



The Early Impact of the Affordable Care Act upon Colorectal Cancer Screening Utilization in Florida

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Abstract

Background: Colorectal cancer is the second leading cause of cancer-related deaths in the United States. Although preventable and curable through screening, early detection and treatment, a lack of health insurance is a major obstacle to receiving colorectal cancer screening (CRCS). Despite the Affordable Care Act (ACA) increasing access to health insurance by mandating coverage of CRCS, disparities in utilization rates continue. Therefore, researchers sought to better understand ACA related facilitators and impediments that affect the utilization of CRCS and collect specific recommendations from healthcare professionals to increase screening utilization rates in Florida.

Methods: Researchers conducted in-depth interviews with 22 healthcare professionals. Data were coded and analyzed using an applied thematic analysis approach and interpreted according to levels of the Social Ecological Model.

Results: Eight physicians and nurses, 7 healthcare workers/care coordinators, 5 administrators and insurers, and 2 health advocates completed interviews. In their view, the early days of the ACA *facilitated* CRCS uptake through use of frontline staff, patient provider communication, and increased access to healthcare. *Barriers* that remained, included out of pocket patient costs, limited Medicaid expansion, acceptance of ACA plans by only certain providers and removal of patient incentives. Recommendations for increasing CRCS included more promotion and awareness, removing costs and ensuring patient navigation.

Conclusions: The ACA offered increased access to healthcare coverage, utilization of CRCS and encouraged better communication between healthcare providers and patients. However, persistent barriers remain and include varied CRCS-related patient costs and restricted provider networks included in ACA sponsored plans. Continued healthcare policy reform is needed to make CRCS affordable for all Americans.

Keywords

Insurance; Barriers; Healthcare; Patient; Medical; Facilitators; Providers; Policy

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ABSTRACT

Background: Colorectal cancer is the second leading cause of cancer-related deaths in the United States. Although preventable and curable through screening, early detection and treatment, a lack of health insurance is a major obstacle to receiving colorectal cancer screening (CRCS). Despite the Affordable Care Act (ACA) increasing access to health insurance by mandating coverage of CRCS, disparities in utilization rates continue. Therefore, researchers sought to better understand ACA related facilitators and impediments that affect the utilization of CRCS and collect specific recommendations from healthcare professionals to increase screening utilization rates in Florida.

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INTRODUCTION

Colorectal cancer (CRC) is the second leading cause of cancer-related death among men and women combined (Centers for Disease Control and Prevention, 2017a, 2017b, 2019). Colorectal cancer screening (CRCS) may prevent CRC through early detection and removal of polyps before they turn into cancer yet screening rates among adults aged 50 and older are suboptimal and vary among population subgroups. According to a recent report by the American Cancer Society (ACS) on CRCS rates for adults aged 50 and older, 66% of Americans were up to date for CRCS via stool-based testing or colonoscopy. However, differences in screening exist by race/ethnicity in reporting that 68% of whites, 65% of blacks, 59% of American Indian/Alaska Native, 59% of Hispanics and 55% of Asians are currently up to date for CRCS via stool testing or endoscopy (American Cancer Society, 2020a).

Across the state of Florida, rates of CRCS for adults aged 50 and older (71%) are slightly higher than the national average (69.7%) (America's Health Rankings, 2020). However, statewide disparities by race/ethnicity persist (75% of Non-Hispanic whites, 61% of Non-Hispanic blacks, 61% of Hispanics, 51% of American Indian/Alaskan Natives). Beyond race/ethnicity, research also suggests that various subgroups within Florida are at the greatest risk for not being screened for CRC. These include individuals without health insurance coverage (35% screened) and individuals with a lower socioeconomic status (less than high school, 48% screened; earning less than \$25,000, 62% screened) (Aguado Loi et al., 2018; America's Health Rankings, 2020; American Cancer Society, 2019, 2020b; Lasser et al., 2008; Oliver et al., 2013; Oliver et al., 2012).

