

**Report of the
Indiana Cancer Consortium's Cervical Cancer Task Force**



**Indiana Cancer
Consortium**

December 2005

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EXECUTIVE SUMMARY

- Cervical cancer is almost completely preventable, especially when cytological screenings are done regularly.
- Human Papilloma Virus (HPV) infection is associated with the development of cervical cancer; however, the presence of HPV does not ensure cervical cancer will develop.

The Cervical Cancer Task Force members are unanimous in their view that both private and public entities must work together for cervical cancer to be eliminated. As a result, the Task Force offers five recommendations:

The Indiana Breast and Cervical Cancer Program (IN-BCCP) has been operational since 1996. For women aged 40-64, IN-BCCP covers pelvic exams for those who have not had a hysterectomy, conventional Pap tests for screening and follow-up, and human papilloma virus (HPV)/deoxyribonucleic acid (DNA) testing for women with atypical squamous cells of undermined significance (ASCUS) findings on their Pap tests. At this time, the IN-BCCP is providing services at near capacity, based on current funding and staffing levels. In fiscal year 2004-2005, the IN-BCCP provided services to at least 5,800 women, which is an increase of at least 500 women screened than in the previous year. (Final figures for 2004-2005 are not yet available.) Based on current funding levels and increased program efficiency, the program estimates its screening capacity is a maximum of 7,000 women. Therefore, the ICC Cervical Cancer Task Force recommends:

Recommendation #1 Advocate for increased federal funding for the National Breast and Cervical Cancer Early Detection Program, which screens and diagnoses women who do not qualify for Medicaid or Medicare, lack insurance and meet certain income and age requirements

In Indiana, overall mortality rates are comparable to the rest of the country; however, incidence and mortality rates show a disparity between Caucasian women and African-American women. The incidence rate is higher in African Americans and despite similar screening rates with Caucasians, the mortality rate is higher in African Americans after age 50. Cultural beliefs about cancer may delay or prevent screening. Therefore, the ICC Cervical Cancer Task Force recommends:

Recommendation #2 Commission a study of public and private programs from other states with large minority populations to identify successful strategies to decrease the burden of cervical cancer in African American women.

Although the future seems promising on the HPV vaccine front, policy makers are strongly cautioned to avoid scaling back cervical cancer screening. It will take many years before cervical cancer screening guidelines can be developed that will be cost-effective for the population as a whole. When an HPV vaccine receives FDA approval, the CDC's Advisory Committee on Immunization Practices (ACIP) guidelines should be followed. In preparation for an HPV vaccine, government leaders are encouraged to ensure that every child has a medical home to get care and vaccines. Public entities are encouraged to educate the general public and providers about HPV and its link to cervical cancer. Therefore, the ICC Cervical Cancer Task Force recommends:

Recommendation #3 Support implementation of a widespread science-based public health education campaign to address HPV and its association with cervical cancer.

While there are conflicting guidelines among the various organizations, a similar theme emerges when reviewing the common denominator for each set of recommendations. Simply put, the biggest risk factor for the development of cervical cancer is failure to be screened. Therefore, the most important factor to decrease cervical cancer development in the population is to provide access to regular health care and regular cervical cancer screening. According to the Northern Indiana/South Bend Project survey, over 40% of women who attended the Pap-A-Thon had health care coverage but either could not afford the co-pay or did not have preventive services covered within their health care plan. Therefore, the ICC Cervical Cancer Task Force recommends:

Recommendation #4 Commission a study to examine public and private insurance coverage for cervical cytology tests.

Recommendation #5 Increase the number of adequately insured Hoosiers, thus increasing the number of women with access to screenings and treatment for cervical cancer.

INTRODUCTION

Cervical cancer is highly preventable. Routine cytological screening tests, including the conventional Papanicolaou test (commonly called a Pap test) and the newer liquid-based test, can detect abnormalities before cervical cancer has developed. Cervical cancer rates have significantly decreased since the mid 1900's as more women have received regular screening. However, in the past 10 years the incidence rate has remained unchanged due to a persistent population of unscreened or poorly screened women.

