

From Cancer Treatment to Health Policy for the Uninsured: The Breast and Cervical Cancer Prevention and Treatment Act of 2000

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Health Services Research in Progress: Main Study Purposes

- Immediate
 - To gauge the course of implementation of a unique model of health insurance of major import to cancer treatment and of far-reaching precedence
- Longer term
 - To allow the measurement of the impact of an insurance intervention on access by women to quality cancer treatment for breast and cervical cancer

Research Objectives

- To measure the evolution from public law to functioning health care intervention
- To measure the viability of condition-specific insurance coverage and its potential application to other sick uninsured populations (e.g., persons with identified HIV, mental illness, other forms of cancer, diabetes)
- To assist the CDC better understand the relationship between population based screening and access to insured care
- To illuminate the profound ethical issues raised by the Act's peculiar structure, which emanated from Congress's own limited understanding of how the health care system operates

What Makes This Health Services Research Project So Important from a Policy Vantage Point?

- The legislation has the potential to do enormous good and lends itself to important replication
- Despite its potential, the legislation contains a potentially profound limitation that grows out of Congress' failure to understand the impact of fragmented health care financing arrangements for uninsured people
- The legislation attempts to bridge two worlds -- population based screening and public insurance -- that have the most limited imaginable history of collaboration despite their shared public missions