Screening Modalities

CRCS strategies recommended by the United States Preventive Services Task Force (USPSTF) include several tests with noted guidelines for frequency of use for people at average risk (Bibbins-Domingo et al., 2017). Recommended tests include either stool samples or direct visualization. Stool-based tests include the guaiac-based fecal occult blood test (gFOBT) administered annually, the fecal immunochemical test (FIT) administered annually and the FIT-DNA multitargeted stool DNA test administered every one to three years. Stool-based tests are collected at home and do not require bowel preparation, anesthesia or assistance with transportation to or from a healthcare center following sedation. A positive result during one of these stool-based tests requires an investigation with a colonoscopy. The other type of CRCS tests involves direct visualization. These tests include colonoscopy, performed every ten years for people who are not at an increased risk for CRC, CT colonography (i.e. virtual colonoscopy) performed every five years, flexible sigmoidoscopy performed every five years and flexible sigmoidoscopy with FIT performed every ten years plus the FIT administered every year. Although the direct visualization tests require testing less frequently, bowel preparation and anesthesia are required procedures. If visualization by tests other than a colonoscopy return positive, a follow-up colonoscopy is recommended.

Impediments to CRCS

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Although CRCS can prevent CRC through early detection and the removal of polyps, prior research identified several impediments perpetuating low utilization rates among adults aged 50 and older. These included patient level factors such as fear and embarrassment, limited health literacy, low financial resources/income, as well as provider level factors such as providers' counseling and communication practices, willingness to make the recommendation, or misalignment in testing preferences (Bass et al., 2011; Bromley et al., 2015; White et al., 2010). However, the most persistent systemic level barrier that affects CRCS utilization is a lack of insurance coverage or affordability for patients (Ayanian et al., 2003; Berkowitz et al., 2008; Bromley et al., 2015; Lasser et al., 2008; Morgan et al., 2010; Robinson et al., 2011).

Healthcare Policy and CRCS

In the Balanced Budget Act of 1997, Medicare covered CRCS only for people with high risk of CRC. With the Consolidation Appropriation Act of 2001, CRCS was extended to all Medicare beneficiaries and cost sharing decreased to 20% co-insurance between 2007-2010. To date, the Patient Protection and Affordable Care Act (ACA) remains a major achievement in the United States healthcare reform to expand insurance coverage and deliver healthcare services to low-income and vulnerable communities. However, a significant number of vulnerable communities still lack access to health services, including preventive screening. In 2011, under the ACA, all cost sharing was waived for initial CRCS (Lissenden et al., 2017). In fact, the ACA expansion created several competing state level marketplaces and expanded eligibility for the Medicaid program. This expansion also promoted insurance enrollment, reduced financial burden, lowered cost sharing, and offered federal protections preventing discrimination based on health status (McIntyre et al., 2019). As a result, an increased number of low-income consumers and families up to 400% of the federal poverty line had better access, treatment and preventive care such as cancer screenings. Approximately 20 million people have become insured since ACA implementation (Martinez, 2018).

More specifically, the ACA increased accessibility and affordability for preventive and recommended cancer screening for millions of Americans. The ACA has even led to a significant increase in early stage diagnosis. The number of early stage CRC diagnoses increased by 8% per year with a 6.7% increase for people 65-75 years old and 10.5% increase for individuals 75 and older. In addition, the ACA has reduced the number of late stage CRC diagnoses for men by 10.3% (Lissenden et al., 2017).

Despite the ACA increasing access to health insurance and mandating coverage of preventive healthcare, disparities in screening utilization still exist (Mbah et al., 2020). A recent study suggests that CRCS utilization is the highest in states that expanded Medicaid (Xu et al., 2020). Some states, including Florida, have yet to take full advantage of the ACA through expansion of Medicaid. Despite the collection of evidence-based findings and promotional efforts by agencies such as the Centers for Disease Control and Prevention (CDC) to implement CRCS strategies through state funding and programming, individuals without health insurance are much less likely to screen for CRC (Centers for Disease Control and Prevention, 2015).