In Indiana, overall mortality rates are comparable to the rest of the country; however, incidence and mortality rates show a disparity between Caucasian women and African-American women and between socioeconomic status, despite insurability. The National Cancer Institute (NCI) Center to Reduce Cancer Health Disparities hypothesizes that cervical cancer is an indicator of low access to health care in poor communities. In a recent NCI report, the analysis of cervical cancer data showed women from high cervical cancer mortality regions also exhibit high mortality rates for other screenable and treatable diseases, including breast cancer and colon cancer¹.

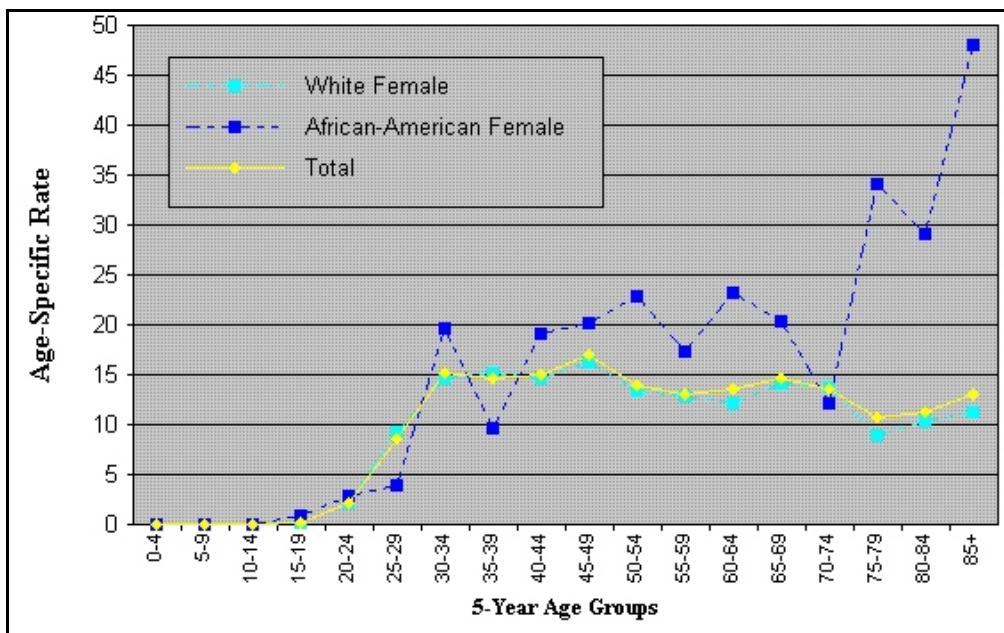
Continued efforts need to be targeted at populations with higher incidence rates such as African-American females and under screened women, e.g., women in the Hispanic/Latino population. Special attention also needs to focus on populations with health insurance but without preventive health care coverage. It is imperative that both public and private sectors focus attention on this preventable disease.

This report describes Indiana's cervical cancer burden, issues related to different screening options, and what needs to be done to address this problem. The following sections describe the cervical cancer disease burden in Indiana and nationally, Human Papilloma Virus (HPV) and its link to the development of cervical cancer, screening technologies for cervical cancer, barriers to effective screening, Indiana programs for cervical cancer screening and treatment, and policy and funding recommendations that can help eliminate the cervical cancer burden in Indiana.

