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Authors

E. Kathleen Adams, Sarah C. Blake, Cheryl Raskind-Hood, Linien Chien, Mei Zhou, Jonathan Liff, and William Eley

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E. Kathleen Adams, Ph.D.
Rollins School of Public Health, Emory University

Sarah C. Blake, M.A.
Rollins School of Public Health, Emory University

Cheryl Raskind-Hood, M.S., M.P.H.
Rollins School of Public Health, Emory University

Linien Chien, M.P.H., M.S.
Rollins School of Public Health, Emory University

Mei Zhou, M.S., M.A.
Georgia Health Policy Center, Andrew Young School of Policy Studies

Jonathan Liff, Ph.D.
Rollins School of Public Health, Emory University

William Eley, M.P.H., M.D.
School of Medicine, Emory University

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Corresponding Author: E. Kathleen Adams, Emory University 1518 Clifton Rd., NE, Atlanta, GA, 30322, email: eadam01@sph.emory.edu

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Original Research: BREAST AND CERVICAL CANCER PREVENTION AND TREATMENT ACT

Abstract

The Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) provided states with an optional Medicaid eligibility category for uninsured women with breast and/or cervical cancers. The BCCPTA is the first and only such effort to use a population-based public health screening program, the National Breast and Cervical Cancer Early Detection Program (NBCCEDP) to provide a pathway to publicly funded health insurance for otherwise uninsured low-income women. Georgia was one of the first states to adopt the BCCPTA and was one of only twelve states that provided Medicaid eligibility to women screened by non-NBCCEDP providers. We use 2003 Georgia Medicaid claims and enrollment data to investigate the scope of the state's BCCPTA enrollment and enrollees' costs as well as demographic characteristics of breast and cervical cancer patients in Georgia's BCCPTA and other Medicaid eligibility categories. Georgia's Medicaid coverage of women with breast and/or cervical cancer under BCCPTA accounted for over one-third of all women with these cancers covered by the state in 2003 alone. Those newly eligible under BCCPTA were more likely to have breast, as opposed to cervical, cancer and to be older than those women with breast/cervical cancers enrolled in Georgia Medicaid due to low-income, pregnancy or disability status. Georgia's Medicaid program spent over $29 million on BCCPTA enrollees in 2003 at a cost of over $12,000 per enrollee. BCCPTA enrollee costs were more similar to those for disabled women with these cancers, about $19,500, than to costs for low-income/pregnant women which equaled about $7,500. By expanding Medicaid coverage, BCCPTA can potentially bring women in at earlier stages of their cancer and provide needed coverage/treatment. Future research should examine the potential effect of BCCPTA on reduced morbidity and mortality among these low-income women.

The Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) in Georgia: Women Covered and Medicaid Costs in 2003

On October 24, 2000, President Clinton signed the Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA). The BCCPTA, enacted as Public Law 106-354, gave states the ability to establish a new optional Medicaid eligibility category for uninsured women under 65 who had been screened under the National Breast and Cervical Cancer Early Detection Program (NBCCEDP) and found to need treatment either for breast or cervical cancer or for a precancerous cervical condition. The NBCCEDP serves the uninsured with incomes below 250% of the federal poverty level (FPL). The first and only such effort to use a population-based public health screening program (NBCCEDP), BCCPTA was established as an effort to reduce the decades-old "treatment gap" for low-income women with no medical insurance by providing a pathway to publicly funded health insurance (Medicaid).

The BCCPTA has generated significant interest as a policy approach for addressing the challenges of the uninsured facing serious illness. Within a year of its passage, a majority of states had adopted the BCCPTA. Georgia adopted the BCCPTA pursuant to broad statutory authority by the Medicaid agency and began enrolling women in its BCCPTA program, the Women's Health Medicaid Program (WHMP), on July 1, 2001. From implementation through June 2006, BCCPTA enrolled approximately 4,800 women (Georgia Department of Community Health, 2006). Although BCCPTA mandated that women be screened by the NBCCEDP, states had options to also extend eligibility to women screened by non-NBCCEDP providers. Georgia is one of 12 states that selected this more expansive screening option. In 2005, only 25% of BCCPTA women were screened in health departments through Georgia's NBCCEDP screening program (known as "Breast Test and More"); the majority (75%) was screened by private providers (Department of Community Health, 2006).