Nearly 10 years post ACA implementation, individual and systemic level barriers continue to exacerbate low CRCS utilization rates and contribute to falling short of national goals (i.e. 80% in every community). Therefore, researchers wanted to learn more about what impact the ACA had in the Medicaid limited state of Florida from the perspective of those working within the healthcare system. To our knowledge, this is the first such qualitative study of the early impact of

the ACA upon CRCS. Specifically, this study examined ACA related facilitators and impediments that affected the utilization of CRCS and specific recommendations from healthcare professionals to increase screening utilization rates across the state.

METHODS

This study was conducted as part of a larger study funded through the CDC grant to the Florida Prevention Research Center (FPRC) (awardee - 1U48DP005024-01). While conducting a systematic literature review, study staff determined that the published literature did not adequately reflect the ACA's contribution to CRCS (Young et al., 2019). Thus, trained staff conducted in-depth interviews to ensure the FPRC's five-year project goals for increasing CRCS awareness and utilization, also reflected the current healthcare environment across the state of Florida. This design allowed for candid discussions exploring the early impact of the ACA on individuals who fit the screening guidelines for CRCS. Staff trained in qualitative methods completed 22 in-depth key informant interviews lasting up to one hour between August 2015 and February 2016 (see Table 1). The study was approved with a waiver of signed consent by the University of South Florida (USF) IRB#: Pro00018813.

Recruitment and Eligibility

Researchers utilized purposive and snowball sampling to recruit key informants who were knowledgeable about the healthcare system and navigating newly insured individuals to obtain CRCS across the state of Florida (Bernard, 2011). Key informants included healthcare providers, community health workers, health or insurance administrators and health advocates. Initial interviewees were recruited through direct outreach and referrals from a community coalition's established network of providers, community organizations, clinics, and insurance navigators. Participants were also recruited from the Federally Qualified Healthcare Centers that received funding from the Health Resources and Services Administration in Florida to specifically hire navigators to assist with enrolling patients through the insurance exchange. Additional recruitment came from recommendations of early interviewees and a flyer emailed through the USF Health listserv.

Key informants were eligible to participate in the study if they provided consent and 1) considered themselves knowledgeable about the ACA and had expertise in navigating newly insured individuals to obtain CRCS, or 2) were a healthcare provider who performed CRCS.

Data Collection

Researchers followed a semi-structured, open-ended interview guide with three a priori domains that were decided based on the focus of the grant (i.e. ACA, CRCS in the context of ACA, and CRCS generally). Within these domains, the guide contained probes for the respondent's background relevant to CRCS; experience with ACA implementation; how the ACA changed CRCS; insights on barriers and facilitators to CRCS; and recommendations on how to increase CRCS. The interview guide was pilot tested with the FPRC's community advisory board. Interviews were conducted in person or by phone depending on the preference of the participant and each participant was offered a small honorarium (i.e. \$40 target gift card) for participation. Interviews and debriefing notes were audiotaped and transcribed by a professional transcription company. Key informant interviews were conducted until saturation was reached.

Data Analysis

Trained coders analyzed the transcripts in Atlas.ti version 7 using applied thematic analysis techniques. Detailed themes were classified broadly under the domains of the semi-structured

interview guide. For this article, authors focused on the key areas of barriers to CRCS, facilitators to CRCS and recommendations for increasing CRCS rates. To facilitate triangulation, findings were then conceptualized within the Social Ecological Model (SEM) adapted for health promotion. Presenting findings within the SEM conforms to the CDC's Colorectal Cancer Control Program's (CRCCP's) multi-level approach to CRC prevention (Centers for Disease Control and Prevention, 2015).