CERVICAL CANCER DISEASE BURDEN, INDIANA AND NATIONAL

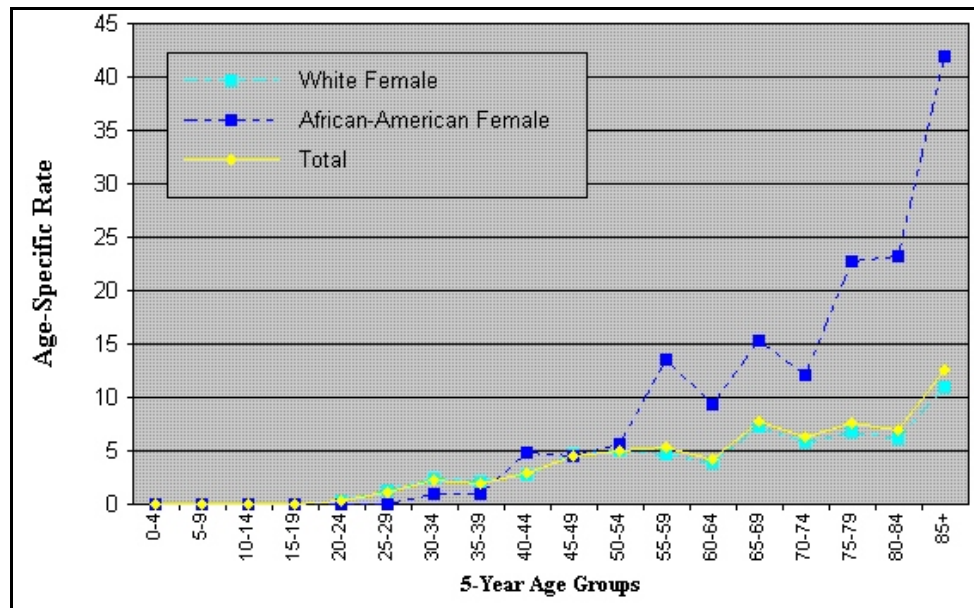
Cervical cancer is almost completely preventable, especially when cytological screenings are done regularly. Although Indiana cervical cancer incidence (new cases) and mortality (death) rates are comparable to the rest of the country, disparities persist. Age-specific incidence and mortality rates show that cervical cancer risk increases with age and that increased risk is disproportionately higher for African American women compared to Caucasian women. Figure 1 displays the disparity in incidence rates from 1998-2002. Figure 2 explicitly shows the disparity in mortality rates between Caucasians and African Americans.

Figure 1. Age Specific Incidence Rates, 1998-2002



Source: Indiana State Department of Health, Epidemiology Resource Center and Division of Chronic/Communicable Disease, State Cancer Registry, Cervical Cancer Incidence and Mortality Annual Report 2002

Figure 2. Age Specific Mortality Rates, 1998-2002

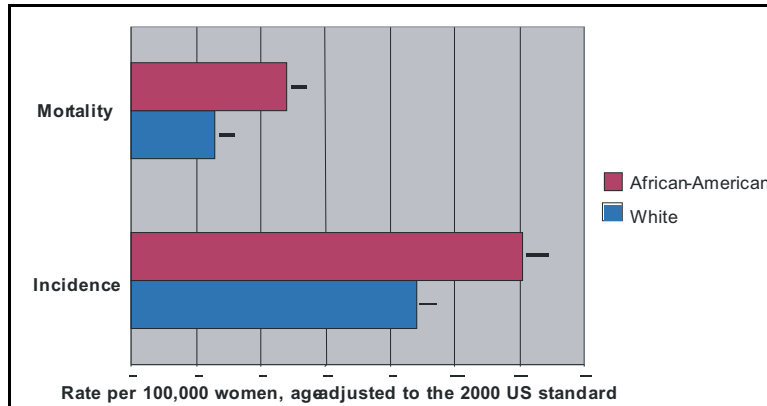


Source: Indiana State Department of Health, Epidemiology Resource Center and Division of Chronic/Communicable Disease, State Cancer Registry, Cervical Cancer Incidence and Mortality Annual Report 2002

In 2002, 274 Indiana women were diagnosed with invasive cervical cancer for an age-adjusted incidence rate of 8.7 per 100,000, which is significantly higher than the national average of 7.2 per 100,000. Death rates and racial disparities present a different picture. In 2002, 80 Indiana women died of cervical cancer for a mortality rate of 2.4 per 100,000, which is similar to the estimated national rate of 2.5 per 100,000. However, from 1998 to 2002, African American women in Indiana experienced both a significantly greater incidence and mortality from cervical cancer than Caucasian women (12.1 vs. 8.8 cases per 100,000; 4.8 vs. 2.6 deaths per 100,000) **(Figure 3)**