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Another distinction of BCCPTA from other Medicaid eligibility categories is that women are eligible for Medicaid only as long as they are "in treatment" for their cancers, but they can utilize any Medicaid covered service while eligible. If a BCCPTA woman is no longer in treatment at the time of recertification and if she is not eligible for Medicaid under other eligibility categories, she is disenrolled and usually referred back to her screening provider for follow-up care. The definition of "in treatment" is not explicit, however, and states differ in the timing and types of recertification required to confirm active cancer treatment. In order for BCCPTA women to get recertified in Georgia in 2003, they simply responded to Georgia's Medicaid program by letter every six months indicating that they were still in active treatment. Since this time, Georgia's Medicaid officials have considered a more formal process, whereby Breast Test and More staff could assist with the recertification process. Given the unique collaboration of states' screening programs and Medicaid agencies in determining eligibility, many NBCCEDP case managers assist women before, during, and after their treatment has ended. Although assisting with redetermination has become a logical role for these case managers, it is unclear what this change will mean for the percentage of women retaining coverage under BCCPTA eligibility.

BCCPTA Study

Despite successful enrollment, little is known about how states' adoption and implementation of the BCCPTA impacts low-income, uninsured women with breast and cervical cancer, nor how much it expands pre-existing Medicaid coverage of women with cancer. In 2004, Emory University received funding from the American Cancer Society (ACS) to examine the impact of BCCPTA in Georgia. This study uses quantitative data from Medicaid enrollment/claims and Georgia's Comprehensive Cancer Registry (GCCR) data to assess if: 1) implementation of BCCPTA shortened the length of time between initial diagnosis and eventual enrollment into Medicaid; 2) women enrolling in Medicaid do so at earlier stages of cancer post BCCPTA and hence, with greater treatment options; and 3) significant variation (e.g., urban/rural) in treatment patterns exist. As a first step, we use 2003 Medicaid claims and enrollment data to ask:

- *What is the scope of BCCPTA enrollment and costs in Georgia's Medicaid program?*
- *How does this fit into Georgia's overall coverage of women with breast or cervical cancer?*
- *What are the demographic characteristics of women enrolled in the BCCPTA program, or in other Medicaid programs?*

Assembling the claims/enrollment data is necessary to determine the procedure/diagnostic codes to identify women in Medicaid with evidence of breast and cervical cancers for our larger study. The resulting descriptive data are presented here to highlight the role that BCCPTA is playing in Georgia's Medicaid program.

BACKGROUND LITERATURE

Women facing critical health challenges are in need of health insurance. If early symptoms or chronic diseases are not medically managed, uninsured women are more likely to experience poorer medical outcomes or to be diagnosed at later stages of life-threatening diseases such as cancer; in turn, they experience a greater risk of death from breast cancer (ACP, 2000; CDC, 1998). The BCCPTA was developed to reduce both morbidity and mortality among women with such conditions.

Even prior to BCCPTA, Medicaid served as an important safety net for women with chronic health conditions and yet, there are relatively few studies specific to Medicaid enrollees with cancer (CDC, 1998). One earlier study showed that the Medicaid insured presented with more advanced disease. Further, both Medicaid enrolled and uninsured women diagnosed with local

or regional stage disease had worse survival than privately-insured women, although there was no significant difference among women with distant metastases (Ayanian, Kohler, Abe, and Epstein, 1993). Another study found older, black women of lower socio-economic status treated in public hospitals (likely eligible for Medicaid) were more likely to have late stage breast or cervical cancer than younger, white, higher social class women treated in non-public hospitals (Mandleblatt, Andrews, Kerner, Zauber, and Burnett, 1991).

A study that linked Medicaid enrollment and Detroit cancer registry data found that Medicaid-insured women were more likely to have late-stage diagnosis, less likely to receive radiation if they had breast conserving surgery (BCS) and more likely to receive no surgery than other insured women (Bradley, Given, and Roberts, 2002). This linkage also provided new insight on racial disparities. Before controlling for Medicaid and area poverty, African-American women had a higher likelihood of each unfavorable outcome but after controlling, African-American women only differed in treatment choice. They were less likely to have any surgery and if they did, it was more likely to be BCS (Bradley, 2002). Thus low socioeconomic status, as evidenced by Medicaid enrollment, was a better predictor than race of disease stage at diagnosis.

