



# House of Representatives

General Assembly

**File No. 642**

January Session, 2001

Substitute House Bill No. 6709

*House of Representatives, May 7, 2001*

The Committee on Appropriations reported through REP. DYSON of the 94th Dist., Chairperson of the Committee on the part of the House, that the substitute bill ought to pass.

## **AN ACT CONCERNING MEDICAL CARE FOR WOMEN WITH BREAST OR CERVICAL CANCER.**

Be it enacted by the Senate and House of Representatives in General Assembly convened:

1 Section 1. Section 17b-278b of the general statutes is repealed and  
2 the following is substituted in lieu thereof:

3 (a) [To the extent authorized by federal law, the] The Commissioner  
4 of Social Services [may] shall provide coverage under the Medicaid  
5 program in accordance with Public Law 106-354 to women diagnosed  
6 with breast or cervical cancer. The commissioner shall seek any federal  
7 waivers or amend the state Medicaid plan as necessary in order to  
8 secure federal reimbursement for the costs [to such plan] of providing  
9 [treatment and other medical services to women diagnosed with breast  
10 or cervical cancer under the breast and cervical cancer early detection  
11 and treatment referral program established under section 19a-266]  
12 coverage under the Medicaid program to such women. Such coverage  
13 shall not be dependent on the available income or assets of an

14 applicant.

15 (b) To qualify for medical assistance under this section, a woman  
16 shall: (1) Have been screened for breast or cervical cancer under the  
17 Centers for Disease Control and Prevention's National Breast and  
18 Cervical Cancer Early Detection Program and found to be in need of  
19 treatment for breast or cervical cancer, including a precancerous  
20 condition of the breast or cervix; (2) not otherwise have creditable  
21 coverage, as defined in 42 USC 300gg(c); (3) not have attained the age  
22 of sixty-five years; (4) not be eligible under any mandatory Medicaid  
23 eligibility group; and (5) be a resident of this state and a United States  
24 citizen or a qualified alien, as defined in Section 431 of Public Law 104-  
25 193.

26 (c) The commissioner shall deem an applicant who has been  
27 determined eligible for medical assistance under this section as having  
28 been eligible for up to three months prior to the month in which an  
29 application was filed if the requirements in subsection (b) of this  
30 section were met during such three-month period. An individual  
31 determined eligible for medical assistance under this section shall  
32 remain eligible until the individual's course of treatment is completed  
33 or until eligibility criteria are no longer met. The commissioner shall  
34 establish procedures for the granting of presumptive eligibility in  
35 order to ensure prompt access to services for applicants.

36 (d) The Commissioner of Social Services shall implement policies  
37 and procedures necessary to carry out the provisions of this section  
38 while in the process of adopting such policies and procedures in  
39 regulation form, provided notice of intention to adopt the regulations  
40 is published in the Connecticut Law Journal within twenty days of  
41 implementation of such policies and procedures. Such policies and  
42 procedures shall be valid until the time final regulations are effective.

43 Sec. 2. This act shall take effect from its passage.

*HS*      *Joint Favorable Subst. C/R*

*APP*

*APP*      *Joint Favorable*

The following fiscal impact statement and bill analysis are prepared for the benefit of members of the General Assembly, solely for the purpose of information, summarization, and explanation, and do not represent the intent of the General Assembly or either House thereof for any purpose:

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**OFA Fiscal Note**

**State Impact:** Significant Cost

**Affected Agencies:** Department of Social Services

**Municipal Impact:** None

**Explanation**

**State Impact:**

This bill requires the Department of Social Services to provide coverage under the Medicaid program to certain low-income women diagnosed with breast or cervical cancer in accordance with the federal Breast and Cervical Cancer Prevention and Treatment Act of 2000. It is anticipated that this benefit will cost up to \$500,000 annually. The Appropriations Act, sHB 6668 (as favorably approved by the Appropriations Committee) includes an additional \$400,000 in each year of the biennium to implement this Medicaid extension.

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**OLR Bill Analysis**

sHB 6709

***AN ACT CONCERNING MEDICAL CARE FOR WOMEN WITH BREAST OR CERVICAL CANCER.***

**SUMMARY:**

This bill requires the social services commissioner to provide Medicaid coverage to women diagnosed with breast or cervical cancer who have been screened under the Centers for Disease Control and Prevention's (CDC) National Breast and Cervical Cancer Early Detection Program and need treatment, including treatment for related precancerous conditions. Current law allows, but does not require, the commissioner to seek a federal waiver or amend the state Medicaid plan to gain federal reimbursement for treating these women.

To qualify for Medicaid under this special program, a woman (1) must be under age 65, a Connecticut resident, and a U.S. citizen or qualified alien and (2) cannot have other insurance coverage for such treatment or be eligible under any mandatory Medicaid eligibility group. The bill requires Medicaid coverage for this specific group of women regardless of their available income and assets. (Other Medicaid applicants must meet various income and asset limits.)

If a woman is eligible for Medicaid under this bill, she must also be considered as having been eligible for up to three months before the month when she applied if she was otherwise eligible during that time. She remains eligible until her treatment is finished or she no longer meets the eligibility criteria. The bill also requires the commissioner to establish procedures for granting presumptive eligibility to ensure applicants' prompt access to services.

The bill requires the commissioner to implement policies and procedures needed to carry out its provisions while she is still in the process of adopting them as regulations. She must publish a notice of intention to adopt the regulations in the Connecticut Law Journal

within 20 days after implementing them. The bill makes these provisional policies and procedures valid until the final regulations take effect.

EFFECTIVE DATE: Upon passage

**BACKGROUND**

***Related Federal Law***

Federal law established the screening program in 1996. It is administered at the federal level by CDC and in Connecticut by the Department of Public Health. Under the program, low-income women without health insurance are eligible for free mammograms, Pap tests, and other diagnostic procedures for detecting breast or cervical cancer. The screening program serves women whose incomes are at or below 200% of the federal poverty level if they have no health insurance or have insurance that excludes routine Pap tests and mammograms.

In October 2000, Congress passed the Breast and Cervical Cancer Prevention and Treatment Act (PL 106-354), which gives states the option of providing Medicaid coverage to women who went through the screening program and were diagnosed as having breast or cervical cancer. The new law also allows states to implement presumptive Medicaid eligibility for these women. "Presumptive eligibility" means the state enrolls certain people provisionally in Medicaid for a limited time until full Medicaid applications are filed and processed, based on a Medicaid provider's determination that the person is likely to qualify for Medicaid.

**COMMITTEE ACTION**

Human Services Committee

Joint Favorable Substitute Change of Reference  
Yea 12 Nay 0

Appropriations Committee

Joint Favorable Report

Yea 51    Nay 0