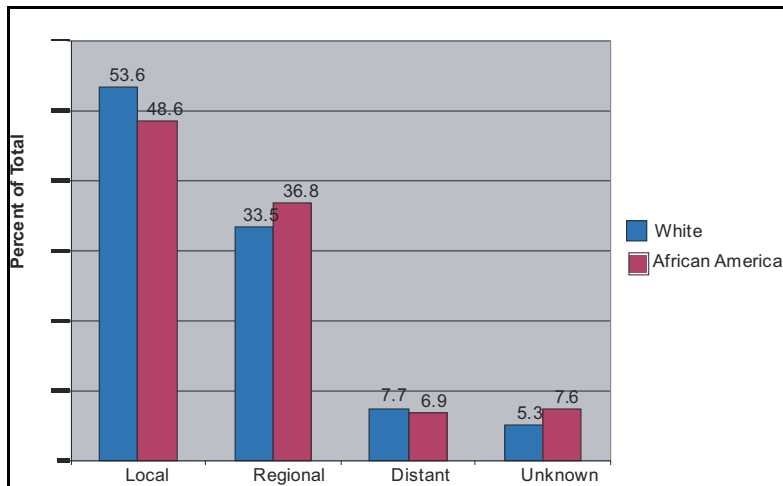
Cancers diagnosed early are more likely to be cured than are those diagnosed at a later stage. For example, the five-year national relative survival rate for women diagnosed at a local stage was 92.4 in 1995-2001. Nationally, from 1995-2001, 55% of cervical cancer cases were diagnosed early (localized). In Indiana, from 1998-2002, 52.7% of cervical cancer cases were diagnosed early, at the local stage **(Figure 4)**. African-American women in Indiana, however, are less likely to be diagnosed at an early (localized) stage than are Caucasian women. Because of small numbers, incidence and mortality rates are not available for Indiana Hispanic/Latino populations.

Figure 3. Age Adjusted Cervical Cancer Rates, 1998-2002



Source: Indiana State Department of Health, Indiana State Cancer Registry and Epidemiology Resource Center, 2005

Figure 4. Stage at Diagnosis by Race, 1998-2002

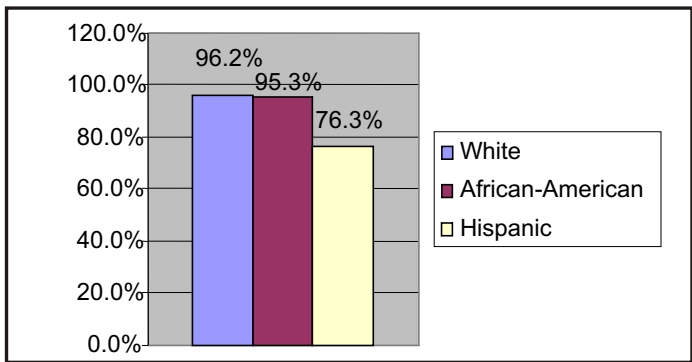


Source: Indiana State Department of Health, Indiana State Cancer Registry and the Epidemiology Resource Center, 2005

Early diagnosis is dependent upon regular Pap tests. The Behavioral Risk Factor Surveillance System, Indiana Statewide Survey Data, 2002 show that an estimated 94.7% of Indiana women have had at least one Pap test in their lifetime. Of women reporting having ever had a Pap test, the percentage of African-Americans (95.3%) was not statistically different from the percentage of Caucasians (96.2%). However, the percent of Hispanic women reporting having ever had a Pap test (76.3%) was significantly lower than both Caucasians and African-Americans (**Figure 5**). Of those women reporting they have had at least one Pap test in their lifetime, almost two

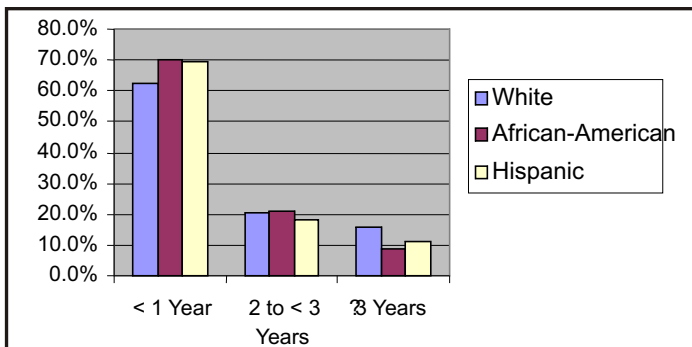
thirds (63.1%) have had a Pap within the past 12 months and 83.8% within the past 3 years (Figure 6). In addition, both African-Americans and Hispanics were more likely to have had a Pap test within the past 12 months than were Caucasians.