Trustworthiness of Data

Data collected for the study were evaluated for trustworthiness using several strategies, including leaving an audit trail, peer debriefing, triangulation, reflexive journaling, rich and thick description of data and methods, and inter-rater reliability (Baxter, 2008; Creswell et al., 2018; Guba, 1981; Jootun et al., 2009; Krefting, 1991; Lincoln et al., 1985; Malterud, 2001; Nicholas et al., 1995, 2000; Onwuegbuzie et al., 2007; Royse et al., 2010; Shenton, 2004; Tashakkori et al., 2000). The audit trail began during the initial planning phase of the study and was incorporated into the recruitment phase. Investigators documented the steps they took and decisions they made during the analyses (Creswell et al., 2018; Royse et al., 2010). With this, other researchers should be able to reanalyze the data and substantiate the findings. Peer debriefings took place during regularly scheduled weekly meetings with the research team where investigators shared their experiences related to recruitment, interviewing participants, data analysis and other aspects of the study. Debriefing notes were either written or recorded and submitted for transcription. Investigator triangulation was employed during this study. The research team represented different disciplines (public health, anthropology and gerontology), enabling different perspectives to be brought to the interpretation of the data. Additionally, data collected through in-depth interviews were conceptualized within levels of the SEM that has been previously adapted for CRCS and prevention by the CDC.

Further strategies to enhance trustworthiness during analysis included team member collaboration to develop the codebook from the semi-structured interview guide and employing inter-rater reliability strategies. Transcripts of in-depth interviews were reviewed and independently coded by two investigators (AE and LB) to identify emerging themes. Discrepancies related to coding and the application of themes were discussed and resolved among the investigators. Investigators also used reflexive journaling to document their progress, any issues they encountered during the process, and what steps they took to resolve these issues.

RESULTS

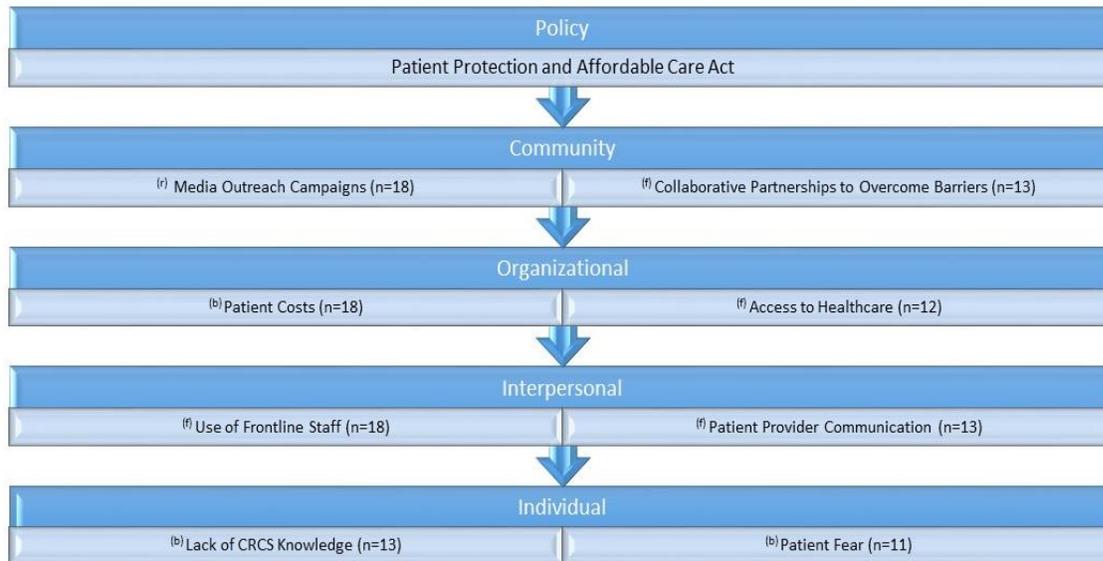
Interviews were completed with 22 key informants. Table 1 presents the breakdown of respondents within each group and specific role.