Another study used Medicaid claims data to identify incident cases in Ohio's Medicaid population with registry data as the "gold standard" (Koroukian, Cooper, and Rim, 2003). The overall sensitivity was 68.7%, but varied by sub-group and was as high as 78% for those enrolled all year. A linkage of Medicaid and California registry data found that of the 14,305 matched cases, 70% were not enrolled in Medi-Cal (California's Medicaid program) either prior to or during the month of diagnosis (Perkins, Write, Allen, Samuels, and Romano, 2001). These authors concluded that despite difficulties in linking, such data can be used to assess access to care and cancer outcomes in this large, understudied and vulnerable population.

DATA AND METHODS

While BCCPTA women can be identified based on eligibility codes, other women with breast or cervical cancer in Medicaid programs can only be identified using diagnosis/procedure codes found in claims. We use calendar year 2003 claims to identify all women with evidence of these cancers. We compiled lists of diagnosis and procedure codes (and NDC chemotherapy codes) from publications, consultation with Georgia Medicaid staff, and with our team's clinical oncologist. We cast a broad net to find women with breast or cervical cancers in Georgia Medicaid but were conservative when using procedure codes without a cancer diagnosis (during the year) since this could lead to over-identification of cancer cases. The list of codes employed to derive the samples is shown in Table 1.

We identified all unique women with at least one claim with any of these codes from inpatient, outpatient, drug, and long-term care claims. From this pool of women, we excluded: 1) women over 65; 2) women dually enrolled in Medicare; and 3) women in a nursing home during the year. These exclusions were necessary since not all 'crossover' claims - those involving both Medicare and Medicaid payments - nor long-term care claims include all diagnostic, procedure, and payment detail. By making these exclusions, we identified a group of relatively younger women insured largely by Medicaid who were more comparable with those eligible for Medicaid through BCCPTA.

We then grouped women by the eligibility category on their first (cancer-related) claim during the year: 1) BCCPTA; 2) welfare or pregnancy-related; and 3) disabled women. Women with dependent children could qualify for Georgia Medicaid under welfare-related criteria at approximately 33% of the Federal Poverty Level (FPL); FPL for a family of three equaled $15,260 in 2003 (CMS,

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Table 1
ICD-9 Breast and Cervix Cancer Diagnosis Codes, NDC Chemotherapy Codes, and CPT Breast and Cervix Procedure Codes

	Codes
Breast Cancer Diagnosis ICD-9 Codes	233.0,174.0-174.9,238.3,239.3
Cervix Cancer Diagnosis ICD-9 Codes	622.1,233.1,180.0-180.9
Chemotherapy NDC Codes	54569-3765-00, 54569-8602-00, 00555-0446-09, 00555-0446-63, 00555-0446-05, 00555-0904-01, 00555-0904-14, 00555-0904-05, 51552-0838-02, 63370-0251-10, 63370-0251-15, 63370-0251-25, 63370-0251-35, 00172-5656-49, 00172-5656-58, 00172-5656-70, 00172-5656-80, 00172-5657-46, 00172-5657-60, 00172-5657-70, 00172-5657-80, 38779-0341-03, 38779-0341-01, 38779-0341-04, 38779-0341-05, 62991-1151-02, 62991-1151-01, 00378-0144-91, 00378-0274-93, 00378-0274-01, 54868-3004-02, 54868-3004-01, 00054-4831-21, 00054-8831-25, 00054-4831-26, 00054-4834-13, 00054-4834-22, 00054-8834-25, 49452-7571-05, 49452-7571-01, 49452-7571-02, 49452-7571-06, 49452-7571-03, 00093-0784-06, 00093-0784-86, 00093-0782-56, 00093-0782-01
Breast Procedure CPT Codes	19160; 19162; 19180; 19182; 19200; 19220; 19240
Cervix Procedure CPT Codes	57520; 57522

2003). Pregnant women under 235% of the FPL would have qualified for Georgia Medicaid, and a woman with a disabling condition and on Supplemental Security Income (SSI), approximately 74% of the FPL, would have qualified in 2003 (VCU, 2006).