Figure 5. Women Who Have Ever Had a Pap Test



Source: Indiana Behavioral Risk Factor Surveillance System, Indiana State Department of Health, 2005

Figure 6. Of the Women Who Have Had At Least One Pap Test, How Long Has it Been Since the Last Pap Test?



Source: Indiana Behavioral Risk Factor Surveillance System, Indiana State Department of Health, 2005

In summary, despite similar screening rates, there remains a mortality disparity that appears to be based on minority status. This report recommends that the State of Indiana address this disparity.

HUMAN PAPILLOMA VIRUS

Human Papilloma Virus (HPV) infection is associated with the development of cervical cancer. HPV is the most common sexually transmitted infection (STI) so common that virtually all sexually active individuals are at risk. The Centers for Disease Control and Prevention (CDC)

has reported that as many as 80 percent of adults will get a genital type of HPV by the age of 50. Fortunately, most HPV infections are naturally cleared from the genital tract. These are referred to as “low risk” HPV types and are linked to skin and genital warts, but not to cervical cancer. On the other hand, after persistent HPV infections, some HPV types may cause abnormal cell growth or cervical dysplasia (precancerous condition). These HPV types are linked to cervical cancer and referred to as “high risk” HPV types.

HPV is spread from person to person through intimate skin-to-skin contact or sexual intercourse. Although condoms provide some protection, they cannot prevent infection completely, because they do not cover all areas of the genital region.

With early detection and treatment, cervical cancer can be prevented. Although there is no treatment for an HPV infection, it is possible to treat the cellular changes caused by HPV. When considering current and new technologies, it is important to note that even though HPV infection is associated with cervical cancer; persistent HPV infection does not ensure its development.

CURRENT TECHNOLOGY

Current technology consists of conventional cytology (the Pap test), liquid-based cytology, and human papilloma virus (HPV) typing. The Pap test was introduced in the United States in 1941, followed shortly thereafter by a dramatic drop in the incidence of cervical cancer among American women. The Pap test is a simple, inexpensive, cost-effective, and reliable form of screening for cervical cancer, with a proven track record, and correlates with lower death rates from cervical cancer. Newer technology (liquid-based tests) is available, but despite a multitude of studies, there is no documented evidence that using liquid-based test reduces death rates or increases early detection of cervical cancer.

A review of 25 prospective studies comparing liquid-based tests to conventional pap tests noted that only 7 of these studies provided histological correlation with the Pap test. Therefore, it is not possible to confirm the true sensitivity or specificity of this technology. Sensitivity is the ability of the test to correctly identify those individuals who are positive for a certain disease. Specificity is the statistical probability that an individual who does not have the particular disease being tested for will be correctly identified as negative. In addition, there was neither a reduction in the number of Pap tests identifying atypical squamous cells of undetermined significance (ASCUS) nor a reduction in unsatisfactory specimens, both cited as benefits of the newer liquid-based technology. The final conclusion of this review is that current evidence is

inadequate to determine whether the new technology is better than the conventional Pap test. Similar conclusions are drawn when reviewing the data regarding HPV testing. Although HPV is associated with cervical cancer, it is ubiquitous, and identifying the organism does not improve the detection or prevention of cervical cancer. HPV testing can be of some benefit in triaging patients with an ASCUS Pap test, but this use is limited.

The causative relationship between HPV and cervical cancer has provided the rationale for production of a prophylactic HPV vaccine. This vaccine would protect those who have not been previously exposed to HPV. Since HPV infection can occur within several months of initiation of sexual contact, vaccination at an age of 8-10 years or less may be required for effective prevention. The duration of protection and societal acceptance of vaccination has not yet been determined. However, several pharmaceutical companies are in various stages of testing potential HPV vaccines and it is probable a vaccine will be on the market within the near future.

Although the future seems promising on the HPV vaccine front, policy makers are strongly cautioned to avoid scaling back cervical cancer screening. It will take many years before cervical cancer screening guidelines can be developed that will be cost-effective for the population as a whole. The CDC's Advisory Committee on Immunization Practices (ACIP) will soon discuss the vaccine to determine guidelines for its usage. When an HPV vaccine receives FDA approval, the CDC's Advisory Committee on Immunization Practices (ACIP) guidelines should be followed. In preparation for an HPV vaccine, government leaders are encouraged to ensure that every child has a medical home to get care and vaccines. Public entities are encouraged to educate the general public and providers about HPV and its link to cervical cancer.

