Options for CDC's Cancer Screening Programs: Implications of the Affordable Care Act

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Background and Introduction

Screening to promote early detection of cancer is a fundamental tool in preventive medicine and public health that facilitates earlier treatment and reductions in cancer mortality. Systematic reviews of the research demonstrate that early detection and treatment for breast and cervical cancers can reduce cancer-related mortality.[1, 2] One of the most important barriers to women being screened is the lack of health insurance coverage.[3, 4] The Centers for Disease Control and Prevention (CDC) administers two programs designed to increase screening, particularly among low-income and vulnerable populations: the National Breast and Cervical Cancer Early Detection Program (NBCCEDP) and the Colorectal Cancer Control Program (CRCCP). NBCCEDP operates through a series of grants provided to state, territorial, and tribal agencies that help fund screening and related promotion/prevention interventions, particularly aimed at low-income uninsured and underinsured women who would otherwise be unable to afford the costs of clinical breast exams, mammograms, Pap smears, cervical exams, and related screening and diagnostic tests. CRCCP operates on a similar basis and serves low-income uninsured and underinsured men and women who cannot afford fecal occult blood testing (FOBT), sigmoidoscopy, colonoscopy and related tests.

The NBCCEDP, authorized under the Breast and Cervical Cancer Mortality Prevention Act of 1990, is the larger program and operates in all 50 states, the District of Columbia, 5 territories and 12 tribal organizations that collectively offer services through more than 20,000 local providers, such as community health centers, private physician practices, local and tribal health departments, cancer centers, health plans and charity hospitals. In 2010, the program screened 326,000 women for breast cancer and 300,000 women for cervical cancer, detecting

[1] Nelson HD, Tyne K, Naik A, et al. Screening for Breast Cancer: Systematic Evidence Review Update for the U.S. Preventive Services Task Force. Evidence Review Update No. 74. Rockville, MD: Agency for Healthcare Research and Quality; 2009.
[2] Hartmann K, Hall S, Nanda K, et al. Screening for Cervical Cancer: Systematic Evidence Reviews, No. 25 Rockville, MD; 2002.
[3] Schueler K, Chu P, Smith-Bindman R. Factors Associated with Mammography Utilization: A Systematic Quantitative Review of the Literature. *J Women's Health.* 2008; 17(9): 1477-98.
[4] Shi L, Lebrun L, Zhu J, Tsai J. Cancer Screening among Racial/Ethnic and Insurance Groups in the United States: A Comparison of Disparities in 2000 and 2008. *J Health Care Poor Underserved*. 2011; 22:945-61.

5,530 breast cancers and about 4,800 cervical cancers and high-grade precancerous lesions.[5] In addition, under the Breast and Cervical Cancer Prevention and Treatment Act of 2000 (as amended by the Native American Breast and Cervical Cancer Treatment Technical Amendment Act of 2001), states have the option of providing Medicaid coverage for women who are found to have cancer or precancerous conditions under NBCCEDP. As of August 2011, all states and the District of Columbia had adopted Medicaid treatment options.[6] Federal guidelines permit eligibility for uninsured or underinsured women 40 to 64 for breast cancer services and 18 to 64 for cervical cancer services with incomes below 250 percent of the federal poverty level (although some states use lower income criteria). The federal government provides the majority of funds for this program, while states provide state or local matching funds of at least $1 for every $3 in federal funds and sometimes much more.

The CRCCP is a newer and smaller program, modeled on the NBCCEDP and CDC's three-year demonstration program[7] with a greater new emphasis on population level increases in colorectal cancer screening among those insured and uninsured. It currently supports grants to 25 states and 4 tribes. Screening services, as well as education and patient navigation, are offered to uninsured or underinsured low-income men and women aged 50 to 64 years old. Between 2009 and 2010, it screened 8,494 people, found and removed precancerous polyps for 1,187 people and identified 22 with cancer.[8]