Table 1
 Key Informants by Group and Role

Group	Role	<i>n</i>
HealthCare Providers	Medical Doctor	5
	Nurse	3
Health Workers	Care Coordinator	2
	Health Navigator	3
	Community Health Worker	2
Administration	Clinic Administrator	4
	Insurer	1
Advocates	Colorectal Cancer Advocate	2
	<i>Total</i>	22

Codes were categorized as sub-themes and grouped according to the broader themes of barriers to CRCS, facilitators to CRCS and recommendations for increasing CRCS rates. Sub-themes were then presented within context of the SEM. Figure 1 highlights the eight sub-themes that were discussed by at least half of participants. Exemplary quotes were selected, cleaned of hesitation language for clarity and included in table 2.

Figure 1
Top Sub-Themes by Level of SEM



Legend:
b Barrier
f Facilitator
r Recommendation

Note. Some sub-themes may fit within multiple levels of this model.

Table 2
Exemplary Quotes on the Early Impact of the ACA upon CRCS

Theme	Level of the SEM	Sub themes	Exemplary quotations
Barriers	Organizational	Patient Costs	<i>“Financial is a huge barrier... that people...do not understand. They think they are just getting a colonoscopy. The colonoscopy is covered. There’s a pathology fee for polyps that are taken off, an anesthesia fee. There is all these fees that are attached and then also they get home and they get a bill for \$8,000.00 and they can’t understand why. So people have said there’s an economic barrier for sure.” -Medical Doctor</i>

Organizational	Removal of Patient Incentives	<p><i>“This is where there’s limitations by the federal government of saying, “No. You can’t give a patient certain inducements to do something.” Well, but this actually is something ... I think it’s right for the member. It’s right for the whole health system and I don’t think it should be looked at as a detriment to doing something. ...That’s federal regulations that is...negatively impacting what you want to achieve. I think system-wise, if you can sort of overcome that that would be another area for potential help.” -Medical Doctor</i></p>
Organizational	Delay Due to Insurance Authorization Requirement	<p><i>“...I don’t really pay that much attention to the insurance. If the insurance plan is in there, the only time I look it up is to see if they need to have authorizations or anything... We’ve gone through a lot of changes at [Cancer Center]and we know that some HMOs take a week. You know, ‘cause I’ll call the guy who gets our authorizations and ask them, “Hey, I have this patient that wants to have a colonoscopy...Can you check out their insurance and tell me if I can schedule it this week?” ...And he does that, you know. They know it’s an HMO, I need at least seven business days.” -Administrator</i></p>
Individual	Lack of CRCS Knowledge	<p><i>“...people will tell you, “Well, I didn’t know that. I didn’t know I have to do this,” so that’s one thing... the second...I’ll say...is a clear understanding of what it is about...from the point of the patient.” -Medical Doctor</i></p>
Individual	Patient Fear	<p><i>“You should have a colonoscopy. It’s like, “Whoa. What is that? I heard that the preparation for that</i></p>

Facilitators	Community Collaborative Partnerships to Overcome Barriers	<p><i>is severe and it really takes up a whole...” You know, the people have these concepts that make them afraid and they go, ‘Ah, I’m not gonna do that.’” -Nurse</i></p>
	Organizational Access to Healthcare	<p><i>“...although we have provided the colonoscopy services, originally we had worked with = Name = at the = Department of Health Colon Cancer Screening Program = and through = Name =, we would submit our patients to her. If they were eligible for the Department of Health screening, then they would get their colonoscopies done at = Cancer Center = which have the agreement with the Department of Health and then we would get the results. So we were able to get some colonoscopies, I forget how many – maybe 30 colonoscopies. I don’t have the exact number off the top of my head now, uh, but we have that data.” -Medical Doctor</i></p>
	Organizational Electronic Medical Record	<p><i>“People that have not been to the physician in the past due to lack of insurance, now... the government has...mandated or required them to have insurance. Now they are seeking medical...screenings. I think...at least a physical exam, and mostly come in for physical exam based on their age range.” -Medical Doctor</i></p> <p><i>“...I think having the electronic medical record certainly helps...with the ability to track across time, so you could see if somebody had something done or not and then follow up on it. So, I think the cataloging with the electronic medical records system is helpful...in achieving that.” - Medical Doctor</i></p>