SCREENING FOR CERVICAL CANCER

Cervical cancer screening recommendations from national organizations:

- The American Cancer Society (ACS) recommends that all women begin cervical cancer screening about 3 years after they begin having vaginal intercourse, but no later than 21 years old. Screening should be done annually with the conventional Pap test or every 2 years using the newer liquid-based test. Beginning at age 30, women who have had 3 normal conventional Pap test results in a row may get screened every 2 to 3 years with either the conventional Pap test or liquid-based test. Another reasonable option for women over 30 is to get screened every 3 years (but not more frequently) with either the conventional Pap test or liquid-based test, plus the HPV DNA test.

- The American College of Obstetricians and Gynecologists (ACOG) and The American College of Surgeons (ACOS) recommend annual cervical cancer screening. Both organizations provide recommendations for initiating screening and extending the interval.
- The U.S. Preventive Services Task Force (USPSTF) and the Agency for Healthcare Research and Quality (AHRQ) recommend screening every three years. USPSTF and AHRQ do not recommend new technologies including, liquid-based and HPV testing, concluding that current evidence is not sufficient to justify a possible increase in potential harms or cost.
- The Centers for Disease Control and Prevention (CDC) recently modified its guidelines for cervical cancer screening for the National Breast and Cervical Cancer Early Detection Program (NBCCEDP). CDC now recommends that states may reimburse providers for biennial screening with either the liquid-based test or annual screening with the Pap test, at the conventional Pap test reimbursement level. The CDC report indicated that “Increased sensitivity and decreased specificity are associated with this (new) screening technology.

While there are conflicting guidelines among the various organizations, a similar theme emerges when reviewing the common denominator for each set of recommendations. Simply put, the biggest risk factor for the development of cervical cancer is failure to be screened. The important factors are providing education to women and health care providers and access to regular health care and regular cervical cancer screening, regardless of which set of guidelines is adopted.

BARRIERS TO CERVICAL CANCER SCREENING

Cultural beliefs about cancer may delay or prevent screening. For African Americans, fatalistic views about cancer or the belief that an individual will die regardless of the stage of diagnosis or treatment may exist; in other words, since death is evitable if one is diagnosed with cancer, then screening may be delayed or not initiated. Other cultural influences include not wanting to know if one has cancer and avoiding discussions about cancer because of its taboo nature.

Unfortunately, many women fail to receive timely, or for that matter any, resolution of an abnormal cervical cancer screen. In fact, between 7 and 49 percent of women with abnormal Pap tests do not receive appropriate followup⁷. Specifically, up to 50% non-adherence to follow-up for colposcopy may occur for African-American women. Colposcopy is a procedure that uses a

special microscope (called a colposcope) to look very closely at the cervix. Regardless of race, lack of follow-up is more likely in women with financial barriers, low education levels, low income, and less social support. In addition, fear of over perceived loss of reproductive and sexual functioning, medical procedures, and distress, anxiety, or other emotional responses may affect timely follow-up.

In Indiana, African Americans consistently have higher death rates from cervical cancer than non-Hispanic Caucasians. Although no local data could be identified for the causes of these disparities, researchers have conducted numerous studies across the US to determine factors associated with decreased cervical cancer screening in African Americans. Common factors across studies include lack of health insurance, low educational attainment, poverty, less exposure to reproductive health services providers, not having a usual source of care, not having regular health checks, no health care provider recommendation to get screened, and lack of knowledge about risks. In addition, a survey of the Hispanic/Latino populations in northern Indiana (South Bend/Plymouth/Mishawaka/Elkhart) suggests these women do not receive regular screening due to the lack of insurance or finances to pay for the tests. Of the women surveyed, 75% had no health insurance or were unable to pay for the screening, 10% did not realize it was important for their health and 7% did not feel comfortable with a health care professional.

Health care professionals are a vital component of helping decrease the barriers to cervical cancer screening. The importance of screening needs to be emphasized by all health care providers in a culturally appropriate manner, within the framework of a trusting relationship.

