

Advocating to Eliminate Breast Cancer Disparities

Breast cancer is the second most commonly diagnosed cancer among womenⁱ in the U.S. and the second leading cause of cancer death among women after lung cancer. Breast cancer is the leading cause of cancer death among Black and Hispanic women. Black women continue to be 40% more likely to die from the disease, despite lower incidence than White women. This racial disparity is largely the result of less access to high-quality breast cancer screening and bias in medical treatment Black women experience. Research confirms that the LGBTQ+ community also carries a disproportionate burden of cancer, with lesbian and bisexual women possibly showing an increased risk of breast cancer. LGBTQ+ individuals have consistently low rates of health insurance coverage which impacts screening for breast cancer. Lesbian and bisexual women have an increased risk of breast cancer compared to heterosexual women.^{ii,iii}

Our ability to continue to make progress against cancer relies heavily on eliminating inequities that exist in breast cancer prevention and treatment. That is why ACS CAN advocates for policies to reduce the disparities in breast cancer by improving access to prevention and early detection services, patient navigation services, insurance coverage, in-network facilities, and clinical trials.

Early Detection

Breast cancer screenings and early detection through mammograms save lives, but even today too many don't have access to lifesaving breast cancer screenings. In 2021, 64% of women ages 45 years and older were up to date with breast cancer screening. This means that over 3 in 9 (36%) women are not getting tested as recommended.^{iv} The prevalence of up-to date mammography was lower among American Indian/Alaska Native (47%) and Asian (56%) women than Black (69%), White (65%), and Hispanic (60%) women ages 45 years and older.^{viii} Screening rates were the lowest among uninsured women (29%), recent immigrants (37%) and women without a high school education (49%).^{viii} While screening rates are similar across racial and ethnic populations, Black women are more likely to be screened at lower resourced and nonaccredited facilities and also to experience longer intervals between mammograms and between abnormal results and follow-up.^{v,vi,vii,viii} In addition, only 64% of all breast cancers are diagnosed at a local stage^{iv} – partly due to the underutilization of screening.^{iv} **ACS CAN is committed to ensuring access to and coverage of evidence-based early detection services to reduce breast cancer disparities.**

Increasing Funding for the NBCCEDP

The NBCCEDP is the only nationally organized cancer screening program for breast and cervical cancer in the U.S. for disadvantaged and diverse populations who historically have not had adequate access to or have likely experienced other barriers to breast cancer screening. The NBCCEDP uses population-based approaches, such as public education, outreach, patient navigation and care coordination, to increase screening and reach to limited-income, uninsured, and underinsured women in all 50 states, the District of Columbia, 6 U.S. territories and 13 tribes. Despite the NBCCEDP's proven success, federal and state funding is inadequate and has left many limited-income women unable to receive potentially lifesaving screenings. **ACS CAN urges Congress to increase funding for the NBCCEDP to ensure access to breast cancer screenings for those who continue to lack access to lifesaving screening.**

Ensuring that Breast Cancer Screening Services – Including Follow-on Screening Tests – Are Covered without Cost Sharing

Some insurers apply cost sharing when initial breast cancer screening requires additional follow-on testing to determine whether an individual has cancer, or if dense breast tissue requires additional imaging. These tests are integral to the screening process to determine whether an individual has cancer and therefore should be provided with no patient cost-sharing. While federal law requires most private insurance and Medicaid expansion plans to cover recommended preventive services with no patient cost sharing, there are still instances where a patient may be charged. **ACS CAN advocates to ensure breast cancer screening services – including follow-up testing – are covered without no cost-sharing.**

For more information on ACS CAN's prevention and early detection advocacy work visit <https://www.fightcancer.org/policy-resources/prevention-and-early-detection/screening>.

Patient Navigation

Increasing Access to Patient Navigation Services

Patient navigation services have been shown to help increase cancer screening rates among historically marginalized racial and ethnic populations by providing access to disease prevention education, conducting community outreach, and facilitating public education campaigns.^{ix,x,xii} One study showed that women with access to patient navigation services were significantly more likely to be up to date on their mammography screening compared to women who did not receive these services, with the largest impact among African American Medicare beneficiaries living in urban areas who were previously not up to date on their breast cancer screenings.^{xiii} However, patient navigation is still absent or limited in many cancer programs and hospital settings due to cost concerns and a lack of long-term funding to pay for these services. **ACS CAN advocates to ensure everyone at risk for or diagnosed with breast cancer can access patient navigation.**

Access to Health Insurance, In-Network Facilities, and Clinical Trials

Ensure Reasonable Access to Breast Cancer Screening and Care

Health plan networks are required to meet certain network adequacy standards that include being geographically available to patients – so patients needing need specific providers and testing services do not have to travel too far to access these services. Lack of access to in-network facilities can mean a person is less likely to get screened for cancer or receive care or risk being charged for out-of-network care. **ACS CAN advocates to ensure health insurance networks adequately provide all enrollees reasonable and timely access to an in-network facility that provides mammography, follow-up breast cancer testing, high quality treatment, and appropriate health care providers.**

Expanding Medicaid in the 10 Remaining States that Have Not Done So

Medicaid is a lifeline for thousands of families who without health insurance would not have access to the breast cancer screening, early detection, treatment and follow-up care they need. In 10 states, there are close to 2 million people who fall into the Medicaid coverage gap. The “coverage gap” refers to individuals

American Cancer Society Cancer Action Network | 655 15th Street, NW, Suite 503 | Washington, DC 20005

 @ACSCAN |  @ACSCAN | [fightcancer.org](https://www.fightcancer.org)

Updated 7.07.23

who remain ineligible for Medicaid but earn too little to qualify for premium tax credits for qualified health plans in the Marketplace – 60% of these uninsured individuals are people of color, and the vast majority live in the American South. A cohort study including nearly 1.8 million women with breast cancer between 2012-2016 found that “patients with Medicaid were less likely to present with advanced-stage cancer than those who were uninsured.”^{xiii} **ACS CAN advocates for all states to expand Medicaid and Congress must close the coverage gap for lower income Americans who live in states that have failed to expand to reduce breast cancer disparities.**

For more information on ACS CAN’s access to care advocacy work visit <https://www.fightcancer.org/what-we-do/access-health-care>.