	Interpersonal	Patient Provider Communication	<p><i>“...once I would sit down and explain to patients, they need it...and we get past the ignorance part, our compliance rate was very, very high...regardless of background and anything else. As long as we’ve explained it to them, “This is why you need it,” then the compliance rate usually is pretty high, especially if you have good rapport with the patients – which like in my practice, it was a lot, you know. In the older days, it was a much more personal thing. So, most of the people I knew very well in my practice, they really weren’t strangers and so if I recommended a test, they would usually get it.” - Medical Doctor</i></p> <p><i>“They make phone calls and they can go also into the community. Educate them about what is...what needs to be done and why, and it doesn’t take a long time to do that. (laughter) They should ...it’s just a few words and especially from the old staff and I think the nursing staff does a great job at that, which can be reinforced by the providers.” - Medical Doctor</i></p>
Recommendations to increase CRCS rates	Community	Media Outreach Campaigns	<p><i>“Make blue synonymous with colon cancer like pink is with breast cancer (raise public consciousness about the disease)” -Advocate</i></p> <p><i>“...I think using mass media to some degree would be nice, you know, something like the Katie Couric [special on colonoscopies]. I keep going back to it, but I think it was very effective...” -Medical Doctor</i></p> <p><i>“...The churches might be an interesting place...and then there’s also in cultural jobs or community centers. There’s many different</i></p>

		<i>community centers from the different ethnic groups. That might be something else...” -Health Navigator</i>
Organizational	Remove Costs	<i>“Free testing” -Community Health Worker</i>
Organizational	Provider Incentives	<i>“Reward doctors for a population health mentality (not fee for service). Pay doctors based on outcomes, not services provided. Includes funding for one-on-one outreach from administrative services.” -Medical Doctor</i>
Interpersonal	Patient Navigation	<i>“Navigator program to follow patients, create individualized outreach and care” -Medical Doctor</i>

Barriers across the SEM

In further analyses of sub-themes, *barriers* were fit into corresponding levels of the SEM. *Community* level barriers included the lack of GI clinics to make access easier for residents in certain zip codes. *Organizational* level barriers included the statewide policy decision in Florida to not expand Medicaid leaving thousands without health insurance, the end of grant funding that once provided coverage to many low-income individuals and a fragmented healthcare system. Healthcare professionals also mentioned patient costs, whether hidden costs after waking up or patients’ out-of-pocket financial responsibility related to their health insurance plan deductibles, co-pays, and healthcare procedures, as a barrier influencing low utilization rates. Additional *Organizational* level barriers included limited use of automatic reminder systems to alert providers of patients due for CRCS, a limited network of providers, discontinuity in care, ineffective communication with patients due to incomplete medical records, providers not accepting certain insurance plans and the variation in costs for certain screening procedures by facility. A few key informants also reported inconsistencies in how procedures were coded (i.e. changing a screening colonoscopy to a diagnostic colonoscopy after the procedure). *Interpersonal* level barriers included a lack of referrals from the provider, a lack of knowledge among providers about the evidence-based interventions that exist to increase CRCS, patients not having transportation to/from a colonoscopy appointment and the expensive costs of developing targeted/tailored interventions. The lack of patient knowledge was also attributed to the provider’s lack of cultural competency, insufficient outreach to diverse communities and simply not informing the patient of this screening need. At the *Individual* level, over half of key informants shared that they felt that the patient’s lack of knowledge of CRCS was a general barrier to screening. At the patient level, this related to not knowing the age of eligibility, CRCS guidelines or their insurance coverage. Additional *Individual* level barriers at the patient level included a lack of education or information

related to risks and benefits of CRCS, fear of CRCS, issues performing the FOBT, issues undergoing a colonoscopy screening and general financial barriers.

