days after the date on which determination is made; and

“(B) inform such individual at the time the determination is made that an application for medical assistance under the State plan is required to be made by not later than the last day of the month following the month during which the determination is made.

“(3) APPLICATION FOR MEDICAL ASSISTANCE.—In the case of an individual described in subsection (a) who is determined by a qualified entity to be presumptively eligible for medical assistance under a State plan, the individual shall apply for medical assistance under such plan by not later than the last day of the month following the month during which the determination is made.

“(d) PAYMENT.—Notwithstanding any other provision of this title, medical assistance that—

“(1) is furnished to an individual described in subsection (a)—

“(A) during a presumptive eligibility period;

“(B) by a entity that is eligible for payments under the State plan; and

“(2) is included in the care and services covered by the State plan,

shall be treated as medical assistance provided by such plan for purposes of clause (4) of the first sentence of section 1905(b).”.

(2) CONFORMING AMENDMENTS.—

(A) Section 1902(a)(47) of the Social Security Act (42 U.S.C. 1396a(a)(47)) is amended by inserting before the semicolon at the end the following: “and provide for making medical assistance available to individuals described in subsection (a) of section 1920B during a presumptive eligibility period in accordance with such section”.

(B) Section 1903(u)(1)(D)(v) of such Act (42 U.S.C. 1396b(u)(1)(D)(v)) is amended—

(i) by striking “or for” and inserting “, for”; and

(ii) by inserting before the period the following:
 “, or for medical assistance provided to an individual described in subsection (a) of section 1920B during a presumptive eligibility period under such section”.

(c) **ENHANCED MATCH.**—The first sentence of section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)) is amended—

(1) by striking “and” before “(3)”; and

(2) by inserting before the period at the end the following:
 “, and (4) the Federal medical assistance percentage shall be equal to the enhanced FMAP described in section 2105(b) with respect to medical assistance provided to individuals who are eligible for such assistance only on the basis of section 1902(a)(10)(A)(ii)(XVIII)”.

(d) **EFFECTIVE DATE.**—The amendments made by this section apply to medical assistance for items and services furnished on or after October 1, 2000, without regard to whether final regulations to carry out such amendments have been promulgated by such date.

Applicability.
 42 USC 1396a
 note.

Approved October 24, 2000.

LEGISLATIVE HISTORY—H.R. 4386 (S. 662):

SENATE REPORTS: No. 106-323 accompanying S. 662 (Comm. on Finance).
CONGRESSIONAL RECORD, Vol. 146 (2000):

May 9, considered and passed House.

Oct. 4, considered and passed Senate, amended, in lieu of S. 662.

Oct. 12, House concurred in Senate amendment.

WEEKLY COMPILATION OF PRESIDENTIAL DOCUMENTS, Vol. 36 (2000):

Oct. 24, Presidential statement.



FISCAL NOTE

STATE OF ALASKA
2003 LEGISLATIVE SESSION

Fiscal Note Number: _____
Bill Version: SB78
() Publish Date: _____

Revision Date/Time (Note if correction): Corrected 2/24/03 Dept. Affected: Health & Social Services

Title: MEDICAID FOR BREAST AND CERVICAL CANCER BRU: Medical Assistance
Component: Medicaid Services

Sponsor: GREEN

Requester: SENATE (HES0) Component No.: 2077

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims	970.0	1,108.8	1,265.6	1,442.6	1,642.5	1,867.8
Miscellaneous						
TOTAL OPERATING	970.0	1,108.8	1,265.6	1,442.6	1,642.5	1,867.8

CAPITAL EXPENDITURES						
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CHANGE IN REVENUES (0)						
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FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	687.5	785.8	896.9	1,022.4	1,164.0	1,323.7
1003 GF Match	282.5	323.0	368.7	420.2	478.5	544.1
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other(Specify Type-do not abbreviate)						
TOTAL	970.0	1,108.8	1,265.6	1,442.6	1,642.5	1,867.8

Estimate of any current year (FY2003) cost: 847.3

Mark this box (X) if funding for this bill is included in the Governor's FY 2004 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: (Attach a separate page if necessary)

This legislation continues the optional breast and cervical cancer Medicaid eligibility category, which is due to sunset June, 30, 2003. This legislation also authorizes recipient premiums and cost-sharing to the maximum extent allowed under federal law.

In FY2002 Medicaid spent \$584,364 (\$403,032 Federal funds, \$181,332 general funds) to pay for the treatment costs of 22 women diagnosed with breast cancer, 9 diagnosed with cervical cancer, and 13 with pre-cancerous cervical conditions. In future years we expect expenditures to grow at a rate typical of general Medicaid expenditures, but with only a slight increase in the number of individuals taking advantage of this eligibility category. See our assumptions on the next page.

Prepared by: Kevin Henderson Phone 465-5821
Division: Medical Assistance Date/Time 02/21/2003
Approved by: Joel S. Gilbertson, Commissioner Date 02/24/2003
Agency: Department of Health and Social Services

FISCAL NOTE
FN #

STATE OF ALASKA
2003 LEGISLATIVE SESSION

BILL NO. SB7

ANALYSIS CONTINUATION

Assumptions used in making this fiscal note:

1. The number of women who have taken advantage of this program is lower than the numbers projected last year by the Division of Public Health. Part of the reason for the reduced number of eligibles is that Alaska Native women screened and diagnosed by the four tribal grantees are not applying for Medicaid. The number of anticipated recipients is expected to increase slightly. We assume a 5% increase in total recipients for each fiscal year.
2. To estimate future expenditures, we began by looking at the cost of services provided to women eligible under the breast and cervical cancer category in FY2002. The average cost per recipient in FY2002 was \$24.0 for breast cancer, \$4.9 for cervical cancer, and \$.8 for precancerous cervical conditions. However, the trend for FY 03 appears to be 45% higher than FY2002. The program was new in FY 2002, so we believe the FY2003 increase seen so far is due to the fact that current recipients have had time to move from needing treatment to actually being in or having received full treatment. We established a FY2003 base cost that is 45% higher than FY2002. Beginning with FY 2004 we estimate that Medicaid expenditures in this category will grow at a rate of 10% per year, similar to the national average growth for Medicaid spending.

