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CONQUERING THE CANCER CARE CONTINUUM™

Impact of the Affordable Care Act on Cancer Care

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We have been hearing about the Affordable Care Act (ACA) for quite a while. However, many are still confused as to what this law is trying to accomplish and how it will benefit various populations of patients across the United States. This fourth issue of *Conquering the Cancer Care Continuum*™ provides readers with a comprehensive overview of the ACA as seen from the eyes of an oncology nurse, an insurance payer, and a pharmacist. I think these different viewpoints offer great value and will provide new insights into the potential impact of this legislation on both patients and healthcare professionals.


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Everyone applauds the goals of improving access to care, developing more quality measures by payers (such as penalties for hospitals with high readmission rates), addressing the "doughnut hole," and eliminating preexisting conditions, which have been a known barrier to care for a long time. As millions of people obtain insurance coverage, the healthcare system will be potentially flooded with new patients who may have neglected cancers that now are presented to us for evaluation and treatment. The law also provides for free screenings (for cancers that have methods for screening) with the goal of prevention or early detection. Once cancer is diagnosed, however, care is not necessarily going to be totally free. This remains an issue of confusion for individuals who are just now getting into an insurance program. What has been probably long overdue, and we hope will result in better quality of care, is a requirement that patients receive information that is linguistically and culturally sensitive for them.

Many parents who were planning on having an empty nest once their children finished college are now experiencing these young adults returning home after graduation. In some cases, these adult children are jobless. If they do find employment, there is a good chance that their jobs will not include insurance benefits. Therefore, the ACA also provides a means for "children" up to the age of 26 years to remain on their parents' insurance plan.

As more oncology drugs are converted from intravenous to oral routes of administration, the need for access to these new drugs, education about how to self-administer them, and the need to adhere to the treatment plan as intended becomes crucial. We will all watch, some from a distance and others in the thick of things, as the ACA continues its work in providing insurance coverage with the hope that no one is without insurance benefits going forward. ■

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Impact of the Affordable Care Act on Cancer Care: A Nurse's Perspective

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In 2010, Congress passed (and the President signed into law) comprehensive healthcare legislation called the Patient Protection and Affordable Care Act (PPACA), or as it is more commonly known, the Affordable Care Act (ACA).[1] This legislation provides a health insurance exchange in which individuals and small businesses can purchase qualified health plans (QHPs). According to a report by the US Department of Health & Human Services (HHS),[2] more than 8 million people enrolled in the health insurance marketplace by the end of the initial enrollment period (October 1, 2013–March 31, 2014). This total includes activity associated with individuals who qualified for a special enrollment period that was reported through April 19, 2014.


Beth Faiman, PhD, MSN, APRN-BC, AOCN

The goal of the ACA is to insure the uninsured and protect patients with chronic illnesses who are in the greatest need of quality care. However, this legislation is not perfect, and an important question to ask is whether it is going to benefit patients with cancer. The answer depends on who you ask. Each state's QHP must offer, at minimum, the essential health benefit package,[3] as defined by the HHS. Unfortunately, as was discussed in a previous article in *Conquering the Cancer Care Continuum*™ ("Access to Quality Care: A Nurse's Perspective"), many patients with previously "good" insurance feel that the new plans leave them relatively underinsured. Is it true that some insurance is better than no insurance? Let's review some of the ways in which the ACA will affect patients with cancer.

The goal of the ACA is to insure the uninsured and protect patients with chronic illnesses who are in the greatest need of quality care.

Improved access to care. More patients who are uninsured will have access to cancer care under the ACA, despite the presence of a preexisting condition. In addition, children who are cancer survivors are covered until they are 19 years of age, and patients cannot be dropped from insurance when they become sick. This access to care is critical for individuals with cancer.

No more doughnut holes. The ACA provides a rebate to seniors who hit the coverage gap in Medicare's Part D prescription drug program. Although individuals will often need to tap into additional resources, such as the chronic disease fund, patient access network, and individual pharmaceutical companies, out-of-pocket copayments for oral medications and various services will tend to be less. However, oncologists should be cognizant of prescribed medications so that patients are not placed in a financially disadvantaged position.[4]

No capitation of coverage. In the past, companies could set a lifetime limit on coverage. These limits on insurance are not allowed under the ACA.