Reducing Barriers to Increase Diversity in Cancer Clinical Trials

Clinical trials are vital to advancing new and improved standards of care and give patients the opportunity to access the latest developments in treatment. However, disparities in access to and participation in cancer clinical trials can limit the broader applicability of trial results, leading to social injustice. For instance women who belong to certain racial and ethnic groups^{xiv} are underrepresented in breast cancer clinical trials and those with limited incomes are less likely to participate.^{xv} **ACS CAN advocates for policies that can increase diversity in clinical trials and make it easier for all people with cancer to participate in clinical trials by reducing barriers to enrollment.**

For more information on ACS CAN’s clinical trial and drug development advocacy work visit <https://www.fightcancer.org/policy-resources/research-funding-and-drug-development>.

ⁱ Throughout this document *women* refers to individuals assigned female at birth. However, the NBCCEDP program also provides screening and treatment services to eligible transgender individuals.

ⁱⁱ American Cancer Society (ACS), *Lesbian, Gay, Bisexual, Transgender, Queer (LGBTQ) People and Cancer Fact Sheet*, published 2022, accessed on February 24, 2022, retrieved from <https://www.cancer.org/content/dam/cancer-org/cancer-control/en/booklets-flyers/lgbtq-people-with-cancer-fact-sheet.pdf>.

ⁱⁱⁱ Jason Domogauer, Tal Cantor, Gwendolyn Quinn, Marina Stasenko, Disparities in cancer screenings for sexual and gender minorities, *Current Problems in Cancer*, Volume 46, Issue 5, 2022, 100858, ISSN 0147-0272, <https://doi.org/10.1016/j.currprobcancer.2022.100858>.

^{iv} American Cancer Society. *Cancer Prevention & Early Detection Facts & Figures 2023-2024*.

^v Warnecke RB, Campbell RT, Vijayasingh G, Barrett RE, Rauscher GH. Multilevel Examination of Health Disparity: The Role of Policy Implementation in Neighborhood Context, in Patient Resources, and in Healthcare Facilities on Later Stage of Breast Cancer Diagnosis. *Cancer Epidemiol Biomarkers Prev.* 2019;28:59-66.

^{vi} Lawson MB, Bissell MCS, Miglioretti DL, et al. Multilevel Factors Associated With Time to Biopsy After Abnormal Screening Mammography Results by Race and Ethnicity. *JAMA Oncol.* 2022;8(8):1115-1126. doi:10.1001/jamaoncol.2022.1990.

^{vii} Star J, Bandi P, A KM, Jemal A, SAF. A first look at breast cancer screening in over 1000 community health centers in the United States. *Prev Med.* 2022;161:107115.

^{viii} Nyante SJ, Abraham L, Aiello Bowles EJ, et al. Diagnostic Mammography Performance across Racial and Ethnic Groups in a National Network of Community-Based Breast Imaging Facilities. *Cancer Epidemiol Biomarkers Prev.* 2022;31:1324-1333.

^{ix} Natale-Pereira, A., Enard, K., Nevarez, L., Jones, L. (2011) "The Role of Patient Navigators in Eliminating Health Disparities", *Cancer*, p. 3543-3552, <https://acsjournals.onlinelibrary.wiley.com/doi/epdf/10.1002/cncr.26264>.

^x Nelson HD, Cantor A, Wagner J, et al. Effectiveness of patient navigation to increase cancer screening in populations adversely affected by health disparities: a meta-analysis. *J Gen Intern Med.* 2020;35(10):3026-3035. doi:10.1007/s11606-020-06020-9.

^{xi} Guide to Community Preventive Services. *Cancer Screening: Patient Navigation Services to Increase Cervical Cancer Screening and Advance Health Equity.*

<https://www.thecommunityguide.org/findings/cancer-screening-patient-navigation-services-to-increase-cervical-cancer-screening.html>. Page last updated: January 24, 2023.

^{xii} Marshall, J.K., Mbah, O.M., Ford, J.G. et al. (2016) "Effect of Patient Navigation on Breast Cancer Screening Among African American Medicare Beneficiaries: A Randomized Controlled Trial". *Journal of General Internal Medicine*, 31, p. 68–76. <https://doi.org/10.1007/s11606-015-3484-2>

^{xiii} Le Blanc JM, Heller DR, Friedrich A, Lannin DR, Park TS. Association of Medicaid Expansion Under the Affordable Care Act With Breast Cancer Stage at Diagnosis. *JAMA Surg.* 2020;155(8):752–758. doi:10.1001/jamasurg.2020.1495.

^{xiv} Aldrighetti, C. M., Niemierko, A., Van Allen, E., Willers, H., & Kamran, S. C. (2021). Racial and Ethnic Disparities Among Participants in Precision Oncology Clinical Studies. *JAMA network open*, 4(11), e2133205. <https://doi.org/10.1001/jamanetworkopen.2021.33205>.

^{xv} Unger, J. M., Gralow, J. R., Albain, K. S., Ramsey, S. D., & Hershman, D. L. (2016). Patient Income Level and Cancer Clinical Trial Participation: A Prospective Survey Study. *JAMA oncology*, 2(1), 137–139. <https://doi.org/10.1001/jamaoncol.2015.3924>.