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Policy Matters

Health Reform, Medicaid Expansions, and Women's Cancer Screening

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A B S T R A C T

Background: Health reform, including Medicaid expansion, is increasing insurance coverage and financial access to breast and cervical cancer screening for low-income women, although services for low-income uninsured women are still needed.
Methods: American Community Survey and administrative data about Medicaid and health insurance enrollment are used to estimate the number of low-income women who will be uninsured in 2017, focusing on the age ranges 21 to 64, 40 to 64, and 50 to 64.
Results: Assuming that 29 states expand Medicaid (as of June 2015), the national percentage of low-income women 21 to 64 who are uninsured will fall from 32.2% in 2013 to 14.6% by 2017. Among Medicaid-expanding states, the percentage of uninsured will decrease from 28.7% to 8.0%, whereas in non-expanding states, the level will decrease from 36.9% to 23.3%. About 5.7 million women 21 to 64 and 2.6 million women 40 to 64 will remain uninsured in 2017. The size of the uninsured low-income population will remain much larger than the 659,000 women who have previously received Pap tests and 548,000 obtaining mammograms under the National Breast and Cervical Cancer Early Detection Program in 2013.
Discussion: Even before 2014, women living in states that are not expanding Medicaid were less likely to get mammograms and Pap tests than women in expanding states. Affordable Care Act–related insurance expansions will lower financial barriers to screening and should boost overall screening rates. But disparities in insurance coverage and cancer screening across Medicaid-expanding and non-expanding states could widen.
Conclusions: Programs to support cancer screening for low-income uninsured women will still be needed.

Over the past decade cervical cancer screening rates in the United States decreased and breast cancer screening rates remained flat (National Cancer Institute, 2015). Implementation of the Affordable Care Act (ACA) is decreasing the number of uninsured Americans and should substantially expand access to cancer screening. The number of uninsured Americans decreased sharply in 2014, after health insurance marketplaces and Medicaid expansions began, with greater reductions in states that have expanded Medicaid (Cohen & Martinez, 2015; Smith & Medalia, 2015). The ACA also required most insurance plans to cover breast and cervical cancer screening without cost sharing. These changes can reduce substantially financial barriers and increase the demand for cancer screening.

These changes should increase early detection and treatment of cancers and could lead to improved outcomes (Council of Economic Advisors, 2015). Studies of insurance expansions in Oregon and Massachusetts found increased breast and cervical cancer screening as a consequence of insurance expansions (Baicker et al. 2013; Sabik & Bradley, 2015; Finkelstein et al., 2011).

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Cancer patients residing in counties with fewer uninsured had earlier detection and longer survival times (Smith et al., 2013).

Even so, millions of low-income women will remain uninsured and face financial barriers to screening. The Congressional Budget Office (2015) estimates that the ACA will lower the number of uninsured Americans by 24 million by 2017, but 27 million people will remain uninsured and without an affordable health care coverage option for a variety of reasons, including that many states are not expanding Medicaid, some eligible people do not participate in Medicaid or health insurance marketplaces, and some, such as undocumented immigrants, are not eligible for assistance. Many low-income people are exempt from the mandate to have health insurance or are not even aware of it (Karpman, Long, Kenney & Zuckerman, 2015). Of course, insurance coverage is no guarantor that people will seek or receive screening: they may not be aware of the importance of screening, not receive recommendations or referrals from health professionals, lack transportation, or encounter language barriers.

A key public health program to improve cancer screening is the Centers for Disease Control and Prevention's (CDC's) National Breast and Cervical Cancer Early Detection Program (NBCCEDP), which supports screening and diagnostic services for low-income uninsured or underinsured women, as well as outreach, education, and navigation services. Targeting to the uninsured is particularly important since being uninsured is a leading barrier to screening (American Cancer Society, 2015). Evidence indicates NBCCEDP contributes to reduced breast cancer death rates (Howard et al., 2010), decreases time from cancer diagnosis to Medicaid enrollment, expands women's treatment options (Adams, Chien, Florence, & Raskind-Hood, 2009), and improves the timing of diagnosis and treatment of cancer (Lantz & Soliman, 2009; Richardson, Royalty, & Howe, 2010).