Clinical quality measures will be enhanced with penalties for hospital readmissions. The Centers for Medicare & Medicaid Services is revising its payment structures and mandating better quality measures for patients (including those with cancer) so that hospitals can be reimbursed for services. Quality of services with measurement of these services will be closely evaluated and additional training will be mandated at the graduate level for providers.[5]

Penalties for hospital readmissions may occur and impact the organization more than the patient. For patients with multiple symptom and side-effect management issues, it may be challenging to prevent hospital readmissions. However, many centers have addressed the risk of financial penalties for hospital readmissions. At our center, we have created acute care clinics, which are run by advanced practice nurses (APNs) or physician assistants (PAs) in an effort to prevent admission

to the hospital. Patients who come to the clinic with a symptom to be managed, such as nausea and vomiting, can be seen by a midlevel provider and given appropriate hydration and antiemetics to prevent hospital admission. A call-back system by a nurse navigator, an APN, or a PA has been implemented to address symptom management and provide outpatient treatment versus readmission to the hospital when appropriate.

With the passing of the PPACA, the United States has been given an opportunity to transform its healthcare system. As key members of the cancer care team, nurses need to address the increasing demand for safe, high-quality, efficient care. Future directions should be aimed at meeting the challenge of new and expanding responsibilities, educating patients on the intricacies of the new legislation, and assuming leadership roles to create better-integrated, patient-centered healthcare services. ■

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Impact of the Affordable Care Act: A Pharmacist's Perspective

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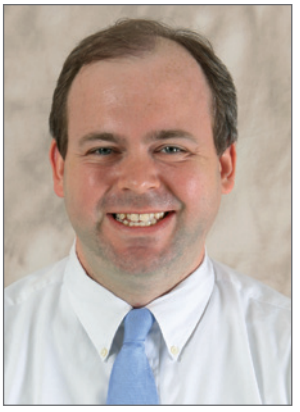
In the spring of 2008, while I was finishing my oncology pharmacy residency training, I had the opportunity to spend a month in a prominent urban hospital very well known for its indigent patient population. Although this experience was primarily focused on learning standard-of-care oncology without cutting-edge investigational therapies and the latest US Food and Drug Administration (FDA)-approved drug options, what stands out in my mind are the patients I saw who were unable to receive the care they desperately needed due to a lack of health insurance. One patient in particular was denied a much-needed stem-cell transplant because the cost of the procedure exceeded his meager insurance policy's lifetime maximum spending limit. It was, and remains today, one of the fundamental reasons why I developed an interest in providing services and access to care for underserved populations.



Steve Stricker, PharmD, MS, BCOP

Unfortunately, such situations are not unique in oncology practices in this country. Although we would like to think of these issues as being relegated to the farthest reaches of rural communities or inner cities, it is simply not true. In fact, regardless of the socioeconomic status of a patient or the quality of the health insurance plan to which one is subscribed, there will inevitably be issues related to ensuring coverage and payment for therapies that, as providers, we can scientifically defend the rationale for prescribing. The system ensures an unmet need for some patients while allowing healthcare spending to explode in an unsustainable model. Although most providers would agree that the system needs to be revamped, not all would agree on the methods for reforming healthcare in the United States. My objective, then, is not to further politicize a highly emotionally charged topic but rather to evaluate the impact of the Affordable Care Act (ACA) on the delivery of oncology services in as objective a manner as possible.

Estimates suggest that people in the age range of 18 to 34 years historically were uninsured at twice the rate of older Americans.

First, the Congressional Budget Office estimates that as of April 2014, the ACA has decreased the number of uninsured nonelderly adults by 12 million, and, by 2019, the decrease will be 26 million.[1] Given the fact that cancer is one of the major causes of mortality in the United States,[2] the ACA will, hopefully, allow more patients with cancer to seek care and especially to seek care earlier, when treatment may offer a greater chance of survival.

Second, the ACA's provision for allowing children to remain covered by a parent's health insurance plan until age 26 years will ensure that college-age Americans are not lost in the vacuum of the now outdated healthcare system. Estimates suggest that people in the age range of 18 to 34 years historically were uninsured at twice the rate of older Americans.[3] Although individuals in this age range have a low incidence of cancer, those diagnosed often faced an inability to pay for the care they needed.

