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The Patient Protection and Affordable Care Act: Impact on the care of gynecologic oncology patients in the absence of Medicaid expansion in Central Virginia☆

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HIGHLIGHTS

- Medicaid expansion opt-out may decrease access to care for low income uninsured and under-insured gynecologic oncology patients in Central Virginia.
- Minority women and women with cancer will be disproportionately affected.

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ABSTRACT

Objective. Many gynecologic oncology (GO) patients in Virginia are low income and their care is supplemented by Disproportionate Share Hospital (DSH) funds. Our objective is to estimate how many new GO patients may lose access to care if the state forgoes Medicaid expansion.

Methods. New patients referred to the GO service between July 1, 2010 and July 1, 2012 were identified. Data were collected regarding age, race, referral diagnosis, payor, and state pay scale. Pay scale 1 (PS1) is equal to the federal poverty level (FPL). Assumptions included the following: (1) pay scale is a surrogate for income, (2) PS1 patients will be ineligible for discounted insurance through the exchanges, and (3) decreasing DSH funds will result in a reduction of the free-care pool.

Results. There were 1623 referrals to the GO service and the majority (83%) was Caucasian. The payor distribution was 44% commercial insurance, 5.6% Medicaid, 31% Medicare, and 10.4% uninsured. Among the 361 women who were PS1, 32% were uninsured. Thirty percent of PS1 patients were minorities and 47.4% had a malignancy. Of note, 52% of new patients with cervical cancer were PS1.

Conclusion. Seven percent of new GO patients are PS1 and uninsured. This population contains a disproportionate number of minorities and women with cancer. These women will have difficulty affording care as DSH funding decreases, particularly in states with lean Medicaid that opt out of Medicaid expansion. The burden of lack of access to care will be shouldered by an unfortunate few.

Introduction

In 2010 Barack Obama signed into law the Patient Protection and Affordable Care Act (ACA) [1,2]. This historic act ultimately aims to increase access to health care for all Americans and decrease the cost of health care but has other equally important goals in mind. For example, with respect to cancer patients, the ACA aims to increase access to cancer care, improve quality of care, examine the causes for cancer care disparities, and investigate differences in cancer care across the country [3,4]. The ultimate goal is affordable, comprehensive, and quality cancer care.

Since its passage in 2010, the constitutionality of the ACA has been challenged in a number of state and federal courts. The most frequent target of the challenges was the individual mandate as many felt that fining individuals for failing to purchase insurance was not within the scope of Congressional power [5]. Many of these separate cases were merged into a single case heard by the Supreme Court, entitled *National Federation of Independent Business v. Sebelius*, in June 2012. The Supreme Court upheld the crucial individual mandate, requiring that all Americans have health insurance or suffer tax penalties. However, the Supreme Court also declared that the states were not required to participate in the Medicaid expansion, an essential component of the ACA in terms of improving access to care for low income patients [6].

The Medicaid program is jointly funded by states and the federal government. Individual states have varying Medicaid eligibility criteria

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within federal minimum standards, particularly with regard to non-disabled adults without dependent children [7]. The ACA, as it was originally written, included the standardization of Medicaid eligibility requirements across the country in order to increase access to care; all US citizens aged 18–65 years who live under 138% of the federal poverty level (FPL) would be eligible for Medicaid under the expanded program. After the ACA was passed, estimates suggested that Medicaid expansion would provide access to care for 16–18 million more Americans [8]. Since states now have the ability to "opt-out" of Medicaid expansion, the number of new Americans that will be covered by the Medicaid program is unknown, but certainly will be lower than original estimates.

Currently the federal government provides funding to hospitals which provide care for patients who have low incomes and are under insured or uninsured via the Disproportionate Share Hospital (DSH) funds. These are also known as indigent care funds, or in Virginia as the "free care pool." As a result of the expectation that all states would participate in the Medicaid expansion, under the full institution of the ACA scheduled for 2014 these funds will begin to be phased out [9]. While the final plan for this staged reduction has not been determined, it is very clear that the DSH funds will significantly diminish. For states that choose to "opt out" of the Medicaid expansion, the same level of DSH funds will no longer be available to cover the cost of caring for uninsured patients [9].

In Virginia, Medicaid eligibility requirements are particularly strict. Patients who are aged 18–65 years are not eligible for Medicaid regardless of income unless they are disabled, pregnant, or have dependent children. At the University of Virginia (UVA) and at other state university teaching hospitals, pay scales have been developed based on income, assets, and number of dependents to determine the amount of money a patient must pay for his or her care. These pay scales range from a 0% co-pay to a 100% co-pay. For patients who meet criteria for indigent care, the hospital and physicians are further reimbursed by the DSH funds. At the time of this writing, Virginia has declared that the Commonwealth will "opt out" of the Medicaid expansion. What this decision means is that with the impending decrease in the DSH funds, the hospitals caring for indigent patients may no longer be reimbursed at the current rate for these patients' care.