RESULTS

The data in Table 2 show that, based on administrative files, a total of 2,379 women were enrolled in Georgia's BCCPTA program at some point during 2003. These women were almost evenly split across the three non-teenage categories; roughly one-third were in each age group under 65. Based on those with race/ethnic data (91% of total), the women enrolled in BCCPTA in 2003 were predominantly white non-Hispanic (54%) with 32% categorized as non-Hispanic Black, 2% as Hispanic, and 2% as "other" ethnic groups. Given the significant proportion of missing race data, it is likely that the percent Hispanic is underrepresented. Survey data on families with children in Medicaid in 2003 indicate 5% of the higher income, and 10% of the lower income families, were Hispanic (Ketsche, 2007). BCCPTA women however, accounted for only 36% of the total 4,573 identified by claims/codes (1,655 BCCPTA, 1,887 welfare/pregnancy related and 1,031 disabled). Based on the costs of those ever enrolled in BCCPTA, Medicaid spent $29 million or about $12,400 per woman. The $27 million spent on BCCPTA enrollees with breast/cervical cancer claims represents 44% of costs for women ($61.6 million)

Table 2

Age, Race, Cost Breakdown for Women Ever Enrolled in BCCPTA, Women with Claims for Breast or Cervical Cancers and Eligible for BCCPTA on First Claim, Georgia Medicaid 2003

	All BCCPTA-Ever Enrolled in Year		BCCPTA w/ Breast/Cervical Cancer Claims and BCCPTA Eligible at First Claim		Women with Breast Cancer Claims and BCCPTA Eligible at First Claim		Women with Cervical Cancer Claims and BCCPTA Eligible at First Claim	
	N=2,379	%	Unduplicated N=1,655 Duplicated N=1,688	%	N=1,093	%	N=595	%
AGE								
<20	33	1%	23	1%	0	0%	23	4%
20-34	773	32%	335	20%	57	5%	284	48%
35-49	773	32%	631	38%	451	41%	194	33%
50-64	800	34%	666	40%	585	54%	94	16%
RACE								
Non-Hispanic White	1284	54%	809	49%	468	43%	355	60%
Non-Hispanic Black	762	32%	586	35%	439	40%	158	27%
Hispanic	59	2%	33	2%	16	1%	18	3%
Other	49	2%	39	2%	30	3%	9	2%
Missing	225	9%	188	11%	140	13%	55	9%
COSTS								
Total	$29,409,475	100%	$27,166,949	100%	$22,171,588	100%	$ 5,857,984	100%
Inpatient Services	$5,469,035	19%	$5,062,505	19%	$3,439,421	16%	$1,790,438	31%
Outpatient Services	$20,865,546	71%	$19,346,937	71%	$16,296,716	74%	$3,682,447	63%
Drug	$3,074,894	10%	$2,757,508	10%	$2,435,452	11%	$385,099	7%
COSTS PER ENROLLEE								
Total	$12,362	100%	$16,415	100%	$20,285	100%	$9,845	100%
Inpatient Services	$2,299	19%	$3,059	19%	$3,147	16%	$3,009	31%
Outpatient Services	$8,771	71%	$11,690	71%	$14,910	74%	$6,189	63%
Drug	$1,293	10%	$1,666	10%	$2,228	11%	$647	7%

identified by claims/codes. Both the BCCPTA and disabled eligibility category of women have costs that represent more of the total than they do of women covered because their per-person costs are significantly higher than those of low-income pregnant women. Most of the latter group are experiencing cervical cancers and at a much lower cost per case.

For BCCPTA and other groups of enrollees outpatient services (e.g. physician and other ambulatory services such as laboratory, screening, etc) are more expensive in total and per person due largely to their greater volume. While inpatient services (e.g. hospital accommodations, surgical services, etc) are more costly per event there is a lower rate of usage per person.

