Law and the Public's Health

This installment of *Law and the Public's Health* examines the evolution of U.S. health law in the context of the early detection and treatment of breast and cervical cancer. The column places this evolution in the context of Affordable Care Act implementation for the population generally and the low-income population specifically.

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THE ACA: IMPLICATIONS FOR THE ACCESSIBILITY AND QUALITY OF BREAST AND CERVICAL CANCER PREVENTION AND TREATMENT SERVICES

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This installment of *Law and the Public's Health* examines the implications of legal interventions into health-care financing and service delivery as a mechanism for improving accessibility and quality of health care for low-income and vulnerable populations. The context for this examination is women's health, in particular breast and cervical cancer. Federal policy developments related to these two leading cancers in women are described, beginning with efforts in the early 1990s to improve access for women at risk for medical underservice and culminating with the passage of the Patient Protection and Affordable Care Act (hereafter, the Affordable Care Act [ACA]).[1] Following a review of pre-ACA policy, this article discusses the potential impact of the ACA as well as the potential ongoing role played by these earlier legislative policies.

BACKGROUND

Breast and cervical cancer are the leading cancers among women. Low-income and minority women are less likely to be screened for both forms of cancer and more likely to die than non-minority, non-low-income women.[2]

To address this significant population health disparity, Congress began to take incremental legislative steps toward creating resources for screening and treatment. In 1990, Congress amended the Public Health Service Act to establish a National Breast and Cervical Cancer Early Detection Program (NBCCEDP).[3] The program provides grants to states to fund breast and cervical cancer screening, support services, case-management services (added by amendments enacted in 1998),[4] and other services and activities aimed at developing greater capacity to serve at-risk populations. The Centers for Disease Control and Prevention reports that 8% to 11% of U.S. women are eligible to receive services through the NBCCEDP, which offers services to women with family incomes <250% of the federal poverty level (FPL). Since its 1991 implementation, the NBCCEDP has furnished nearly 10 million breast and cervical cancer screening exams to almost four million women, with diagnoses of more than 52,000 breast cancers, 2,800 invasive cervical cancers, and nearly 137,000 premalignant cervical lesions.[3]

Despite its success, the NBCCEDP had a decided shortcoming in its lack of any provision to finance the actual diagnosis, treatment, and follow-up care in the case of uninsured women whose exams reveal abnormal results. While charitable resources played an important role in this regard, the policy landscape lacked a reliable source of treatment financing to assure coverage for care. At the time of screening, some women may have been otherwise eligible for private insurance or Medicaid on the basis of parental status, pregnancy, or disability. But because of the medical underwriting process that underlies the individual health insurance market, it would be impossible for an uninsured woman with abnormal test results to buy a private policy at any price.

In response to this problem—and relying on a public financing approach to coverage that avoided the private insurance dilemma and had worked for other populations (e.g., pregnant women and people with disabilities) who are in immediate need of health care—Congress enacted the Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) in 2000.[5] The BCCPTA established a state Medicaid eligibility option to cover uninsured women, regardless of income or assets, whose screenings through NBCCEDP reveal abnormal results. By 2009, every state had adopted

the expansion option, although variations existed on important matters of program design and administration, particularly with respect to which women would be considered screened "under the program" and in the extent to which states aligned public health screening and Medicaid enrollment procedures.[6]

The BCCPTA extended coverage to thousands of uninsured (and uninsurable) women for breast and cervical cancer diagnosis and treatment. At the same time, however, the Medicaid expansions experienced serious shortcomings of their own; namely, the inability to enroll until an abnormality is disclosed. This barrier to early coverage (e.g., at the time of initial screening) potentially delayed entry into treatment, as it can take weeks to complete the enrollment process. The use of Medicaid as the basis of expansion also raised problems related to low Medicaid provider participation rates.[7] Indeed, one authoritative study concluded that delays in treatment access appear to have lengthened for certain women in the wake of the Act's implementation, particularly for minority women.[6]

WHAT THE ACA DOES TO PROMOTE BETTER ACCESS TO BREAST AND CERVICAL CANCER PREVENTION AND TREATMENT FOR LOW-INCOME AND MEDICALLY UNDERSERVED WOMEN

An important question arises when federal policymaking evolves from incremental policy design aimed at addressing specific conditions or populations to broader-based interventions that are population wide and intended to address all health-care needs rather than any particular health problem. In the case of the ACA, it is possible to see the significant ways in which the breast and cervical cancer prevention and treatment environment can be expected to change for the women whose health needs were the focus of the NBCCEDP and the BCCPTA. It is also possible to begin to understand the ongoing role that both programs may continue to play despite the enactment of national health-care reform.