Both programs, and the women and men eligible for them, are affected by the provisions of the Patient Protection and Affordable Care Act (ACA) of 2010. The ACA will substantially reduce the number of people who lack access to affordable cancer screening services, in turn enabling millions of additional Americans to be screened for cancer. A recent study in Oregon randomly assigned low-income people applying for Medicaid benefits; the randomized experiment found that women who received Medicaid had significantly more mammograms and Pap smears in the past 12 months than those who did not.[9,10] Hopefully, this will lead to earlier treatment and to reduced cancer-related mortality and morbidity. The ACA will affect access to cancer screening services through two primary mechanisms.[11] First, it will expand health insurance coverage. Beginning in 2014, more people will be able to obtain coverage through expanded Medicaid eligibility for low-income nonelderly adults up to 133 percent of the poverty line (plus a standard deduction of 5 percent, effectively increasing the limit to 138 percent of poverty) and through federal tax credits for people with incomes below 400 percent of poverty to

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[5] CDC, NBCCEDP: About the Program. Available at http://www.cdc.gov/cancer/nbccedp/about.htm. Accessed Sept. 2, 2011.

[6] CDC, NBCCEDP: About the Program, *op cit.*.

[7] Seeff L, Degroff A, Tangka F, et al. Development of a Federally Funded Demonstration Colorectal Cancer Screening Program. Prev Chronic Dis 2008;5(2): 1-7.

[8] Presentation by Marcus Pleascia, CDC, to the Institute of Medicine Committee on Integrating Public Health and Primary Care, Aug. 11, 2011.

[9] Baicker K, Finkelstein A. The effects of Medicaid expansion: learning from the Oregon experiment. 2011; *NEJM*. 365(8): 683-5

[10] Finkelstein A, Taubman S, Wright B, et al. The Oregon health insurance experiment: Evidence from the first year. NBER Working Paper 17190, July 2011. Http://www.neber.org/papers/w17190. Accessed August 4, 2011.

[11] Hayes K. Availability of certain cancer screening and treatment services under the Affordable Care Act. Department of Health Policy. George Washington University. June 12, 2011. Smith RA, Cokkinides V, Brooks D, et al. Cancer screening in the United States, 2010: a review of current American Cancer Society guidelines and issues in cancer screening. *CA Cancer J Clin*. 2010;60(2):99-119.

purchase private insurance under newly formed health insurance exchanges. Finally, most people be required to have insurance or pay a tax penalty. The Congressional Budget Office estimated that 32 million more Americans would gain insurance due to the ACA.[12]

Second, most insurance policies will include breast, cervical and colorectal cancer screening services without cost-sharing under the ACA. Private health insurance plans (except for those considered "grandfathered") and Medicare will be required to offer, without cost-sharing, preventive health services that have received "A" or "B" level recommendations by the U.S. Preventive Services Task Force. These services include breast, cervical and colorectal cancer screening services.[13] For those currently eligible for Medicaid, the program already covers these services with low cost-sharing. Additionally, states will be offered an incentive to eliminate Medicaid cost-sharing for preventive services. For those newly eligible for Medicaid, the benefit standards will be the same as for those covered by health insurance exchanges, which will include preventive services without cost-sharing. The net effect is that, after the ACA is fully implemented almost all women or men who have health insurance will be covered for cancer screening with no (or very low) cost-sharing.[14]

Although the preventive health services included under the ACA include breast, cervical and colorectal cancer screening, they do not include other related diagnostic testing services. "Screening" refers to initial diagnostic tests to determine whether women who might otherwise appear asymptomatic have an abnormal test result that indicates a potential cancer. But if there is an abnormal screening mammogram, for example, further diagnostic testing, such as fine needle aspiration or excisional biopsies, or other imaging methods, such as magnetic resonance imaging, are typically used to confirm that there is a cancer, to determine the specific type of cancer and to formulate strategies for treatment. In addition, diagnostic testing may also be done on a routine basis for those who have previously been diagnosed and treated for cancer. If, after successful treatment of a cancer and remediation, women are still viewed as being at higher risk, they are typically asked to have routine diagnostic mammograms afterward.

While virtually all health insurance would cover diagnostic services as being medically necessary, they may be subject to high deductibles, coinsurance or copayments that may still create financial barriers for lower-income patients. The ACA ensures that there is no cost-sharing for screening services, but these additional diagnostic tests are not considered screening services. The NBCCEDP covers these diagnostic testing services for uninsured and underinsured women, in addition to screening services.

