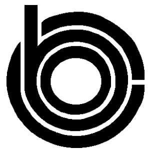

CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

November 10, 1999

H.R. 1070
Breast and Cervical Cancer Prevention and Treatment Act of 1999

As ordered reported by the House Committee on Commerce on October 28, 1999

SUMMARY

H.R. 1070 would allow states to receive federal Medicaid funds for providing medical care to low-income women who have been screened under a Centers for Disease Control and Prevention (CDC) screening program and found to have breast or cervical cancer. The bill also would reduce Medicare expenditures on partial hospitalization services for mental health conditions; would require the CDC to undertake surveillance, prevention, and education activities with respect to the human papillomavirus (HPV); and would require manufacturers of condoms to change their labels to state that the product does not effectively prevent transmission of HPV.

CBO estimates that the bill would increase direct spending by $205 million over the 2000-2004 period. Assuming appropriation of authorized amounts for CDC's new responsibilities, CBO estimates increased discretionary spending of $43 million over the same five-year period.

H.R. 1070 would impose a private-sector mandate as defined in the Unfunded Mandates Reform Act (UMRA), but CBO estimates that the costs associated with the mandate would fall well below the $100 million threshold established in UMRA. H.R. 1070 contains no intergovernmental mandates as defined in UMRA. CBO estimates that states would spend an additional $93 million on their Medicaid programs over the 2000-2004 period to implement the provision that would allow them to increase such spending for the treatment of breast and cervical cancer.

ESTIMATED COST TO THE FEDERAL GOVERNMENT

The estimated budgetary impact of H.R. 1070 is shown in the following table. The costs of this legislation fall within budget functions 550 (health) and 570 (Medicare).

	By Fiscal Year, in Millions of Dollars				
	2000	2001	2002	2003	2004
CHANGES IN DIRECT SPENDING					
Breast and Cervical Cancer Treatment					
Medicaid					
Estimated Budget Authority	0	25	60	85	110
Estimated Outlays	0	25	60	85	110
Mental Health Partial Hospitalization					
Medicare					
Estimated Budget Authority	-7	-16	-17	-17	-18
Estimated Outlays	-7	-16	-17	-17	-18
Medicaid					
Estimated Budget Authority	a	a	a	a	a
Estimated Outlays	a	a	a	a	a
Total Direct Spending					
Estimated Budget Authority	-7	9	43	68	92
Estimated Outlays	-7	9	43	68	92
CHANGES IN SPENDING SUBJECT TO APPROPRIATION					
Centers for Disease Control and Prevention					
Estimated Authorization Level	12	10	10	10	11
Estimated Outlays	4	9	10	10	10

a. Savings of less than $500,000.

BASIS OF ESTIMATE

For the purpose of this estimate CBO assumes that H.R. 1070 will be enacted in November 1999 and that the authorized funds will be appropriated for each fiscal year.

Optional Medicaid Coverage of Certain Breast or Cervical Cancer Patients

H.R. 1070 would give states the option of providing Medicaid coverage to women who have been screened under the CDC's National Breast and Cervical Cancer Early Detection Program and found to have breast or cervical cancer. States with a federal Medicaid match rate below 75 percent would receive a 75 percent match rate for services to women newly eligible for Medicaid under the provision. States with a higher match rate would receive their regular match rate. Federal Medicaid funds would be available beginning in fiscal year 2001. CBO estimates that the provision would increase federal Medicaid spending by $280 million over the 2000-2004 period.

Under current law, women with breast or cervical cancer are eligible for Medicaid only if they fall into an existing eligibility category. The principal eligibility categories for low-income women are pregnancy, and welfare-related or disability-related coverage (which is largely based on receipt of either Temporary Assistance for Needy Families or Supplemental Security Income). If a woman is found to have breast or cervical cancer, does not have health insurance, and does not qualify for Medicaid, she either pays for treatment with her own funds, receives treatment through a state, local, or privately funded program, receives charity care, or goes without treatment.