What about the impact on drug therapy and pharmacy specifically? With the implementation of Medicare Part D, many older Americans were provided with insurance coverage for oral medications. A notable deficit in these plans was the so-called "doughnut hole," which required patients to pay, at times, unaffordable amounts of money out of pocket in order to ensure that their treatment remained uninterrupted. The ACA plans to reduce, and ultimately close, this coverage gap. With the growing percentage of orally administered chemotherapy drugs, coverage for these expensive medications becomes much more signifi-

cant. To date, oral chemotherapy parity legislation has been enacted in 33 states plus the District of Columbia, but further assurance of access to care for these medications is essential, especially considering that 25% to 30% of all new oncology drugs in development are administered orally.[4] The ACA plans to do just that.

In addition, the ACA offers assurance that patients may participate in clinical trials of investigational therapies without fear of losing their insurance plan or finding a lack of insurance coverage for drugs received in this setting. Given that many professional oncology organizations and clinical practice guideline groups recommend consideration of clinical trials for virtually every patient diagnosed with cancer, eliminating access to these studies would seem to breach the Hippocratic Oath of "Do no harm." During this era of (some) insurance plans that prevented coverage for their subscribers who elected to join a clinical trial, many patients were refused access to drugs which, while not yet FDA approved, frequently had demonstrated efficacy in other, earlier human studies. This advance opens clinical trial access to many more patients, which may prove beneficial not only for current patients but for future generations of patients as well.

Do I think that the ACA will resolve all of our healthcare system issues? No. However, there are aspects of the ACA that I believe will increase access to high-quality cancer care for a larger proportion of the population. Likewise, as providers, we will be challenged to become more efficient and to, arguably, do more with less. We will be required to demonstrate a more evidence-based approach to cancer care, we will be encouraged to explore more cost-effective therapies when guidelines allow for interchangeable options for equally staged patients with cancer, and we will be challenged to provide higher quality care lest our patients "bounce back" and reimbursement be reduced for subsequent hospitalizations. Furthermore, adding an additional 30 million Americans to the currently stressed healthcare system will require thinking outside of the box regarding the management of patients, which should create better opportunities for multidisciplinary cancer care delivery. I envision a system with the oncologist as the head of a team and nurses, nurse practitioners, physician assistants, and clinical pharmacists shouldering a greater percentage of direct patient care within a setting of collaborative practice agreements. When each member of the healthcare team is allowed intellectual freedom to practice to the highest levels of their licensure and certification, job satisfaction is improved and patient care is bettered by empowering each person to truly take ownership of the services they have been trained to provide. Although the ACA is not perfect and there is certainly room for modification, growth, and improvement, there are some highlights that should allow us to help more patients who may have historically been left on the outside of the healthcare system looking in. ■

There are aspects of the ACA that I believe will increase access to high-quality cancer care for a larger proportion of the population.

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Impact of the Affordable Care Act on Cancer Care: A Payer's Perspective

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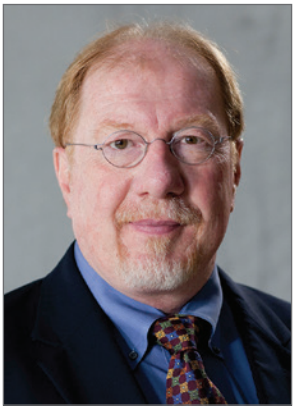
The Affordable Care Act (ACA), officially called the Patient Protection and Affordable Care Act,[1] which began implementation in March 2010 and will not be fully implemented until 2018, has impacted oncology care in both positive and negative ways. This legislation provides opportunities for addressing disparities in cancer care, and it has the potential to expand access to care and improve services among vulnerable groups.[2] However, the ACA alone cannot eradicate the problem of cancer disparities but instead builds a new foundation for creating meaningful policy changes.


Kenneth L. Schaecher, MD, FACP, CPC

The goal of the ACA was to increase access to care for the 46 million Americans who were uninsured[3] for reasons varying from being excluded from the insurance pool because of preexisting conditions, being "young immortals" who electively defer insurance coverage when healthy, or being unable to afford insurance options. Although the ACA is far from a perfect piece of legislation, in many ways it has helped overcome barriers to cancer care.