With respect to the insurance expansions expected under the ACA, a recent analysis by George Washington University estimates that the Affordable Care Act would reduce the number of low-income uninsured 40 to 64 year old women eligible for breast cancer screening under the NBCCEDP by 62 percent between 2009 and 2014 to 1.7 million women and would lower the

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[12] Cost estimate from Congressional Budget Office to Speaker Nancy Pelosi, March 20, 2010.

[13] For breast cancer screening, the Act refers to the Preventive Services Task Force recommendations prior to November 2009.

[14] The ACA provisions regarding insurance coverage and cost-sharing apply to screening services and do not include diagnostic services or treatment. Diagnostic testing may occur after an initial screening shows evidence of a potential cancer or for those who have a history of cancer. Diagnostic testing might include more detailed mammograms, biopsies or other services.

number of uninsured 18 to 64 year old women for cervical cancer screening by 60 percent to 4.5 million women.[15] The number of 50 to 64 year old men and women eligible for colorectal screening would fall by 61 percent nationally to 1.6 million. The share that is uninsured will vary from state to state, although the level of variation across states would be smaller than it is today. Since the ACA establishes national eligibility standards, states with less generous Medicaid eligibility and/or higher uninsurance rates today will tend to have greater gains in insurance coverage than states with more generous Medicaid eligibility and/or lower levels of uninsurance. Nonetheless, there will still be some variation across the nation because of other differences in economic or demographic characteristics that are associated with insurance coverage. (As with any projection model, our estimates are subject to a number of limitations and could be affected by unanticipated changes in the law, the economy or other factors.)

Despite expected reductions in eligible populations, we found that the number of people who have been served by the program continues to be well below the number who are projected to be eligible, even after the ACA insurance expansions have been fully implemented. For example, over the two year period 2008-9, 518,000 women received breast cancer screening, which is about 30 percent of the 1.7 million who are projected to be eligible. From 2007 to 2009, 783,000 women received cervical cancer screening services, or 18 percent of the estimated 4.5 million expected to be eligible.[16]

While the number of women who are eligible after health reform will still substantially exceed the number who can be served nationally (depending, of course, on the level of program funding), the characteristics of women who remain uninsured will change and the concentration of eligible women in any given local service area will decline. These changes could have repercussions for local operations.

The GW analyses indicate that more of the remaining uninsured women will be Hispanic or Asian, have limited English proficiency and be less educated, compared to those currently eligible. Many of the women who remain uninsured will be eligible for insurance (e.g., eligible for Medicaid or tax credits to help purchase insurance), but remain uninsured, suggesting that they are harder to reach, further out of contact with the health care system and perhaps less likely to be motivated by preventive health concerns. Similarly, because the concentration of eligible women in most areas will decline, providers would probably need to conduct relatively more outreach in order to attract patients in numbers comparable to the levels they now serve or be able to serve a larger catchment area.

Options for Programmatic Changes

An important overall finding from these analyses is that millions of low-income women will gain health insurance coverage after the ACA-based insurance expansions take place.

[15] Levy A, Bruen B, Ku L. Estimates of the Uninsured after Health Reform and the Impact on CDC's Cancer Screening Programs. Manuscript submitted for publication.
[16] For the colorectal program, we expect the number eligible to fall from 4.2 million in 2009 to 1.6 million in 2014, a 61 percent reduction. Only 8,500 had been served from 2009 to 2010, about 0.5 percent of those projected to be eligible. Unpublished GW analysis.

Coupled with the removal of cost-sharing barriers for women who have almost any type of health insurance coverage, insurance-based access to breast and cervical cancer screening will be greatly enhanced. Research about the relationship between insurance status and screening, including the Medicaid experiment in Oregon, suggest that these gains in insurance coverage will translate into much higher levels of women screened for cancer.

A primary goal of the CDC cancer screening programs is to help support services for those who are unable to otherwise afford screening on their own because they are uninsured or underinsured. The ACA substantially reduces the scope of the problems of uninsurance and underinsurance for cancer screening, but a substantial number of people will still have poor access to these services because they are both uninsured and have low incomes. The core reason for the CDC cancer screening program will continue to be relevant, even though the ACA will reduce the number of women who will be uninsured or underinsured.