Facilitators across the SEM

Sub-themes were assessed and all *facilitators* of CRCS were grouped by levels of the SEM. Inherently, the sub-theme of increased access to healthcare coverage provided through the ACA *policy* emerged from discussions with over half of key informants as a prominent facilitator. Participants also shared that previously uninsured individuals now having access to healthcare and the inclusion of preventive screenings to be covered at no cost were key *Policy* level influences on current CRCS utilization. At the *Community* level, facilitators included having several GI specialists in the area, outreach and awareness campaigns, partnerships and coalitions, finding a “champion for the cause” and CRC awareness month in March. *Organizational* level facilitators included the availability of grant funding that would cover many critical components to CRCS (i.e. screenings, preparation for colonoscopy, transportation to/from appointment and follow-up care for the under or un-insured patients who needed a diagnostic colonoscopy or oncologic care). Additional *Organizational* level facilitators included the use of screening reminders produced from (up-to-date) medical records, incentives provided by employers and insurance companies for consumers to stay up-to-date with screenings, the wide-spread distribution of FIT kits, follow-up by the clinic after a visit for CRCS, educating front-line staff to better facilitate patients through CRCS, establishing patient medical homes, individual patient navigation for continuity of care and organizational goal setting. *Interpersonal* level facilitators included provider recommendation and referrals, one-on-one communication from doctors or nurses, ensuring that health education materials were provided in the patient’s preferred language and the sharing of personal testimonies with others by patients who had been screened. Provider communication for screening was discussed as a critical reason for increased screening utilization rates and many participants agreed that a key *Interpersonal* level facilitator was how frontline staff helped communicate the importance of screening to patients and facilitate the screening process (e.g., scheduling the screening, preparation of screening materials). Other anecdotes of the frontline staff in action described the use of clinic-based navigators, nurses, and receptionists to assist the patient in following through with a screening. Navigators also provided education on policy coverage details (i.e. free preventive care such as cancer screenings) at enrollment. Participants also described how members of the community (i.e. non-medical personnel) would partner with patients and follow them throughout the screening process, reminding them when screenings were due and providing advice on their screening options. *Individual* level facilitators of CRCS included patient knowledge of family history and risk for developing CRC, knowing insurance policy coverage details and having the ability to conduct the FIT test independently.

Recommendation to increase CRCS across multiple levels of the SEM

When coding the recommendations that participants shared for increasing CRCS when resources were unlimited, sub-themes were also aligned with various levels of the SEM. *Community* level recommendations included a mass media outreach campaign with a celebrity spokesperson, the distribution of print-based campaigns (i.e. flyers), billboards throughout neighborhoods and more community-wide events to promote CRC awareness and prevention. *Organizational* level recommendations included a push for more corporate partnerships and alliances for promoting CRC awareness and prevention, designating a point person within clinics to follow the patient throughout the entire screening process (i.e. patient navigation services) and

direct mailings (i.e. reminders and/or FIT kits) from clinics to patients who are eligible for CRCS. The removal of CRCS related costs, whether for diagnosis, treatment, or follow-up, and provisions or incentives for individuals to complete screenings and remain up-to-date were also shared recommendations to increase CRCS through changes made at the *Organizational* level.

