Implications of the Affordable Care Act on Surgery and Cancer Care

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KEYWORDS

• Affordable Care Act • Health reform • Access to care • Surgical oncology
• Care delivery

KEY POINTS

- The Affordable Care Act (ACA) was the largest health reform in a generation, and it affects all aspects of health care, including surgical oncology.
- The ACA dramatically increased insurance coverage for millions of Americans, including for many patients with cancer.
- Early data suggest that insurance gains have been associated with increased and earlier diagnosis of malignancy, but long-term and cancer-specific outcomes remain unclear.
- The ACA invests in newer models of payment and care delivery, including efforts to shift toward pay for performance and increase care integration.
- Ongoing study and input from frontline providers, including surgical oncologists, are needed to evaluate how elements of the ACA are affecting diagnosis of cancer, access to appropriate care, and higher quality of cancer care delivery.

INTRODUCTION

The Patient Protection and Affordable Care Act (ACA), signed into law March 23, 2010, was the largest piece of health care legislation since the creation of Medicare and Medicaid nearly 45 years earlier. At the time of enactment, more than 46 million Americans lacked health insurance coverage and millions more were underinsured, having insurance plans that failed to cover many health conditions or medical and surgical intervention. Simultaneously, rising health care costs were increasingly affecting patients, health systems, states, and the federal government. These deficiencies in accessibility, affordability, and quality were driving factors for the key elements of the ACA.[1]

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This article provides an overview of the major elements of the ACA that influence patients with cancer, providers, care delivery, and research. Although many provisions are closely interrelated, this article is organized into broad categories of (1) insurance coverage expansion, (2) insurance market reform, and (3) care delivery.

INSURANCE EXPANSION

Before passage of the ACA, significant disparities in presentation, treatment, and survival existed according to patients' insurance status. Evaluation of more than 470,000 nonelderly adult patients diagnosed with one of the 10 deadliest malignancies from 2007 to 2010 found that patients with non-Medicaid insurance coverage were significantly less likely to present with distant disease (16.9%) compared with those with Medicaid (29.1%) or no insurance coverage (34.7%).[2] Furthermore, Medicaid and uninsured status was associated with significantly higher odds of failure to receive definitive surgical or radiation therapy for nonmetastatic disease (odds ratio [OR], 1.14; 95% confidence interval [CI], 1.11–1.16; and OR, 1.52; 95% CI, 1.48–1.57, respectively). Controlling for demographic and oncologic factors, Medicaid and uninsured status were also associated with higher mortality compared with non–Medicaid-insured patients (hazard ratio, 1.44; 95% CI, 1.41–1.47; $P<.001$; and hazard ratio, 1.47; 95% CI, 1.42–1.51; $P<.001$, respectively). Separate analysis of more than 3.7 million patients captured in the National Cancer Database from 1998 to 2004, found that nonwhite, particularly black, patients are significantly more likely to be uninsured and to present with an advanced stage disease at time of diagnosis compared with non-Hispanic white patients.[3] However, disentangling the multiple drivers of disparities and identifying levers to improve inequity has remained challenging given considerable interplay between insurance coverage, race/ethnicity, income, and other social determinants of health.[4]

The ACA increased insurance coverage through four key mechanisms. First, Medicaid eligibility was to be expanded to all people with incomes up to 138% of the federal poverty level. Second, the law created non–group insurance marketplaces available for individuals and small business, with subsidies available to individuals earning between 100% and 400% of the federal poverty limits. Third, the law allowed for young adult dependents to maintain coverage on parental plans up to the age of 26 years. A fourth aspect of the law includes the individual coverage mandate requiring all individuals to have some insurance coverage or pay a tax, with exceptions for economic hardships. Projections have suggested that this individual mandate contributes to 7 million to 8 million additional individuals having coverage.[2] Additional provisions included an employer mandate requiring business to offer insurance coverage to their employees (with certain exemptions, including for small businesses) and tax credits to employers for contributions to employee health insurance coverage. Between 2010 and 2014, when nongroup marketplaces were fully operating, a separate Early Retiree Reinsurance Program helped bridge employee-based coverage for people retiring between the ages of 55 and 65 years.

Medicaid Expansion

Before 2010, Medicaid represented a federal-state partnership that provided health insurance coverage predominantly to low-income children, parents, pregnant women, and disabled Americans. The ACA expanded eligibility criteria to include all nonelderly adults earning up to 138% of the federal poverty limit, with the federal government initially assuming 100% of cost and gradually decreasing to 90% by 2020. However, a 2012 Supreme Court decision found that individual states could