BCCPTA Eligible Women

We identified 1,655 unduplicated women with breast or cervical cancers with BCCPTA eligibility on their first cancer claim. The difference between this and the 2,379 *ever* enrolled in BCCPTA during 2003 is comprised of: 1) 29 women who did not have BCCPTA on their first claim, but who were enrolled during the year, and 2) 695 women in BCCPTA who either did not have a claim or had one outside of our identified diagnosis or procedure codes. Some of the 695 may have had precancerous cervical conditions (which qualify for BCCPTA). While we found such codes among their leading diagnoses, by and large, the leading diagnoses were not cancer-related. These 695 women could also have had disease in

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remission, but still considered "under treatment;" the great majority of them (almost 75%) either had no claim during the year (15%) or had at least one 'case management' claim/procedure (59%) listed by Georgia BCCPTA.

The split between breast and cervical cancer using the data based on claims is shown in Columns 2-3 in Table 2. Among the 1,688 duplicated (33 had claims for both) BCCPTA women with either cancer, breast cases accounted for 65%. Total payments for BCCPTA women with claims for breast or cervical cancer were $27 million, equal to $16,415 per woman. For breast cancer cases, total payments were $22 million, equal to $20,285 per woman. For cervical cancer cases, total payments were $5.8 million, equal to $9,845 per woman.

Welfare and Pregnancy Related Eligible Women

The Georgia Medicaid program serves many women with these and other cancers outside of BCCPTA. As shown in Table 3, almost 1,900 women with either cancer and in either welfare or pregnancy-related eligibility categories received treatment in 2003. (Data on the age/racial distributions should be compared with that in Columns 2-3 in Table 2 which are also derived based on claims/codes). These data indicate that women with breast or cervical cancers in these eligibility groups are far more likely to be under age 35 (78% versus 33%) than BCCPTA enrollees and indeed, more likely to be teenagers (19% versus 1%). Even accounting for missing race, they are more likely to be non-Hispanic Blacks than are BCCPTA enrollees.

In contrast to BCCPTA, cervical cancer was far more common among Medicaid patients in the welfare or pregnancy categories (77% of these 1,895 duplicated cases). The costs per case among these younger women are lower at $7,548 overall (total payments were $14 million). For those with breast cancer, the average cost per case was $12,200 (total payments were $5 million) while costs for cervical cancer cases averaged $6,234, with total payments of $9 million.

Disabled Women

Georgia and other states' Medicaid programs have historically served the low-income with disabling conditions. As shown in Table 4, a little over 1,000 women with evidence of breast or cervical cancers and disabled by these or other conditions were served in 2003. As among BCCPTA women, the cases are predominately breast cancer (72%), and the costs per woman are similar at almost $20,000. There are almost 300 disabled women with evidence of cervical cancer, and these cases are just as costly as for BCCPTA women at $19,718. Women in this eligibility category are likely to be older than either BCCPTA women or women in the welfare and pregnancy related categories with approximately 59% between the ages of 50 and 64.

CONCLUSIONS AND IMPLICATIONS

Prior to BCCPTA, many uninsured women with breast or cervical cancer qualified for Medicaid only when they were at late stages of disease and perhaps disabled by it (Ayanian et al., 1993). The time between diagnosis and treatment was likely long for uninsured women who could not either afford treatment or find doctors willing to provide charity care. The BCCPTA created a potentially new and quicker pathway into Medicaid. The data shown here indicate that BCCPTA women with breast cancer are more like the Medicaid disabled than those eligible through other avenues, in terms of age and costs, but are still younger and somewhat less expensive to serve. BCCPTA women with cervical cancers are certainly younger than the disabled women, and they have markedly lower costs. This may reflect detection/treatment at earlier stages of disease or a lack of co-morbidities among BCCPTA women compared with those the disabled possess.