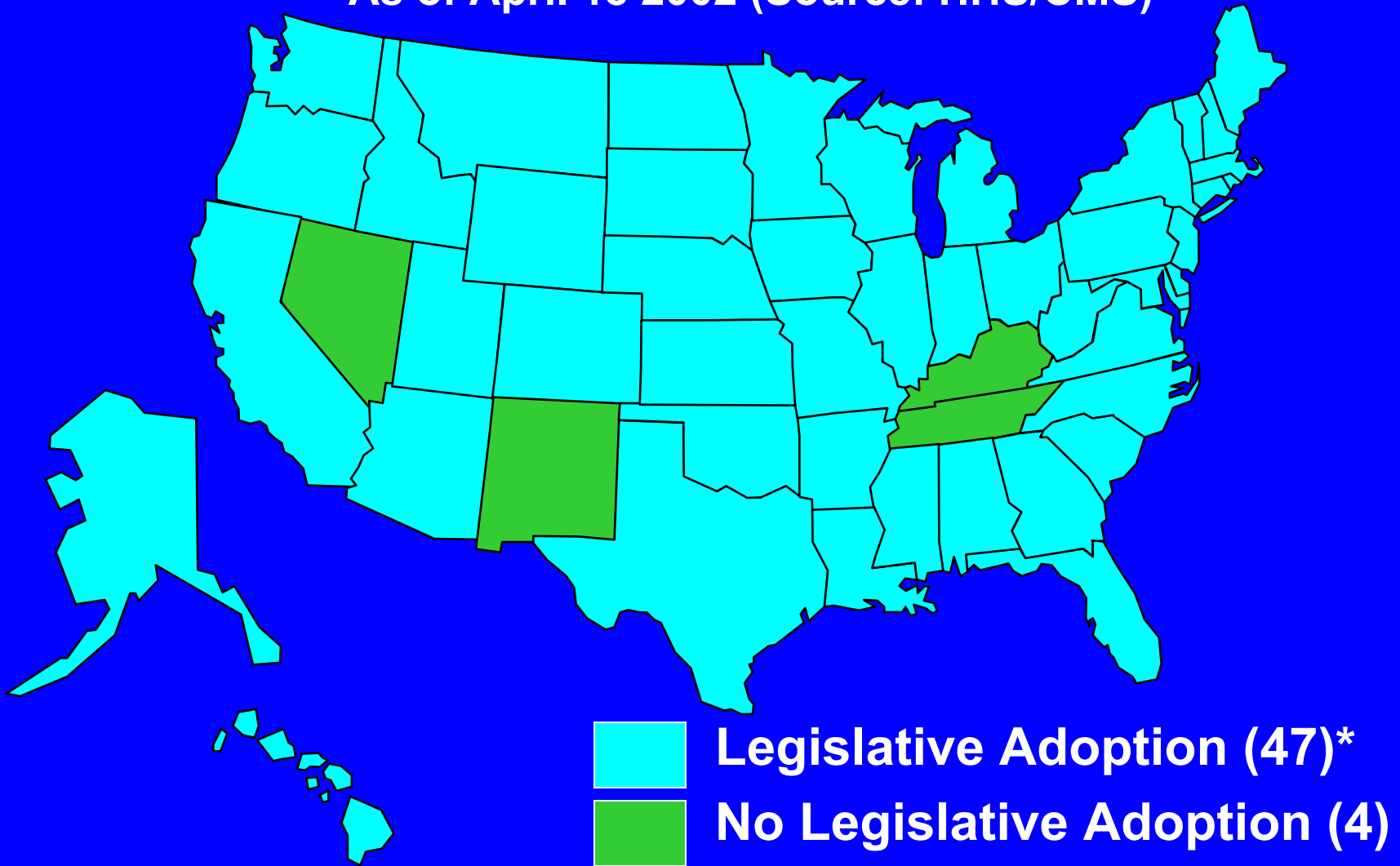
Terms of the Legislation

- Enacted in October, 2000
- Deceptively simple state coverage option permitting states to extend Medicaid to individuals who :
 - have not attained age 65
 - have been screened for breast and cervical cancer *under the [CDC] breast and cervical cancer early detection program* and need treatment for breast or cervical cancer
 - are not otherwise covered under “creditable coverage”

States Respond with Lightning Speed

Implementation of BCCPTA

As of April 18 2002 (Source: HHS/CMS)



* Note: legislation does not equal full implementation; implemented in 37 states to date.

Problem Number 1: What Did States Adopt, Anyway?

- Which individuals are recognized as having been identified “under” the “CDC program”? What does this pathway really mean?
- What about women identified through alternative cancer screening programs (e.g., neighborhood clinics or family planning programs funded through entirely other sources of public funding, public hospitals, migrant health centers, etc.)
- How do states address this looming inequity created by the Act’s terminology?

Federal Guidelines

- Three implementation design choices: broad, broader, broadest entry “pathways”
 - 1. Only individuals whose screens were underwritten by specific CDC screening funds
 - 2. Individuals screened by providers that receive CDC funding, regardless of the funding source for their particular screen
 - 3. Individuals screened by any provider of cancer screening to uninsured patients

Implications

- Medicaid coverage for women screened by a mobile van supported by CDC funds but not migrant women served by a rural migrant clinic
- Medicaid coverage for women screened by a CDC-funded hospital but not by another that donates services
- In short, women get insurance help depending on their source of population-based services

What's Going On Here, Anyway?

- Did Congress really intend this result? If not, how did this law ever come into existence?
- Did states fully appreciate the significance of the “pathway” distinctions they were permitted to draw?
- As the pathway implications become clear, what actions if any does government take?
- Is this a model we want to replicate? If so, how do we avoid the pathways dilemma, or do we? Does the nation in fact want a policy of rationing by the peculiarities of health care delivery system configuration?

Our Task as Policy Researchers is More than Answering the Technical Health Services Questions

- If we do our job properly, then the ethical and policy dilemmas created by the Act probably will be fully understood as a direct outgrowth of the highly fragmented approach the U.S. takes to health care financing, and options for addressing this dilemma will be offered.

Problem #2: Public Health/Insurance Collaboration

- Can public health and insurers collaborate?
- Can agencies accustomed to identifying evidence of abnormality translate relatively passive screening efforts into active insurance enrollment and treatment support efforts?
- Can insurers collaborate with population health experts in the design of coverage rules, delivery structures, and other aspects of insurance?
- Can two autonomous agencies develop the data networks they need to be able to communicate design and administration matters in real time?

Our Role as Policy Researchers

- To use health services research techniques to illuminate basic lessons about one of the critical issues of our time: the ability of public health and health care payers to collaborate around a matter of high population concern