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News and topics

Anticipating the effect of The Patient Protection and Affordable Care Act for patients with urologic cancer

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Abstract

The Affordable Care Act seeks to overhaul the US health care system by providing insurance for more Americans, improving the quality of health care delivery, and reducing health care expenditures. Although the law's intent is clear, its implementation and effect on patient care remains largely undefined. Herein, we discuss major components of the Affordable Care Act, including the proposed insurance expansion, payment and delivery system reforms (e.g., bundled payments and Accountable Care Organizations), and other reforms relevant to the field of urologic oncology. We also discuss how these proposed reforms may affect patients with urologic cancers. Published by Elsevier Inc.

Keywords: Patient Protection and Affordable Care Act; Affordable Care Act; Urologic oncology; Accountable Care Organizations; Bundled payments; Health care reform

1. Introduction

The Patient Protection and Affordable Care Act, often referred to as the Affordable Care Act (ACA), was signed into law on March 23, 2010. This legislation seeks to overhaul the US health care system by providing insurance for more Americans, improving the quality of health care delivery, and reducing health care expenditures. Although the law's intent is clear, its implementation and effect on patient care remains largely undefined. Herein, we discuss major components of the ACA and consider how these may affect patients with urologic cancers (Table 1).

2. Insurance expansion

Perhaps the most publicized aspect of the ACA is the expansion of insurance coverage, which will affect an estimated 32 million uninsured individuals by 2019. It is estimated that this legislation will increase the percentage of nonelderly insured individuals from 83% to 94%. There are multiple methods proposed in the law to achieve this laudable goal, including the individual mandate, state-based health benefit exchanges, tax credits, penalties to employers who do not provide coverage, expansion of Medicaid, and the protection of individuals with preexisting conditions (including cancer).

The effect of insurance coverage on the field of urologic oncology will depend on several factors, including whether states and individuals follow the law and the demographics of the newly insured. Critics argue that the success of the individual mandate will be limited to some extent if individuals choose to pay a penalty rather than obtaining coverage, as the former may be less expensive than insurance premiums [1]. Additionally, although it is estimated that 16 to 20 million additional individuals will be insured by expanding Medicaid eligibility up to 133% of the federal poverty level, many states are reluctant to support the expansion, a fact that could limit greatly the effect of the ACA on access to care [2].

Given that urologic malignancies represent 25% of all cancer diagnoses annually, if some or all of the insurance expansion policies are successful, there may be a significant increase in the number of patients diagnosed and treated with urologic cancer, including many more individuals presenting with early-stage disease. It is important to note, however, that 76% of the current 48 million uninsured are younger than 55 years (41.5% are younger than 34 years), and that most urologic cancers occur in older patients [3]. Based on the age demographics of the currently uninsured,

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Table 1
Key provisions in the Affordable Care Act and potential implications for urologic oncology

Provision	Description	Effect on urologic oncology
Insurance expansion	• 25 million Americans are expected to gain insurance by 2017 • Mechanisms include individual mandate, state-based health benefit exchanges, tax credits, penalties to employers who do not provide coverage, expansion of Medicaid, and the protection of individuals with preexisting conditions (including cancer) • True effect will depend on whether individuals follow the individual mandate and states expand Medicaid	• Expected increase in the number of patients diagnosed and treated with urologic cancer, including many more individuals presenting with early-stage disease and cancers in young patients, such as testicular cancer • Smaller effect in urologic oncology than other fields because 76% of the current 48 million uninsured people are younger than 55 years • May reduce race/ethnic and socioeconomic disparities in cancer care
Bundled payments (BP)	• Lump-sum reimbursement for an acute hospitalization and all charges up to 30 days after discharge • May provide incentives for physicians to better coordinate care, lower costs, and improve quality • May reduce unnecessary and duplicative services, however, may also cause skimping of necessary services. • Pilot programs are currently being tested across the country	• Current BP pilots do not include urologic cancer surgeries or conditions or both • Potential targets include inpatient procedures such as radical cystectomy and nephrectomy
Accountable Care Organization (ACO)	• Group of physicians, hospitals, and health care systems that collectively accept responsibility for delivering care to a population of at least 5,000 Medicare beneficiaries • May motivate providers to enhance communication and reduce unnecessary and duplicative services	• May help reduce duplicative diagnostic and surveillance imaging in the treatment of urologic cancers • There may be new disincentives for both primary care physicians and specialists to encourage the use of expensive technology and treatments, such as robotic surgery or novel therapies for castration-resistant prostate cancer • ACOs may limit access to expensive cancer-focused hospitals, which may lead to worse oncologic outcomes
Patient-Centered Medical Homes (PCMH)	• Selected physicians are empowered with additional resources and incentives that support greater care coordination between specialists, physician extenders, and family members	• Pilot programs for PCMH have largely focused on primary care physicians as center of care; however, oncologists and urologists may be able to serve as the center of care in select cases • PCP as the center of care may be beneficial for patients with urologic malignancies who also have multiple comorbidities
Other reforms relevant to patients with urologic cancer	• Health insurers are mandated to cover routine costs for oncology patients in clinical trials and they cannot deny insurance to patients who have cancer as a preexisting condition • Strong emphasis on cost-effectiveness research (CER), which will help urologic oncologists and their patients make better treatment decisions • The Patient-Centered Outcomes Research Institute (PCORI) provides funding for investigators interested in studying patient preferences, educational tools, and comparative effectiveness of treatments related to urologic malignancies	

therefore, it is anticipated that expanded insurance coverage may lead to greater demand for urologic treatment of cancers that affect young patients, such as testicular cancer. Although there may be an increase in the number of young patients treated for kidney, bladder, and prostate cancer, given the average age of onset of these cancers, the overall effect will likely be small, as was the case for breast cancer after the Massachusetts insurance reforms [4].

Importantly, expanded insurance coverage may accelerate efforts to address both race/ethnic and socioeconomic disparities in cancer care. At present, race/ethnic minorities comprise a disproportionate fraction of the uninsured population in the United States, and expanded coverage through the ACA may yield greater access to screening and treatment of urologic cancers for many historically underserved communities. In the field of prostate cancer, the positive effect of providing care to the previously uninsured and underinsured has been demonstrated through the Improving Access, Counseling and Treatment for Californians with prostate cancer (IMPACT) program. Since 2001, the IMPACT program has provided free treatment to men with prostate cancer and household incomes under 200% of the federal poverty level. Despite the high-quality care available to IMPACT patients, the men served by this program still have a higher incidence of metastatic and high-risk prostate cancer at the time of diagnosis, which may reflect minimal access to early detection programs prior to enrollment [5]. By providing better access to primary care and early detection opportunities, provisions in the ACA may help narrow this disparity.

Although the insurance expansion does offer opportunities to improve access to care and reduce socioeconomic disparities, a consequent concern is whether the current urologic oncology workforce will be able to handle such increases in demand, particularly in regions that are already underserved by urologic oncologists. Accordingly, a potential