Congress created the National Breast and Cervical Cancer Early Detection Program in 1990 and appropriated $158 million for the program for fiscal year 1999. The funds support screening activities in all 50 states, in the District of Columbia and U.S. territories, and for several American Indian/Alaska Native organizations. States set their own income eligibility levels, at or below 250 percent of the federal poverty line. Most states have set eligibility criteria at about 200 percent of poverty. The CDC estimates that the program currently screens 12 to 15 percent of the eligible population. Program funds are not available for treating breast and cervical cancer.

The provision's effect on federal Medicaid spending depends on the number of women who would receive Medicaid-funded treatment as a result of the bill, the cost of the treatment, and the number of states that would choose the option. The following discussion focuses on the estimate for breast cancer treatment, which accounts for over 90 percent of the estimated costs of the bill. A brief discussion of the cost of cervical cancer treatment can be found at the end of the section.

Number of beneficiaries. The states provided 208,000 mammograms with funds available under the CDC screening program in 1997. Some states currently supplement the CDC screening funds with their own funds for screening, diagnosis, and treatment. Under the bill,

CBO expects that the number of mammograms under the CDC program would rise to 500,000 by 2003, as states that fund diagnosis and treatment services redirect their funds to supplement the screening funds in the CDC program. Because participation in that program would provide access to federal Medicaid funds for diagnosis and treatment of breast cancer, states would have an incentive to redirect their own funds into the CDC screening program.

Of women screened for breast cancer by the CDC program since its inception, about 0.5 percent, or 5 per 1,000, have been found to have breast cancer. Another 7 percent have had abnormal screens that required additional diagnosis and perhaps minor treatment. CBO assumes that the same incidence of cancer and other abnormal results would continue under the bill, resulting in the identification of about 2,500 new cancers and 35,000 abnormal mammograms each year by 2003.

In addition to those new cases, CDC reports that it has already diagnosed over 3,600 breast cancers. CBO anticipates that about 1,500 of these women would receive coverage under the bill if their states adopt the option.

Cost of Treatment. Based on data from a large health maintenance organization, CBO has estimated the average cost of breast cancer treatment by age and year since diagnosis. In the first year after diagnosis, CBO estimates that cancer treatment would cost about $17,000. In subsequent years, CBO estimates about $6,000 a year in ongoing care costs, until the last year of a patient's life, when costs total about $30,000. CBO used information from the National Cancer Institute's Surveillance, Epidemiology, and End Results (SEER) Program to estimate age-specific mortality rates from the time of diagnosis.

For women who have an abnormal mammogram, but who are not ultimately diagnosed with cancer, CBO estimates average treatment costs of about $2,000 in the year after the mammogram for follow-up diagnostic and treatment services.

The costs discussed above are for cancer treatment only and are expressed in fiscal year 2000 dollars. Because the bill would extend full Medicaid coverage during the time the woman needs cancer treatment, CBO added $1,000 a year to the costs of cancer treatment (one-third of the average per capita Medicaid cost for adults) to determine total Medicaid costs for women newly eligible because of the bill. CBO expects that the average annual cost of treatment would rise at the same rate as the Consumer Price Index for medical care.

State participation. In 2001, CBO anticipates that, states with 30 percent of potential Medicaid costs would choose to cover breast cancer patients screened through the CDC

program in their Medicaid programs. By 2005, CBO projects that proportion would rise to two-thirds.

Cervical Cancer. The costs of cervical cancer treatment under the bill stem principally from treatment of pre-cancerous conditions since screening often results in an abnormal finding at an early stage of the disease. CBO anticipates about 100 new cases of cervical cancer would be diagnosed each year under the screening program, with average annual treatment costs similar to the treatment costs for breast cancer. CBO expects about 10,000 abnormal pap smears each year, with treatment costs averaging $1,000 to $2,000. In total, CBO estimates that treatment of cervical cancer under the bill would cost about $10 million a year by 2004.