In this paper, we estimate the number of low-income women who will gain insurance coverage by 2017 and those who will remain uninsured depending on whether a state expands Medicaid or not. "Low-income" is defined as family income at or below 250% of the federal poverty level (FPL), which is the federal income criterion for NBCCEDP. The target population for cervical cancer screening is women 21 to 64 and for breast cancer screening is women 40 to 64, with women 50 to 64 considered a priority population. Virtually all women 65 or older are insured, at least through Medicare.

This report updates an earlier paper that estimated health reform-related changes in insurance coverage for women in 2014 (Levy, Bruen & Ku, 2012). A key difference is that this paper includes estimates related to whether a state decides to expand Medicaid. The earlier analysis was developed before the Supreme Court's 2012 ruling in *NFIB v Sebelius* (Rosenbaum & Westmoreland, 2012), which gave states the option to expand Medicaid. It assumed the Medicaid expansion was required in all states, based on the original intent of the ACA. As of June 2015, 29 states were expanding Medicaid; the rest were not or were still considering the issue (Kaiser Family Foundation, 2015). States may alter their plans in the future; more may choose to expand Medicaid and some that have already expanded could reverse course. Other difference in this update are technical in nature, using more recent data.

This paper estimates the number of women who will be uninsured in 2017, both with and without a Medicaid expansion. The insights about changes in insurance coverage under health care reform can provide insights into the changes in the demand for cancer screening in the near future and improve policy planning to help ensure that CDC's program is addressing current and future needs (Plescia, Wong, Pieters, & Joseph, 2014).

Methods

The estimation approach in this report is adapted from the methods described in Levy et al. (2012) and August et al. (2016) with some important modifications. A key concept in these papers is that the ACA was largely modeled on Massachusetts' 2006 health reform law (Gruber, 2011; Holtz-Eakin, 2011), so recent coverage for Massachusetts residents can be used to estimate coverage for residents of other states.

This model uses data about women 18 to 64 from the 2013 American Community Survey Public Use Microdata Sample, which surveys about 3 million people with response rates of greater than 90% (Census Bureau, 2015). Our models included data about health insurance status, race/ethnicity, marital status, having children, employment status, industry of employment, poverty status, citizenship status, disability, and education.

We constructed weighted multivariate logit models of health insurance status in Massachusetts. We then applied the model coefficients from Massachusetts to demographic and economic characteristics of the American Community Survey Public Use Microdata Sample respondents in all 50 states and the District of Columbia to predict individual-level probabilities of being insured under health reform. We project forward from 2013 to 2017 by modifying survey weights to account for expected population growth and shifts in the age distribution between 2013 and 2017, based on Census projections (Census Bureau, 2014).

We recognize that states differ from Massachusetts in many ways and calibrated estimates to account for state-specific differences in policies, ACA implementation efforts, market characteristics, and other state traits. We adjusted our estimates to incorporate more recent data available from administrative sources. We used state counts of persons receiving tax credits in health insurance marketplaces as of February 2015 (Office of the Assistant Secretary for Planning and Evaluation, 2015) and changes in Medicaid enrollment between late 2013 and December 2014 (Centers for Medicare and Medicaid Services, 2015). These were adjusted to account for the estimated share of marketplace and Medicaid enrollees who were non-elderly adults with incomes at or below 250% FPL. Other adjustments account for the share of Medicaid and marketplace enrollees who might otherwise have been insured privately and expected growth in the number of marketplace and Medicaid enrollees by 2017. Overall, the average calibration adjustment is modest; our final estimates of the number of uninsured women is 4.9% lower than estimated by the base model. But the difference varies by state; revised estimates are higher than the base model increase in some states, but lower in others. (Other details about the methodology are available from the authors.)

For every state we estimate scenarios of 1) Medicaid expansion to at least 138% of poverty by 2017 and 2) no expansion, using state-specific eligibility levels in the absence of an expansion. (For expanding states, we use Medicaid or similar state program eligibility, including income level and categorical eligibility status in 2013; for non-expanding states, we used January 2015 eligibility criteria [Brooks et al., 2015; Kaiser Family Foundation, 2015]). For scenarios without an expansion model, results are modified based on the expected changes in the uninsured population from 2013 to 2017, but with no gain in insurance coverage for those whose incomes fall between the state's current Medicaid eligibility level and 100% of poverty,