When BCCPTA was created, there was little information for state policy makers

Table 3

Age, Race, Cost Breakdown for Women with Claims for Breast or Cervical Cancers and Enrolled in Welfare or Pregnancy-Related Category on First Claim, Georgia Medicaid 2003

	Women with Breast or Cervical Cancer Claims and Welfare or Pregnancy-Related Eligibility at First Claim		Women with Breast Cancer Claims and Welfare or Pregnancy-Related Eligibility at First Claim		Women with Cervical Cancer Claims and Welfare or Pregnancy-Related Eligibility at First Claim	
	Unduplicated N=1887 Duplicated N=1,895	%	N=440	%	N=1455	%
AGE						
<20	352	19%	47	11%	305	21%
20-34	1118	59%	138	31%	982	67%
35-49	363	19%	206	47%	163	11%
50-64	54	3%	49	11%	5	0%
RACE						
Non-Hispanic White	811	43%	147	33%	669	46%
Non-Hispanic Black	1051	56%	280	64%	774	53%
Hispanic	3	0%	1	0%	2	0%
Other	11	1%	4	1%	7	0%
Missing	11	1%	8	2%	3	0%
COSTS						
Total	$14,243,272	100%	$5,368,003	100%	$9,070,747	100%
Inpatient Services	$3,399,623	24%	$1,271,492	24%	$2,225,033	25%
Outpatient Services	$9,414,445	66%	$3,492,421	65%	$6,013,085	66%
Drug	$1,429,204	10%	$604,089	11%	$832,629	9%
COSTS PER ENROLLEE						
Total	$7,548	100%	$12,200	100%	$6,234	100%
Inpatient Services	$1,802	24%	$2,890	24%	$1,529	25%
Outpatient Services	$4,989	66%	$7,937	65%	$4,133	66%
Drug	$757	10%	$1,373	11%	$572	9%

regarding the costs that Medicaid would face since data on the costs of cancer treatment are often limited. Many states made estimates of anticipated BCCPTA costs but these have not been made available to researchers. In a study based on the Medical Expenditure Panel Survey (MEPS), Medicaid insured (age <65) had expenses close (93%) to those of the privately insured, but both had much higher expenses than the uninsured (Thorpe and Howard, 2003). The uninsured were also found to have lower provider encounters and fewer hospital admissions, perhaps indicative of less cancer care. On an annualized basis, the expenses for the Medicaid insured were $15,610 (Thorpe and Howard, 2003), lower but still quite consistent with the dollar amounts reported here for Georgia Medicaid women with breast cancer.

While BCCPTA women accounted for over one-third of the women under age 65 served by Georgia's Medicaid program in 2003 (the second year of BCCPTA), it is important to note the role Medicaid coverage plays independent of BCCPTA. Georgia Medicaid insured almost 2,000 younger women with breast and especially, cervical cancers among women in their pregnancy or welfare eligibility groups. That these young women end up using Medicaid for these diagnoses relates in part to screening for cervical cancer at younger ages than other cancers and that many women who are single heads of households and/or young married

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Table 4:

Age, Race, Cost Breakdown for Women with Claims for Breast or Cervical Cancers and Enrolled in Disability Category on First Claim, Georgia Medicaid 2003

	Women with Breast or Cervical Cancer Claims and Disability Eligibility at First Claim		Women with Breast Cancer Claims and Disability Eligibility at First Claim		Women with Cervical Cancer Claims and Disability Eligibility at First Claim	
	Unduplicated N=1031 Duplicated N=1,042	%	N = 749	%	N=293	%
AGE						
<20	13	1%	3	0%	10	3%
20-34	98	10%	26	3%	73	25%
35-49	316	31%	215	29%	106	36%
50-64	604	59%	505	67%	104	35%
RACE						
Non-Hispanic White	356	35%	251	34%	109	37%
Non-Hispanic Black	497	48%	361	48%	142	48%
Hispanic	7	1%	6	1%	1	0%
Other	9	1%	6	1%	3	1%
Missing	162	16%	125	17%	38	13%
COSTS						
Total	$20,210,958	100%	$14,862,105	100%	$5,777,233	100%
Inpatient Services	$5,540,801	27%	$3,739,745	25%	$1,918,383	33%
Outpatient Services	$11,054,919	55%	$8,392,379	56%	$2,884,074	50%
Drug	$3,615,238	18%	$2,729,981	18%	$974,776	17%
COSTS PER ENROLLEE						
Total	$19,603	100%	$19,843	100%	$19,718	100%
Inpatient Services	$5,374	27%	$4,993	25%	$6,547	33%
Outpatient Services	$10,723	55%	$11,205	56%	$9,843	50%
Drug	$3,507	18%	$3,645	18%	$3,327	17%

mothers are likely to lack private insurance coverage (Guyer, Broaddus, and Dude, 2001). Given high cure rates for cervical cancer with early detection/treatment, both traditional Medicaid eligibility and the expansion through BCCPTA can serve as a critical safety net and perhaps help reduce morbidity and mortality related to this preventable cancer.