Nonetheless, this important change in the health care environment provides an opportunity to consider possible changes to these programs. The National Breast and Cervical Cancer Early Detection Program Reauthorization Act of 2007 (P.L. 110-18) included authorization for funding of the program through fiscal year 2012 and the program will soon be up for reauthorization. The table below reviews the level of federal funding authorized for fiscal years 2008 to 2012 and the actual appropriations levels. As seen, actual appropriations have fallen short of the authorized levels. There were small nominal increases in appropriations between 2008 and 2010, but the increases were less than the pace of health care cost increases, and funding levels declined slightly, in nominal terms, in FY 2011. The final funding level for FY 2012 has not yet been determined, but given the budget pressures under the Budget Control Act of 2011, it is plausible that FY 2012 appropriations levels will remain below the levels authorized and might be less than FY 2011 levels.

Table1. Authorized and Appropriated Funds for the NBCCEDP

Fiscal Year	Authorized Level	Appropriated Level
2008	$225 mil.	$182.2 mil
2009	$245 mil.	$186.3 mil.
2010	$250 mil.	$189.0 mil.
2011	$255 mil.	$185.3 mil.
2012	$275 mil	Not yet known

In the following discussion, we outline potential changes in the NBCCEDP policies in light of the impacts of the ACA. We consider three primary options and discuss one other operational change which may be appropriate in response to the expected changes. These options are not mutually exclusive and each could be considered on its merits.

1. Retain the Current Program Structure and Reallocate State and Local Funding
2. Modify the Level of Funding That Must Be Spent on Screening to Expand Resources for Other Public Health Approaches
3. Expand Income Eligibility Criteria
4. Focus on Harder to Reach Populations

Similar types of options may exist for the Colorectal Cancer Control Program (CRCCP), but this paper focuses primarily on the NBCCEDP since it is the larger program, has a more established policy structure and is subject to reauthorization in the near future. The CRCCP is still a relatively young and small program and its policies are more flexible and formative.

Retain Current Structure and Reallocate Funding

The GW estimates indicate that there will be substantial changes in the number of women eligible for breast and cervical cancer screening under the NBCCEDP after health reform is implemented, but the level of change will vary from state to state. Nationally, 62 percent of the women eligible in 2009 would not be eligible in 2014, but the level of reduction varies by state. (While we put our estimates of the number of uninsured and eligible women in terms of 2014, in reality it may take longer for the insurance expansions to be fully implemented, in which case the changes might not occur until a later time.) Figure 1 illustrates the projected percent change in women eligible for breast cancer screening between 2009 and 2014 by state. In a number of states (Arkansas, Kentucky, Louisiana, Mississippi, Montana, North Dakota, South Dakota, West Virginia and Wyoming), the reduction will exceed 73 percent, while other states will have reductions less than 50 percent (Arizona, District of Columbia, Massachusetts, New Jersey, New York, Rhode Island, Vermont).

Another way of viewing this is the actual percentage of low-income women 40 to 64 year s old who are uninsured in 2014, which is depicted in Figure 2, as compared to the changes in the