Access to and the obligation of coverage

Coverage affordability and accessibility regardless of health status represent the two fundamental tenets of the ACA. Beginning in January 2014, the private health insurance market will be transformed through a federal ban on the denial of coverage based on health status or preexisting condition.[8] Thus, it will be possible for all people to enroll in coverage regardless of their health status at the point of enrollment. As a result, women who have recently received abnormal screening results cannot be denied coverage in the private insurance market. The ACA combines this antidiscrimination ban with the establishment of state health insurance Exchanges to greatly simplify the process of enrolling in an individual insurance plan in the case of women who do not have access to coverage through their employers or Medicare.

The ACA addresses financial access to coverage through two devices: (*1*) a Medicaid expansion to cover all low-income non-elderly adults with family incomes <133% FPL[9] and (*2*) the creation of advance refundable income tax credits for individuals with family incomes from 144% to 400% FPL.[10] The ACA provides that both forms of "insurance affordability" assistance (a term developed by the Department of Health and Human Services in proposed implementation regulations)[11] are to be made accessible through the Exchange enrollment process, thereby simplifying matters for individuals and families unsure of the subsidy for which they may be qualified.

The ACA also envisions continuous coverage. That is, Exchanges will operate not only at the point of initial enrollment, but also as the mechanism by which coverage and insurance affordability assistance both are renewed on an annual basis or more frequently if life circumstances necessitate changes in coverage (e.g., loss of a job with an attendant drop in income, divorce, or marriage).

The *quid pro quo* for this foundational elimination of barriers to coverage access and affordability is a requirement of coverage for all people who are eligible for coverage under the ACA (citizens and individuals legally present in the U.S.) and for whom affordable coverage exists.[12] The individual coverage requirement can be expected to not only significantly expand the reach of health insurance, but also to alter the timing of coverage to better ensure earlier access to preventive care and coverage in the event that a health condition does arise. As a result, the proportion of low-income and medically underserved women who are uninsured at the time they receive an abnormal screening result can be expected to decline.

Access to quality prevention and treatment care

The ACA provides for enrollment into qualified health plans (QHPs) in the case of women eligible for advance refundable premium tax credits through state Exchanges,[13] and into Medicaid benchmark coverage arrangements[14] for women whose incomes are low enough to qualify them for medical assistance. In both cases, coverage will reflect certain essential health benefits[15] that control for patient cost-sharing and that consist of ambulatory patient services, emergency

services, hospitalization, maternity and newborn care, mental health and substance use disorder services (including behavioral health treatment), prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services (including oral and vision care). Preventive services to be covered by all health plans (whether offered through Exchanges, Medicaid benchmark plans, employer products, or individual products purchased in the non-Exchange market)[16] are pegged to A and B recommendations of the U.S. Preventive Services Task Force and must be offered without cost-sharing, thereby removing barriers to recommended breast and cervical cancer exams, as both are recommended.[17]

The ACA provides for enrollment not simply into health-care financing arrangements, but also into QHPs and Medicaid benchmark coverage arrangements, in which coverage is tied to provider networks, as is the custom with modern insurance products. Whether plans are sponsored by state Medicaid agencies or Exchanges, they will be required to meet federal and state access and quality standards for both primary and specialty care[18,19] and will also need to satisfy quality performance benchmarks developed by both the federal government and state purchasers.[16] Furthermore, while cost-sharing for QHPs purchased through state health insurance Exchanges can be relatively steep (e.g., the standard plans available to women receiving advance refundable tax credits would have an actuarial value of only about 70%),[20] the ACA also imposes annual limits on out-of-pocket cost-sharing,[21] bars annual and lifetime limits on coverage,[22] and requires all plans to cover the routine costs associated with participation in clinical trials.[23]

In sum, beginning in January 2014, the ACA moves the population toward what might be thought of as a "new normal." This new normal is a health-care environment in which most Americans are continuously enrolled in health insurance products that cover high-value preventive services, offer a reasonable range of diagnostic and treatment services, limit out-of-pocket exposure along with arbitrary annual and lifetime ceilings on coverage, and even promote access to advanced treatments through clinical trials. Enrollment is into health plans that not only finance care but that are also tied to networks furnishing care, thereby reducing the likelihood of coverage untethered from accessible treatments—a problem that historically has affected Medicaid.

CHALLENGES

Despite its major advances, the ACA leaves important challenges in a breast and cervical cancer prevention and treatment context.