The elimination of preexisting conditions as a barrier to insurance coverage has definitely aided patients with active cancer or a history of cancer.

The elimination of preexisting conditions as a barrier to insurance coverage has definitely aided patients with active cancer or a history of cancer. Patients with active cancer were essentially uninsurable if they did not have insurance prior to the cancer diagnosis, and many patients who had a history of cancer could not obtain affordable health insurance to allow them to obtain necessary testing to monitor for recurrence of the disease or manage late complications related to treatment.

The availability of public exchanges in 2014 and Medicaid expansion, though both flawed in their implementation for multiple reasons, have succeeded in creating access to care not previously available. It has been estimated that the pool of uninsured patients has been reduced by as little as 9.5 million to as much as 16.5 million, depending upon how the figure is calculated and the organization's political goals.[4] What is known is that the percentage of the US population that is uninsured has dropped from a peak of 18.0% in the third quarter of 2013 to 13.4% in May 2014.[5] The federal government now requires states to offer Medicaid to people with incomes up to 138% (133% plus a 5% income disregard) of the federal poverty level (FPL), with most of this expansion funded federally.[1] In addition, it offers subsidies to help those with incomes up to 400% of FPL to purchase private insurance through newly created insurance exchanges.[1] Therefore, many patients who could not afford insurance have been able to purchase insurance at affordable prices. Both of these initiatives remain highly politically charged, with many states not opting to expand Medicaid or to assist in development of their state exchanges, which has complicated patient access and has maintained geographic disparities in care.

Another less recognized aspect of the ACA that has positively impacted patient care—and, by extension cancer care—is the requirements for health insurers to provide information to potential and established members that is linguistically and culturally sensitive.[1] The ACA also requires that translation services must be paid for if not directly provided by the insurer. This allows patients better comprehension of their care, alleviating anxieties and resistance that may otherwise occur. It also allows them to understand their benefits in a way that makes them more comfortable in accessing appropriate care.

The authorization of increased funding for community health centers has also helped to increase patient

access to care, as these facilities are able to expand services frequently accessed by minorities and other culturally marginalized patients who have had difficulties navigating other community resources. This has the potential to result in increased health screening for colorectal, prostate, and breast cancer, which should result in earlier cancer detection with resultant improved health outcomes and reduced societal costs.

Finally, the preventive mandates put forward in the ACA have reduced another barrier related to cancer detection. The ACA requires qualified health plans to provide certain services with either an A or B recommendation by the US Preventive Services Task Force, and specific services/therapies related to women's health, with no cost share to the member.[1] This has increased the number of individuals obtaining colorectal and breast cancer screening and undergoing BRCA testing. It is too early to assess whether this has improved the overall health of the population, but it certainly has impacted individual outcomes, as a greater number of individuals for whom cost was a barrier are obtaining testing.

It is important to note that not all impacts from the ACA have been positive for patients or providers. Despite efforts to increase access to quality healthcare, it did not adequately address the other large issue in the United States—affordability. Healthcare in the United States remains the most expensive in the world and yet health outcomes are average in many areas at best. The reimbursement incentive still targets volume, not value, although some shift is occurring. The cost of healthcare is increasing, athough the rate of increase has slowed in the last several years.[2] The various mandates in the ACA have resulted in increased cost to employers and plan holders, resulting in continued cost-shifting to individuals through high-deductible health plans or defined-contribution plans. As oncology care costs continue to rise at a rate disproportionally above the cost of other healthcare costs, due to the extreme pricing tactics of pharmaceutical manufacturers, and as more care is undertaken, some patients are placed in the position of foregoing necessary care.

Additionally, the lack of uniformity across states with regard to the benefits of the exchange plans, the presence of "grandfathered" plans, "grandmothered" plans, and different metal levels for exchanges have resulted in persisting or greater confusion for patients and providers as to what is covered when. This confusion has added to the inertia of care, and, in some instances, patients forego cancer therapies due to confusion.

Healthcare in the United States remains the most expensive in the world and yet health outcomes are average in many areas at best.

Overall, it is my belief that the positive impacts have outweighed the negative impacts at this point in the implementation of the ACA. As more aspects of it are implemented, we will see if this holds true. Certainly, the midterm elections may have an impact on the ACA, and what impacts will "ripple" out to patients and providers is unknown at this time. ■

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