Mental Health Partial Hospitalization

CBO estimates that the bill's provisions that deal with partial hospitalization for mental health conditions would lower federal expenditures by $7 million in 2000 and by $75 million over the 2000-2004 period. Under current law, Medicare provides qualified beneficiaries with certain partial hospitalization services. The bill would reduce Medicare fee-for-service expenditures by prohibiting the provision of those services in residential settings, authorizing the Secretary of Health and Human Services (HHS) to specify new conditions of participation for community mental health centers (CMHCs), requiring inpatient psychiatric hospital admissions by CMHCs to be certified by a state-licensed mental health professional, and requiring periodic recertification of CMHCs by the Secretary. The bill would result in lower payments to Medicare+Choice plans because, under current law, capitation payments are based on fee-for-service spending. It also would reduce receipts from Medicare Part B premiums. Because Medicaid pays the Medicare Part B premiums for low-income beneficiaries, the bill would result in a small reduction in Medicaid expenditures.

Surveillance of HPV

H.R. 1070 would require the CDC to study the prevalence of HPV, the impact of HPV on individuals, and awareness of HPV; develop and disseminate educational materials related to HPV; and report to the Congress on further steps needed to prevent future HPV infections. The bill also would require HHS, as well as its contractors and grantees, to state the effectiveness of condoms in preventing HPV and other sexually transmitted diseases in all informational materials related to condoms that are made available to the public. CBO estimates that implementing these provisions would cost $43 million over the 2000-2004

period. This estimate assumes that the necessary amounts would be appropriated for each fiscal year and that outlays would follow historical spending rates for similar activities.

Condom Labeling

H.R. 1070 also would require that manufacturers of condoms change the labeling of condoms to state that condoms do not effectively prevent transmission of HPV and that the virus can cause cervical cancer in women. The provision would apply to condoms manufactured after the expiration of a 180-day period following the date of enactment. If manufacturers fail to comply, their products would be deemed misbranded and subject to administrative actions by the Food and Drug Administration.

CBO expects that all manufacturers would comply with this requirement; therefore, there would be no additional cost to the federal government to enforce compliance. Assuming full compliance, CBO estimates that there would be no increase in revenues arising from civil penalties that could be assessed on noncompliant manufacturers.

PAY-AS-YOU-GO CONSIDERATIONS

The Balanced Budget and Emergency Deficit Control Act sets up pay-as-you-go procedures for legislation affecting direct spending or receipts. The net changes in outlays and governmental receipts that are subject to pay-as-you-go procedures are shown in the following table. For the purposes of enforcing pay-as-you-go procedures, only the effects in the budget year and the succeeding four years are counted.

	By Fiscal Year, in Millions of Dollars									
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Changes in outlays	-7	9	43	68	92	125	149	177	204	238
Changes in receipts	not applicable									

ESTIMATED IMPACT ON STATE, LOCAL, AND TRIBAL GOVERNMENTS

H.R. 1070 contains no intergovernmental mandates as defined in the Unfunded Mandates Reform Act (UMRA). A new coverage option in the bill would allow states to increase spending in their Medicaid programs for the treatment of breast and cervical cancer. CBO

estimates that the state portion of Medicaid expenditures for this optional coverage would total $93 million over the 2000-2004 period.

State spending for the treatment of breast and cervical cancer among women who would otherwise be ineligible for Medicaid would qualify for at least a $3 federal match for every $4 in state spending. Some states may already be covering this type of treatment in state-funded public health programs. In those cases, the federal matching funds would allow states to increase their overall level of spending for existing programs or to redirect a portion of their current spending to screening or other state programs.

ESTIMATED IMPACT ON THE PRIVATE SECTOR

H.R. 1070 would impose a mandate upon condom manufacturers and distributors that operate in the U.S. market. The bill would require such companies to meet new labeling requirements that would state that condoms do not effectively prevent the transmission of HPV and that such a virus can cause cervical cancer. The mandate would require companies to incur a largely one-time cost for modifying their labels. CBO estimates that the costs associated with the mandate would fall well below the $100 million threshold established in UMRA.

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