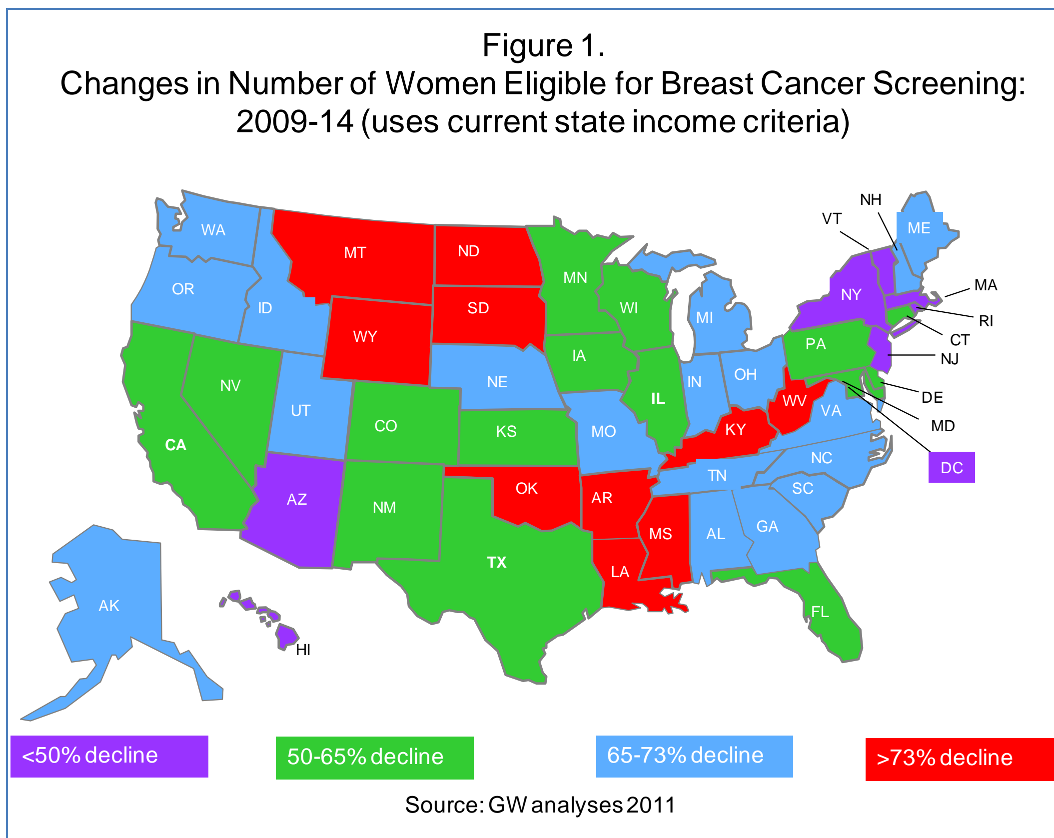
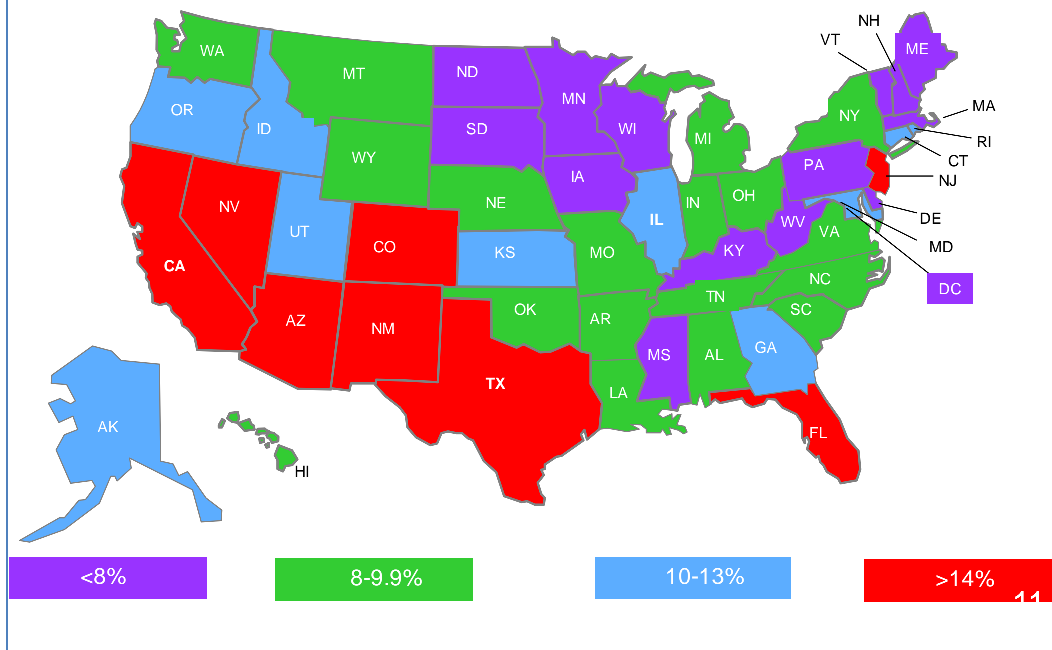


Figure 1.
Changes in Number of Women Eligible for Breast Cancer Screening: 2009-14 (uses current state income criteria)

Figure 2.
Uninsurance Rates for Low Income (<250% FPL) Women 40-64, 2014



number eligible. Southwestern states are expected to continue to have comparatively higher rates of uninsured low-income women than northern or eastern states. By either measure, the expected distribution of eligible women after health reform is implemented will be different than the current distribution.