INDIANA PROGRAMS FOR CERVICAL CANCER SCREENING AND TREATMENT

Indiana Breast and Cervical Cancer Program

The Indiana Breast and Cervical Cancer Program (IN-BCCP) has been operational since 1996. The IN-BCCP provides reimbursement for screening mammography and clinical breast exams for women aged 50-64 years who meet income guidelines and are uninsured or underinsured. For women aged 40-64, IN-BCCP also covers pelvic exams for those who have not had a hysterectomy, conventional Pap tests for screening and follow-up, and human papilloma virus (HPV)/deoxyribonucleic acid (DNA) testing for women with atypical squamous cells of undermined significance (ASCUS) findings on their Pap tests. Current policies support the use of federal funds for biennial screening with the liquid-based test or annual screening with the Pap

test, when reimbursing providers at the conventional Pap test reimbursement level. Women who live in households with an annual income up to 200 percent of the federal poverty level and who are not otherwise covered by insurance (including Medicare and Medicaid) are eligible for coverage under the IN-BCCP. Women age 65 and older are also eligible for the program if they are not covered by Medicare. Unfortunately, CDC estimates only 20% 21% of eligible women aged 50 to 64 years can be funded to receive Pap tests and mammograms through NBCCEDP.

Through June 29, 2004, the IN-BCCP served 26,136 women, funded 23,494 Pap tests, 15,790 mammograms, and 31,930 clinical breast exams. The program identified 258 cases of breast cancer and 18 cases of invasive cervical cancer. Of the women served, 74% were Caucasian, 14% African American, 2% Multiracial, 1% Asian/Pacific Islander, 1% Native American, 7% Other, and 1% Unknown. In addition, 21% of women served claimed Hispanic/Latino ethnicity.

At this time, the IN-BCCP is working at near capacity based on current funding and staffing levels. In fiscal year 2004-2005, the IN-BCCP provided services to at least 5800 women, which is an increase of at least 500 women screened than in the previous year. (Final figures for 2004 2005 are not yet available.) IN-BCCP Regional Coordinators and Outreach Workers are responsible for this steady increase in screening levels. Based on current funding levels and increased program efficiency, the program estimates its capacity is screening a maximum of 7000 women. If recruitment exceeds capacity, the primary option is to develop a waiting list.

National Breast and Cervical Cancer Prevention and Treatment Act of 2001

The National Breast and Cervical Cancer Prevention and Treatment Act of 2001 allows states to extend Medicaid eligibility to women screened through the Breast and Cervical Cancer Early Detection Program (NBCCEDP). Indiana responded immediately, passing Public Law 152 of 2001, which made women screened and diagnosed with breast or cervical cancer eligible for a specific category of Medicaid by virtue of their enrollment in IN-BCCP. Eligibility for Medicaid under this law is “limited to the duration of treatment required for breast or cervical cancer.”

Since 2001, IN-BCCP has enrolled approximately 600 women in the IN-BCCP Medicaid Treatment Program. Approximately 65% of these women presented with a precancerous condition and treatment recommendation from their provider or with invasive cervical cancer.

PUBLIC AND PRIVATE PARTNERSHIPS

Public and private partnerships have enhanced the IN-BCCP's ability to enroll eligible women in

their program. Examples of this come from across the state.

American Cancer Society (ACS)

An ACS national priority is to increase breast and cervical cancer screening rates among the medically underserved, especially through the National Breast and Cervical Cancer Early Detection Program (NBCCEDP) by:

- Advocating for increased funding for the IN-BCCP at national and state levels and incorporating the message into the ACS Celebration on the Hill, fall 2007.
- Incorporating the NBCCEDP message into ACS's "Making Strides Against Breast Cancer" events. ACS staff and volunteers are working to engage the Strides audience as advocates and encouraging them to educate uninsured women in their communities about the availability of life saving services offered by the IN-BCCP program. ACS is providing information about the problems posed by lack of screening as well as an introduction to the IN-BCCP services in any particular area. A key Strides message is, "Please join us in making sure that every woman has access to screening."
- Working with state health departments to strengthen relationships between their local offices and ACS local area service centers. A statewide survey is being conducted to determine the degree of collaboration among ACS offices and the IN-BCCP program. The relationship is strengthened through retreats attended by ACS and IN-BCCP staff to explore how to better work together. In addition, ACS offers grants to divisions and health departments to hold the retreats.