Access to affordable coverage

The ACA leaves out certain women: (*1*) those who are not legally present in the U.S. and who, thus, do not qualify under the new system; and (*2*) women who will continue to face affordability barriers; that is, those for whom no plan is considered to be affordable under the law because their premium payments (whether to an employer or through their state Exchange) exceed 8% of their annual income.[24] For women facing affordability barriers, the Medicaid BCCPTA will remain an important source of last-resort health-care financing; for these women, as well as those not legally present, the NBCCEDP will continue to represent an essential source of affordable screening services. Furthermore, premium affordability programs will be needed, and, of course, subsidized care will be needed for women barred from coverage as a result of legal status issues.

In addition, breaks in coverage may be possible. The ACA provides for seamless subsidized coverage between Medicaid and state Exchanges. At the same time, the high number of individuals and families who experience periodic fluctuations in income is expected to create continuous enrollment challenges for states.[25] As a result, women may experience lapses in coverage as their life circumstances raise the risk of coverage breaks, and as they move from one source of coverage to another depending on the source of financial subsidy (i.e., Medicaid vs. advance premium tax credits).

High out-of-pocket cost-sharing

While the coverage available to women through state insurance Exchanges will be broad, cost-sharing is also expected to be high, again because of built-in limits resulting from the limited level of advance premium tax credits. As the Institute of Medicine noted in its 2011 report on essential health benefits,[26] premiums will need to remain low to limit the number of people barred from coverage as a result of affordability issues. In other words, deductibles and cost-sharing will be high. Annual limits on out-of-pocket payments will play an important role in mitigating individual financial burdens in this regard, but they cannot eliminate them. Providers screening and treating lower-income women who cannot pay these fees, such as public hospitals, community health centers, and other safety-net providers, will continue to face serious revenue shortfalls, which will have to be recouped.

Provider networks

Although health plans participating in Medicaid or Exchanges are expected to maintain provider networks that assure reasonable access to care, physicians already are in short supply (particularly in the primary care specialties), and in many parts of the country, specialty networks may be seriously limited. Interventions to extend care through the establishment of primary care access points in medically underserved communities and the creation of practice teams to support specialty care will be important. In this regard, the ACA provides for a major investment in community health center development to double health center capacity by 2019,[27,28] and the ACA also makes investments in new modes of service delivery whose purpose is to stretch available resources through more efficient approaches to care. But these investments alone cannot overcome the absence of effective cancer treatment programs in communities that experience problems of medical underservice, particularly if such programs eschew participation in provider networks offered through subsidized insurance arrangements.

Patient outreach and support

As noted by the Medicaid and Children's Health Insurance Program Payment and Access Commission (better known as MACPAC), access is more than just provider availability and participation. It is also a function of whether patients are able to appropriately navigate the health-care resources that are available.[7] For this reason, programs that work alongside insurance—and indeed that eventually may be part of insurance provider networks—to assist women at risk for medical underservice through outreach and patient support activities will continue to play a central role for women facing long and difficult courses of cancer treatment and through survivorship.

Access to clinical preventive care

It is true that clinical screening services for breast and cervical cancer will be available through ACA-level coverage, but plans will need provider networks to fully realize the promise of care. In medically underserved communities, access points such as NBCCEDP project grantees will continue to play an important role in extending entry-level care, even for women who are insured.

IMPLICATIONS FOR PUBLIC HEALTH POLICY AND PRACTICE

The ACA's advances are enormous. At the same time, however, the ACA creates a new collection of challenges for historically medically underserved patients. Many of these patients will be brought into a new system of health-care financing but will need access points and support services, particularly in the case of women who live in medically underserved communities where provider networks for both preventive and treatment care may be inadequate. Furthermore, the ACA will leave pockets of health-care financing lapses, particularly for women who are not legally present in the U.S., women who are facing insurance affordability barriers, and women who experience breaks in coverage. Finally, despite the breadth of coverage that the ACA will offer, its high cost-sharing structure may leave many women seriously underinsured or worse, without the means to pay their premiums.

Public health plays a central role in the formation and implementation of policy solutions on each of these matters: in assuring continuing screening and case-management services; in promoting health-care access standards for health plans participating in Medicaid or state Exchanges; in monitoring the accessibility and quality of care; in championing the preservation of state Medicaid coverage for uninsured women diagnosed with breast or cervical cancer in the event that such coverage is needed; and in supporting patients at risk of medical underservice who face the challenges of navigating prevention, treatment, and aftercare. Furthermore, resources will continue to be needed to support Medicaid coverage for the uninsured women who remain, as well as to assure necessary revenues for providers who treat large numbers of underinsured women. Finally, private resources also will continue to be important for women who, by virtue of their legal status, are barred from the new insurance regime.

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