While data regarding the number of women eligible for cervical cancer screening differ, the general pattern for cervical cancer eligibility is the same as for breast cancer because they both reflect changes in overall insurance coverage of low-income women in the U.S.

One option is to retain the current policy structure of the program, but modify the allocation of funds across the states, in recognition of the major changes that are anticipated in the number of eligible women. For example, funds could be allocated so that the level of funding per eligible woman is relatively similar across the states beginning in 2014. Reallocating funds on the basis of the number of women eligible could promote greater interstate equity.

The current allocation of program funds is not based on the number of eligible women in each state. Other criteria could continue to be appropriate, such as the quality or past performance of grantees or the availability of state matching funds. An advantage of this option is that it might provide greater funding equity across states. A disadvantage is that it could disrupt current funding distribution and seem unfair to states that experience funding cuts. Moreover, if the system was completely formula-driven, it would not include factors such as the strength of the state proposals, the quality or past performance of grantees and the availability of

state matching funds. It could be desirable for these factors to also be included in a funding allocation system. This option would not require a legislative change; CDC has flexibility to make such a change on an administrative basis.

Modify the Level of Funding That Must Be Spent on Screening to Expand Resources for Other Public Health Approaches

After health reform, the number of women who will have insurance coverage for breast and cervical cancer screening will increase considerably, while the number who remain uninsured will fall substantially. Under current policy, state agencies must spend at least 60 percent of program funds for screening of breast and cervical cancer and referrals for treatment, and no more than 40 percent may be spent for other purposes, including other public health approaches, such as consumer education, patient navigation, health professional education, or monitoring and evaluating these services (42 U.S.C. 300m(a)). The "60/40" rule was amended in the 2007 reauthorization to permit CDC to establish time-limited demonstration project waivers for up to five states, under which they may alter the division of funds.

The original purpose of NBCCEDP was to help provide access to breast and cervical cancer screening to low-income uninsured and underinsured women. This original purpose was consistent with literature which found that lack of insurance coverage is one of the most important barriers to adequate screening.[17] After implementation of the ACA, the number of low-income women who are insured will rise appreciably and lack of insurance coverage will be relevant for a much smaller share of women, While far more women will have insurance, many will still face other serious barriers to timely and effective cancer screening such as low incomes or education and other cultural, social, geographic or demographic barriers. Having insurance will improve women's financial access to care, but will not change other underlying characteristics. For example, among Medicare recipients, all of whom have insurance coverage for screening services, about one-third did not obtain a mammogram in the last two years and screening was lower among poorer, poorly educated and Hispanic women.[18]

It may be appropriate to redirect some program funding to help improve education, outreach and navigation services for potentially vulnerable women, regardless of their insurance status to encourage them to receive timely screening. Healthy People 2020 sets goals for the nation that 93 percent of women 21 to 64 obtain cervical cancer screening based on appropriate guidelines and that 74 percent of women 50 to 74 get breast cancer screening.[19] In order to help meet these targets, outreach is needed among both insured and uninsured women, since even among privately insured women of all income levels, many women for whom screening is recommended are not accessing these services.[20] Among low-income women, there may need to

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[17] Schuelder K, Chu P, Smith-Bindman R, *op cit.*

[18] Federal Interagency Forum on Aging-Related Statistics. *Older Americans 2010: Indicators of Wellbeing*. Washington, DC: US Government Printing Office. Available at: www.agingstats.gov/agingstatsdotnet/Main_Site/Data/2010_Documents/Docs/OA_2010.pdf. Accessed July 5, 2011.

[19] Healthy People 2020. See http://healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicid=5. Accessed on Sept. 5, 2011.

[20] Shi L, Lebrun L, Zhu J, Tsai J, *op cit.*

be other supports to help overcome barriers such as a lack of transportation or scheduling problems associated with work or child care.