Northern Indiana/South Bend Project: Pap-A-Thon

This project is an example of how local community groups can enhance IN-BCCP program outreach and provide additional funds for cervical cancer screening within the parameters of the federal/state IN-BCCP program.

The Pap-A-Thon campaign included both educational outreach and actual screening tests. Its purpose was to provide a setting where women could receive a free Pap test and provide education on the risk factors and symptoms of gynecological cancers. Some of the primary Pap-A-thon goals were to gauge how women view the importance of the Pap test, gain a better understanding of women's knowledge about gynecological cancers and to assess who is in need of assistance (by race, age and location).

Volunteer physicians, nurse practitioners and midwives performed the exams, with assistance from medical assistants, registered nurses, case workers, members of the Women's Task Force and community volunteers. Those who were eligible for the IN-BCCP were enrolled in the program. In addition to providing Pap tests, the Pap-A-Thon team assessed women's knowledge through individual conversations, a survey on barriers to cancer screening and a true-false quiz on Pap tests and gynecological cancers. The 12-hour annual Pap-A-Thon served 235 women in its first year and 644 women this year, its third programmatic year. The average patient age was 39 and they came from over 50 different zip codes within the South Bend/Mishawaka/Elkhart/Plymouth area. As an example of the information gathered during the event, 74% of women participants incorrectly believed that the Pap test would detect ovarian and uterine cancer, underlying the significant need to increase both education and awareness. In addition, over 40% of women who accessed this service had health care coverage but either could not afford the co-pay or did not have preventive services covered within their health care plan.

The Pap-A-Thon campaign could be a model for educational and screening programs in other parts of the state. It is important to note that there are no early symptoms for cervical cancer and that 60% of women who get cervical cancer have never been screened or fail to understand the importance of regular screening. Although 54 percent of American women believe they're at risk for developing a gynecological cancer, 58 percent are unaware of any factors that can reduce their risk and 47 percent can't name any symptoms of gynecological cancers. Only 19 percent of women could name any test for reproductive cancers. Population screening provides an opportunity to educate as well as prevent disease. In the Northern Indiana/South Bend Project, total costs for screening, marketing, and educating was \$85/person.

INSURANCE COVERAGE FOR CERVICAL CANCER SCREENING

Medicare

Medicare covers Pap tests and pelvic exams for all women 65 and older once every 24 months. However, if women are at high risk for cervical cancer or are of childbearing age and have had an abnormal Pap test in the past 36 months, Medicare covers the Pap test and pelvic exam once every 12 months. Medicare beneficiaries do pay a portion of their medical expenses, which includes deductibles, co-payments (20% of Medicare-approved amount) and services not covered by Medicare.

Medicaid

The Indiana Health Care Plan (IHCP), Indiana's Medicaid program, reimburses IHCP providers for routine screenings, including Pap tests. However, the only procedure for which screening guidelines are provided is the Pap test. IHCP providers are reimbursed for screening Pap tests every one to three years in accordance with the U.S. Preventative Task Force guidelines. Medicaid does not require a spend-down. The patient is responsible for paying the spend down amount before Medicaid begins, which is determined from the patient's income. Spend down does not apply to women treated under Indiana's Public Law 152 (adoption of the National Breast and Cervical Cancer Prevention and Treatment Act of 2001); those patients have their entire treatment bill paid by Medicaid.

Private insurance coverage

Private health insurance coverage for specific services is not tracked in Indiana. Therefore, private insurance coverage for cervical cancer screening and treatment cannot easily be accessed and reviewed.

RECOMMENDATIONS FOR POLICY CHANGE

Recommendation #1 Advocate for increased federal funding for the National Breast and Cervical Cancer Early Detection Program, which screens and diagnoses women who do not qualify for Medicaid or Medicare, lack insurance and meet certain income and age requirements

Recommendation #2 Commission a study of public and private programs from other states with large minority populations to identify successful strategies to decrease the burden of cervical cancer in African American women.

Recommendation #3 Support implementation of a widespread science-based public health education campaign to address HPV and its association with cervical cancer.

Recommendation #4 Commission a study to examine the extent of public and private insurance coverage for cervical cytology tests and to identify gaps in coverage.

Recommendation #5 Increase the number of adequately insured Hoosiers, thus increasing the number of women with access to screenings and treatment for cervical cancer.

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