The enhanced federal match rate used is 70.87%.

Funding for this bill is in the Division's base budget, however, the Governor's FY2004 Budget has not been finalized at this point.

Cost-Sharing: This legislation authorizes the department to charge recipient premiums or impose the maximum allowed cost-sharing requirements on recipients based upon household income and using a sliding fee scale. Except for the Working Disabled Medicaid Buy-In eligibility category, Federal law and regulations prohibit states from imposing a premium on "categorically needy individuals", including the breast and cervical cancer category. The department does have authority to impose "nominal" deductibles, coinsurance, or co-payments for recipients in this category. 7 AAC 43.052 already imposes the maximum allowable co-insurance payment for outpatient hospital services, the maximum \$3 co-payment for each physician visit, a \$2 co-payment for each prescription drug filled, and \$50 co-payment per day of inpatient hospitalization (up to a maximum \$200). Federal regulations allow states to require a monthly deductible amount capped at \$2 per month per family member, but prohibit states from imposing more than one type of charge at the same time. Slight increases may be made in hospital co-payments and prescription drugs (depending upon the cost of the drug), but considering the small number of recipients the revenue would be negligible and was not estimated.

SENATE COMMITTEE REPORT First Committee of Referral

DATE: 2/21/03

FURTHER: Finance

Date of 5-Day Notice: _____
(in accordance with Uniform Rule 23)

DATE TURNED
IN TO OFFICE: 2.26.03

Health, Education and Social Services Committee considered

SENATE BILL NO. 78

SB 78 MEDICAID FOR BREAST & CERVICAL CANCER

"An Act relating to an optional group of persons eligible for medical assistance who require treatment for breast and cervical cancer; relating to cost sharing by those recipients under the medical assistance program; and providing for an effective date."

and recommends:

be replaced with _____ CS _____ (_____)

adopt previous _____ CS _____ (_____)

attached amendment(s)

adopt Letter of Intent by _____ Committee

further referral to _____ Committee

Senate Bill:

same title

new title

House Bill:

same title

technical title

new: SCR # _____

NEW FISCAL NOTE(S):

Department	Date	Fiscal	Zero	FN#
HSS	2/24	X		

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Zero	FN#

APPROPRIATION - no fiscal note

SIGNATURES AND RECOMMENDATIONS:	Do PASS	Do NOT PASS	No REC	AMEND
<i>Paul Ryan</i>	✓			
<i>Garry White</i>	✓			
<i>Bettye Davis</i>				✓
<i>Lydia Green</i>	✓			
<i>Arthur L. H.</i>			✓	
CHAIR:				

2-28-03

I submit the following testimony on the bills listed below to the committees listed. Please distribute this testimony for public record and copy all the Senate HESS and House and Senate FINANCE committee members. I verbally gave this same public testimony to the Senate HESS Committee on Wednesday, February 26th at 2:00 p.m., but I was informed that the transmission was inaudible in Juneau. Please also copy Senator Bettye Davis and Representative Kerttula.

- ✓ SB-78 - Senate HESS Committee – Chair Dyson and Vice-Chair L. Green
- SB-78 - Senate Finance Committee – Chair L Green
- HB-21 and HB-107 House Finance Committee – Co-chairs Harris and Williams

My name is Carla Williams and I am the president of Alaska Breast Cancer Advocacy Partners and the state field coordinator for the National Breast Cancer Coalition. ABCAP collected over 1200 signatures in the last few weeks supporting the extension of the breast and cervical cancer treatment program. Over the past two years, many people of Alaska (state legislators, governors, U.S. Senators, and people from all walks of life) have worked together to first, get the program into reality and second, to make sure that the program does not end in June 2003. I thank you all. I'm pleased that the legislature is moving a bill forward toward this effort.

I think that people have been working together to pass legislation. Has the public been given all the information they need to make a sound decision? I believe that is debatable.

It is my understanding that SB78 provides the language necessary to make future changes to the breast and cervical cancer treatment program at the discretion of the state without having to go through public scrutiny. It is not a secret that President Bush's recent budget asks for capping federal Medicaid spending and giving broad flexibility to states to cut Medicaid eligibility, benefits, provider reimbursements, along with services in rural communities. Budget deficits are a big problem for states across the U.S. and the federal changes will allow the states to get some relief by tapping into Medicaid and Medicare. If, or when, those federal restrictions are lifted, and I predict they will be lifted sooner than later, states will be given the green light to move forward in their efforts to undermine the original intent of this program, which is to provide financial assistance to women who cannot afford breast and cervical cancer treatment after being diagnosed with cancer through the screening program. Whether our state legislators become the stewards of keeping this program alive and vital, time will tell. Whether people who need these services will be either eligible for the program or able to afford the costs, again, time will tell.

Although co-payments and a sliding scale may make sense to the average person today, I predict that this program will look a lot different in a few years. Since these are only predictions, I cannot accurately know what the future holds for passing SB78, except that by passing this bill, the program will not end this June and I think people, for now, are satisfied with that concept. Thank you for giving me this opportunity to speak.

*Carla Williams, 13001 NORAK PLACE
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