Some of the types of interventions that might help have been identified by the Task Force on Community Preventive Services, based on their review of the scientific evidence. A summary of the Task Force's recommendations, as presented in the Community Guide is shown below in Table 2.[21] It is important to remember that interventions that are identified as having "insufficient evidence" may or may not be effective, but the Task Force concluded there was not sufficient high quality data at the time of review. Fewer recommendations are made for cervical cancer, in part because fewer studies have been conducted. Three types of interventions that are recommended to improve both breast and cervical cancer screening rates include: client reminders (e.g., reminders from their physicians or clinics to get an appointment for screening), small media (e.g., brochures, newsletters, short videos, etc., as compared to mass media such as larger scale advertisement campaigns), and one-to-one education (e.g., personal counseling, education or advice from a physician, health professional, lay educator, etc., about the benefits of cancer screening). Recommendations for breast cancer screening (but not cervical cancer) include: group education, reducing structural barriers and reducing clients' out-of-pocket costs.

Table 2.
Interventions Identified as Effective Methods to Improve Breast and Cervical Cancer Screening by the Task Force on Community Preventive Services

Interventions	Breast Cancer	Cervical Cancer
Client reminders	Recommended	Recommended
Client incentives	Insufficient Evidence	Insufficient Evidence
Small media	Recommended	Recommended
Mass media	Insufficient Evidence	Insufficient Evidence
Group education	Recommended	Insufficient Evidence
One-on-one education	Recommended	Recommended
Reducing structural barriers	Recommended	Insufficient Evidence
Reducing client out-of-pocket costs	Recommended	Insufficient Evidence

This option would give greater flexibility to CDC (and in turn to the state or tribal agencies) to approve use of a greater share of the NBCCEDP grants for other types of educational, public health or navigational services to help vulnerable women. An advantage to this approach is that it would enable more services to be provided to a broader sector of women and help promote improved screening among vulnerable women who are insured. A

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[21] Task Force on Community Preventive Services. The Community Guide: Cancer Prevention & Control: Client-Oriented Screening Interventions. Available at http://www.thecommunityguide.org/cancer/screening/client-oriented index.html. Acccessed on Sept. 9, 2011.

disadvantage is that it would mean that, for a given level of funds, fewer dollars may be available to finance screenings for uninsured women.

This option would might require a legislative change. Although the 2007 amendments gave CDC limited authority to grant demonstration project waivers, a broader modification in the policy may require a modification of the statutory language.

Raise Income Eligibility Criteria

As noted above, the number of low-income uninsured women eligible under current NBCCEDP income criteria will fall by 60 to 62 percent after health reform to 1.7 million 40 to 64 year old women eligible for breast cancer screening and 4.5 million 18 to 64 year old women eligible for cervical cancer screening. As also noted, most women who have insurance, including private insurance, ought to be covered for breast and cervical cancer screening under the ACA without cost-sharing (or with no or very low cost sharing for Medicaid beneficiaries). However, the ACA protections only apply to screening services and do not include further diagnostic services, such as biopsies, diagnostic mammograms, or other diagnostic services that are necessary to determine whether treatment is appropriate, what type of cancer it is, and how to treat the cancer.

While almost all insurance plans consider such diagnostic services medically necessary and cover them, they might be subject to substantial cost-sharing such as deductibles or coinsurance that could add up to hundreds or even thousands of dollars. These amounts might create a serious cost burden for some low- and moderate-income women. The NBCCEDP also covers diagnostic testing services and it is reasonable to believe that the program covers these services for patients whose screening tests detect abnormalities. The CDC reporting system does not separate the counts or cost of "screening" vs. "diagnostic" services, so it is not clear how many of the current number of women receiving services under the NBCCEDP receive diagnostic services.

Under the ACA, more insured women will have insurance coverage for screening without cost-sharing barriers, but many covered women may encounter cost-sharing difficulties paying for diagnostic services. Women who are newly insured by private insurance will not be eligible for Medicaid coverage under the Breast and Cervical Cancer Prevention and Treatment Act options, which requires that women be uninsured and otherwise not eligible for Medicaid.