DISCUSSION

Since the implementation of the ACA, this study is perhaps the first to examine barriers, facilitators and recommendations from healthcare professionals on ways to increase CRCS utilization rates in a state that has not expanded Medicaid. Through the ACA, insurance policies were mandated to provide coverage of no cost preventive healthcare screenings, including CRCS beginning at age 50 for eligible adults. Over ten years later, increasing CRCS rates remain a challenge. The top barriers discussed by participants included remaining patient out-of-pocket costs, despite the ACA policy that mandates “free” preventive health screenings, a general lack of CRCS knowledge and awareness and patient fear. The top facilitators expressed by key informants included an expansion of access and healthcare coverage options and the use of frontline staff for promoting CRCS. Interestingly, when asked for recommendations, most respondents noted information dissemination to raise individual-level awareness of CRCS, although most of the barriers and facilitators mentioned were descriptive of a higher level in the SEM. Discussed barriers from this study corroborate with findings from other research studies that highlight continued barriers of patient costs and lack of CRCS knowledge that attenuate screening rates (Green et al., 2014; Knight et al., 2015; Wang et al., 2018). Similarly, discussed facilitators support current research that suggests key facilitators of CRCS that include having insurance and patient navigation through services (Hughes et al., 2015).

Taking these barriers, facilitators and recommendations into consideration, we interpret these findings as suggesting that the ACA policy alone is insufficient for ensuring maximum utilization rates of CRCS by insured patients. Passage of the ACA addressed *some* of the biggest access barriers to healthcare coverage through subsidizing the cost of insurance for the consumer and mandating preventive healthcare services. However, gaps preventing adequate access to insurance and healthcare services for prevention of CRC still exists. According to the American Community Survey (part of the Census run annually), Florida’s rate of uninsured in 2018 was 13% (Berchick, 2019). In states that expanded Medicaid coverage, average uninsured rates were less than half that.

Despite the preventive care coverage mandate, patients still incur costs to CRCS due to the vague guidelines allowing for varied interpretation by insurance companies. Without specific guidelines identifying non-billable procedures and fees, patients are likely to continue to encounter unexpected bills for hidden fees related to their CRCS. As more Americans enroll in ACA sponsored plans, improvements to state electronic medical record systems and addressing gaps to ensure millions more receive adequate access to insurance and healthcare services must be addressed. Furthermore, patients may be faced with discontinuity of care due to the limited provider network under some ACA sponsored plans and in some cases, medical records being left incomplete.

Although this study exposes the effects on CRCS utilization rates considering health policy changes made within the last decade, this study is not without limitations. Key limitations of this study were the small sample size and limited geographic representation of participants. These

limitations affect the statewide generalizability of these findings based on the limited representation of various perspectives throughout Florida. Despite the limitations, this study had several strengths including the study design to capture diverse perspectives from interviewing healthcare professionals who interact with patients beyond the role of doctors or nurses. As another strength of the study design, policymakers may be informed through the results of this study about the specific need for continued policy reform as it relates to preventing one of the leading causes of cancer-related deaths among both men and women. By conceptualizing based on the SEM, public health practitioners and researchers may also take away *multi-level* strategies for enhancing community tools for increasing cancer prevention such as the Guide to Community Preventive Services. Furthermore, although reports demonstrate an increase in CRCS rates from 2010 to present, this study adds context as to why trends may not meet nor exceed set standards by national agencies such as the National Colorectal Cancer Roundtable of 80% screening rates in every community, or the 70% set by Health People 2020 (Hall et al., 2018).

CONCLUSION

The ACA has increased access to healthcare coverage for millions of previously uninsured Americans and utilization of CRCS has increased in areas where ACA is optimally implemented (e.g., in Medicaid expansion states). Policy changes to cover preventive health screenings have also opened the door for better communication practices between healthcare providers and patients concerning the benefits of CRCS and potential risks associated with delayed and/or the lack of screening. Persistent barriers including patient costs and restricted provider networks accepted across ACA sponsored plans, however, suggest a need for continued policy reform. Considering the ensuing and unrelenting political debate regarding repeal/replacement of the ACA, policy changes that will ensure optimal access and utilization among consumers eligible for CRCS are needed. Continued concerted efforts to *retain* and *enhance* the optimization of the ACA policy is essential for improving CRCS access and ultimately reducing a leading cause of cancer-related death.

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