The NBCCEDP has just been reauthorized through fiscal year 2011. While funding has increased, it still falls far below that needed to cover all uninsured women for free or subsidized screens. If uninsured women still get screened and if screening leads to a cancer diagnosis, BCCPTA can provide needed coverage/treatment. Georgia's experience shows that 75% of the otherwise BCCPTA-eligible women received screening privately. If this experience can be generalized to other states, it is important that they consider expanding BCCPTA to women screened by any provider. Future research should examine the role of BCCPTA in bringing women into Medicaid at earlier stages and potentially, reducing morbidity and mortality as it was intended to do.

REFERENCES

American College of Physicians/American Society of Internal Medicine (ACP). (2000). No Health Insurance? It's Enough To Make You Sick-Uninsured Women at Risk. http://www.acponline.org/uninsured/lack-contents.htm

Ayanian, J.Z., Kohler, B.A., Abe, T. and Epstein, A.M. (1993). The Relation Between Health Insurance Coverage and Clinical Outcomes Among Women with Breast Cancer. *N Eng J Med,* 329: 326-31.

Bradley, C.J., Given, C.W. and Roberts, C. (2002). Race, Socioeconomic Status, and Breast Cancer Treatment and Survival. *J National Cancer Institute,* 94 (7): 490-496.

Centers for Disease Control and Prevention (CDC). (1998). Self-reported use of mammography and insurance status among women aged >=40 years – United States, 1991-1992 and 1996-1997. *MMWR-Morbidity and Mortality Weekly Report*, 47 (39): 825-830

Centers for Medicare and Medicaid Services (CMS). (2003). Medicaid Eligibility, Federal Poverty Guidelines 2003. http://www.cms.gov.

Georgia Department of Community Health (DCH), Medicaid Division. Data as of June 2006. Personal communication.

Guyer, J., Broaddus, M, and Dude, A. (2001). Millions of Mothers Lack Insurance Coverage, Washington Center on Budget and Policy Priorities. http://www.center@cbpp.org.

Ketsche, P, Adams, EK, Minyard, K., and Kellenberg, R. (2007, forthcoming). "The Stigma of Public Programs: Does a Separate S-CHIP Program Reduce It?" *Journal of Policy Analysis and Management*.

Koroukian, S.M., Cooper, G.S., and Rim, A.A. (2003). Ability of Medicaid Claims Data to Identify Incident Cases of Breast Cancer in the Ohio Medicaid Population. *Health Services Research*. 38 (3): 947-960.

Mandelblatt, J., Andrews, H., Kerner, J., Zauber, A. and Burnett, W. (1991). Determinants of Late Stage Diagnosis of Breast and Cervical Cancer: The Impact of Age, Race, Social Class and Hospital Type. *Am J Public Health,* 81(5): 646-649.

Perkins, C.I., Wright, W.E., Allen, M., Samuels, S.J., and Romano, P.S. (2001). Breast Cancer Stage at Diagnosis in Relation to Duration of Medicaid Enrollment. *Medical Care,* 39 (11):1224-1233.

Thorpe, K.E. and Howard, D. (2003). Health Insurance and Spending Among Cancer Patients. *Health Affairs: Web Exclusive*. http://content.healthaffairs.org/cgi/reprint/hlthaff.w3.189v1.pdf.

Virginia Commonwealth University (VCU), School of Business. (2003). Work World: Georgia - Calendar Year 2003 Eligibility for Major Coverage Groups within Medicaid.http://www.workworld.org/wwwebhelp/external/ga_medicaid_2003.html.

https://digitalcommons.georgiasouthern.edu/jgpha/vol2/iss1/1

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