In addition, while the ACA will help many more women gain health insurance, there will be many with incomes greater than 200 to 250 percent of poverty who will still be uninsured. The analysis by George Washington University cited earlier found almost 9 percent of women ages 40 – 65 with incomes under 400 percent of FPL (2.5 million women) and over 10 percent of female adults with incomes under 400 percent (6.1 million women) will be uninsured even after the implementation of health reform. These women (such as a married woman living with her spouse, family income of $37,000) are still likely to face financial barriers when seeking screening or diagnostic services.

One option to help ease this problem would be to expand the income eligibility criteria for the NBCCEDP to a higher level. For example, it might be reasonable to expand limits to 400 percent of the poverty line, since that is the limit for premium tax credits under the ACA (about $58,840 in annual income for a two person family). Under this option, both uninsured and underinsured women with incomes below that level would be eligible for services, including screening and diagnostic services.

This option would expand the potential assistance to pay for screening and diagnostic services to low- to moderate-income women at a level that corresponds to the insurance subsidies of the ACA. It would help ensure financial access to screening and diagnostic services to many more women. On the other hand, it would also mean that the program would be less targeted on those with the lowest incomes.

Focus on Harder to Reach Populations

This final point is not a program policy option in the same sense that the other three are. Instead, it is a reminder that program operations will need to shift in order to meet the needs after health reform insurance expansions are implemented. The women who remain uninsured will be harder to reach. There will be fewer of them and a larger proportion will have limited English proficiency and low education. A larger proportion of them will be Hispanic or Asian, including immigrant women. To the extent that they have remained uninsured even after major insurance expansions (and despite an insurance mandate that applies to many of them), this suggests that those who remain uninsured are more disconnected from the usual sources of health information and could be harder to motivate about preventive health services.

Because of these shifts in the characteristics and concentration of women, program administrators will need to conduct more outreach. In addition, given the increase in the share of women who have limited English proficiency, greater efforts may be needed to ensure that services are available in multiple languages. Federal policy already requires that programs like NBCCEDP provide language assistance to those with limited English proficiency under Executive Order 13166 (Improving Access to Services for Persons with Limited English Proficiency) and other applicable civil rights laws. Such services are likely to become even more important in the future. In many cases, outreach with these services will need to be aimed at women who have little contact with health services, through channels such as churches and other community settings. Many state and local programs already have many of these services and have learned how to more effectively reach the hard-to-reach populations; they will need to draw on these experiences to reach those who remain uninsured in the future.

Conclusions

The three main policy options discussed are: (1) retain the current program but reallocate funding across states, (2) modify the level of funding that must be spent on screening and (3) expand the income eligibility criteria. The three options represent different types of potential changes that would modify the NBCCEDP in light of the changes implemented under the Affordable Care Act. As noted earlier, these are not necessarily mutually exclusive options.

Both options 2 and 3 could be implemented in addition to a reallocation of funding (although that would modify the program structure.) We also note that, regardless, of these options, program operations will have to evolve to meet the needs of a harder-to-reach population of women who remain uninsured.

Another critical factor in considering the future of the program is, of course, the level of funding. The NBCCEDP is a discretionary grant program and, like other such programs, it is subject to an annual appropriations process. In recent years, the actual level of program appropriations has not been as high as the levels authorized under the legislation. It is plausible that, given the current budget environment, further federal or state budget cuts could occur. There is uncertainty regarding the future levels of program funding. If the level of program funding changes dramatically, then a different set of options might be appropriate.

Much of this paper is based on our estimates of the number of low-income women who will gain insurance in or after 2014, when the ACA's insurance expansions are implemented. There is also uncertainty about the pace of implementation (or even whether the law remains intact by 2014). We cannot be sure that the expansions will occur as we project or if they will be quickly or slowly implemented. Because of these uncertainties, there is good reason to continue to provide flexibility to the program and to CDC and the states in administering the program.

If future program funds and policies (and service levels) are comparable to those of recent years, we project that NBCCEDP would serve about one-third (30 percent) of the women eligible for breast cancer screening and one-fifth (18 percent) of those eligible for cervical cancer screening. The demand for program services among low-income uninsured women will still exist, although as discussed above, it may be worth considering other options to improve the effects of the program and to better prevent the harmful toll of breast and cervical cancer among American women.

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