In addition, a "coverage gap" will exist in Virginia. The insurance exchanges created by the ACA were intended to serve patients who have incomes greater than 100% of FPL, since patients making less would be eligible for Medicaid under the expanded eligibility criteria written into the original ACA. Should Virginia opt out of Medicaid expansion, many patients with an income <100% of FPL will not be covered by Medicaid and also will not be eligible to buy discounted insurance through the exchanges.

Currently the patient population at UVA includes a significant proportion of low income uninsured and under-insured patients. The hospital system is reimbursed for providing their care via DSH funds. With the possibility that Virginia may opt out of Medicaid expansion and the decrease in DSH payments looming on the horizon, these low income uninsured and under-insured patients may lose access to free care but still not qualify for Medicaid or be eligible for discounted health insurance. As providers we may lose the ability to provide care for this group of patients. Our objective in this study is to estimate how many new referrals to the gynecologic oncology service at the University of Virginia will no longer have access to care in the event the state forgoes Medicaid expansion.

Materials and methods

Study approval was obtained from the University of Virginia (UVA) institutional review board. We identified all women who presented for a new patient visit to a gynecologic oncology provider between July 1, 2010 and July 1, 2012. Women were identified using departmental records of new patient referrals. UVA's Clinical Data Repository (CDR) was used to obtain additional information including age; race; place of residence; referring physician; referral diagnosis; payor; and state pay scale assignment.

State pay scale assignment

Currently at the University of Virginia, patients who are uninsured, have income up to 200% of the FPL, and whose assets do not exceed a given threshold qualify for the hospital's indigent care program. These patients are assigned a pay scale based on income, number of dependents and assets. A patient's pay scale then determines the co-pay for which he or she will be responsible. The annual income ranges for each pay scale level are presented in Table 1. In short, the income limit for pay scale 1 (0% co-pay) is ≤100% of the FPL and for pay scale 7 (100% co-pay) is >200% of the FPL. The annual income limits for pay scale 2 (5% co-pay), 3 (20% co-pay), 4 (45% co-pay), and 5 (70% co-pay) are between 100% and 200% of the FPL. The amount of assets allowed is also based on the number of people in the household. A household of one person is allowed $2000 in assets, two people $3000 in assets, and another $100 in assets is allowed for each additional person in the household. A patient must meet both income and asset criteria to qualify for the indigent care program.

Study model

Assumptions in our study model include (1) state pay scale, calculated using formulas that include income, number of dependents and assets, is a surrogate for income, (2) in Virginia, women who are currently uninsured with an income <100% of the FPL will be ineligible for a health insurance subsidy to buy discounted insurance through health care exchanges and (3) the reduction of the DSH funds will result in a reduction of the current free care pool.

Results

There were 1623 new patient referrals to the UVA gynecologic oncology clinic during the study time period. The demographic information for the entire population of new referrals is presented in Table 2. The mean patient age was 56.4 years. Most patients (68.5%) were younger than 65 years and therefore did not qualify for Medicare. The majority of women were Caucasian (83%) with smaller percentages of Black

Table 1
State university teaching hospitals guidelines for medically indigent patients: annual income ranges for fiscal year 2013.

	Pay scale 1	Pay scale 2	Pay scale 3	Pay scale 4	Pay scale 5	Pay scale 7
Number of dependents	0% co-pay	5% co-pay	20% co-pay	45% co-pay	70% co-pay	100% co-pay
1	0–11,170	11,171–12,287	12,288–14,893	14,894–18,617	18,618–22,340	22,341–over
2	0–15,160	15,131–16,643	16,644–20,173	20,174–25,217	25,218–30,260	30,261–over
3	0–19,090	19,091–20,999	21,000–25,453	25,454–31,817	31,818–38,180	38,181–over
4	0–23,050	23,051–25,355	25,356–30,733	30,734–38,417	38,418–46,100	46,101–over
5	0–27,010	27,011–29,711	29,712–36,012	36,013–45,018	45,019–54,020	54,021–over
6	0–30,970	30,971–34,067	34,068–41,292	41,293–51,618	51,619–61,940	61,941–over
7	0–34,930	34,931–38,423	38,424–46,572	46,573–58,218	58,219–69,860	69,861–over
8	0–38,890	38,891–42,779	42,780–51,852	51,853–64,818	64,819–77,780	77,781–over