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Review

The Patient Protection and Affordable Care Act: What every provider of Gynecologic Oncology care should know

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HIGHLIGHTS

- The Affordable Care Act is intended to cut the cost of care while increasing quality and improving access.
- As providers of cancer care for women, we can and should impact the implementation of the ACA.
- State medicaid expansion is crucial to assure access to care for cancer patients.

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ABSTRACT

The Patient Protection and Affordable Care Act (ACA) was signed into law by President Barack Obama in 2010. While initial implementation of the law began shortly thereafter, the full implementation will take place over the next few years. With respect to cancer care, the act was intended to make care more accessible, affordable, and comprehensive across different parts of the country. For our cancer patients and our practices, the ACA has implications that are both positive and negative.

The Medicaid expansion and access to insurance exchanges are intended to increase the number of insured patients and thus improve access to care, but many states have decided to opt out of the Medicaid program and in these states access problems will persist. Screening programs will be put in place for insured patients but may supplant federally funded programs that are currently in place for uninsured patients and may not follow current screening guidelines. Both hospice and home health providers will be asked to provide more services with less funding, and quality measures, including readmission rates, will factor into reimbursement. Insured patients will have access to all phases of clinical trial research.

There is a need for us as providers of Gynecologic Oncology care to be active in the implementation of the ACA in order to ensure that our patients and our practices can survive and benefit from the changes in health care reimbursement, with the ultimate goals of improving access to care and quality while reducing unsustainable costs.

Contents

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Introduction

In 2010, President Barak Obama signed into law the Patient Protection and Affordable Care Act (ACA). While the initial implementation of the new law began shortly thereafter, it will not be fully implemented until after 2014. How will the implementation of the ACA affect those of us who provide care for women with gynecologic cancer, and how will it affect our patients? What recommendations can and should we as providers propose as the government issues guidelines and recommendations for the new law? How can we advocate for both ourselves and our patients to ensure that high quality cancer care continues at the most affordable cost?

The United States spends more money on health care than any other nation in the world. Annual per capita medical care expenditures in the United States are 2.5 times higher than those in any other nation, and if current trends are allowed to continue, medical care costs will reach more than 19% of the gross domestic product by 2019 [1]. Even with the high cost of care, our health care quality measures are lower than many other developed countries. For example, the last available measure of female life expectancy had the United States ranked at 46th in the world [2]. The current model of fee-for-service care and the high (over)use of expensive technology and procedures have been targeted as two of the biggest driving forces for the high cost of care, along with insurance (Medicaid and Medicare) fraud, lack of appropriate competition in a free market, and poor coordination of care. As a society, the United States needs a solution to the high cost of health care and the relatively low quality of care.

The ACA was created with these problems in mind. While principally designed to increase access to care by insuring more patients, the new law also aims to improve the quality and cut the cost of care. Specifically with respect to cancer care, the ACA's goals include making cancer care more accessible, affordable, and comprehensive across different regions of the country [3].

So how does the new law measure up for cancer patients? In 1999, the Institute of Medicine (IOM) published a report entitled "Ensuring the quality of cancer care," which was commissioned by the National Cancer Policy Board in order to create a comprehensive review of effectiveness of cancer services and delivery systems, to assess the adequacy of quality assurance mechanisms, and to identify barriers that impede access to cancer care [4]. The findings of this report and related data regarding cancer care in the United States provide a good yardstick against which to measure the success of the ACA in improving the quality and accessibility of cancer care. Considerations in the report included, for example, addressing disparities in health care, such as the fact that Black women with endometrial cancer have worse outcomes than those of their White counterparts [5], and addressing country-wide differences in patterns of care, such as the chemotherapy delivery for ovarian cancer [6], with the ultimate goal of improving overall quality of cancer care. While the ACA has addressed some issues of racial inequality by increasing access to health care and including data collection regarding health care disparities, and does include some quality reforms, which are in the process of being implemented, overall the new law has mixed implications for the care of women with gynecologic cancer, both in terms of the recommendations of the IOM report and from practical evidence in the field since the new law went into effect.

As the ACA is implemented, there is time for those of us who care for gynecologic cancer patients to contribute to the implementation process and ensure access to quality affordable care. The Society of Gynecologic Oncologists (SGO) has very recently released a White Paper that will outline how we can become more involved in the process [7]. The purpose of this paper is to help health care providers for women with gynecologic cancer gain a thorough understanding of the current state of the ACA and how it will affect our practices and our patients. With this knowledge, we can then be prepared to fully participate in the implementation process to ensure that the needs of gynecologic cancer patients and those of us who care for them are reflected in the new rules and regulations.

The current paper will begin with a review of how the ACA can improve cancer care by increasing access to care, removing barriers to preventive screening, and mandating insurance coverage of clinical trials. Then, within each category, the unintended challenges created by the ACA will be discussed, including access to care for those in states who choose not to opt into the Medicaid expansion, hospice reforms, and quality reforms, which as implemented, can create perverse incentives for end of life cancer treatment and for the institutions and doctors charged with that care. This paper is not meant to be a comprehensive discussion of the ACA; rather it is meant to highlight specific issues that are important to be aware of now that will affect us as providers and our patients as the ACA is implemented. Many of the issues discussed have already been experienced personally by one of the authors (L.D.) and data regarding the state of Virginia will be presented as specific examples throughout the text. The reader is encouraged to investigate the same data in their own state.

The Medicaid expansion and Federal insurance exchanges

With its landmark decision in June 2012, the United States Supreme Court upheld the ACA's crucial individual mandate. The creators of the ACA understood that in order to be financially feasible an insurance plan must include a full "risk pool" of enrollees, including both the sick and the healthy. The individual mandate was crucial to the creation of the health insurance exchanges, or marketplaces, where individuals and small businesses can shop for affordable health coverage. These federal- and state-based exchanges will provide access to health care millions of Americans when fully phased in. However, in a surprise move, the Supreme Court also ruled that the federal government could not mandate that states participate in the Medicaid expansion.

Currently, each state in the United States has its own rules regarding Medicaid eligibility. The federal government covers between 50% and 76% (the average is just shy of 60%) of the cost of providing care to Medicaid beneficiaries, with each state's federal "matching rate" depending on its per capita income. States with higher per capita incomes have a lower federal matching rate [8]. The ACA, as it was originally passed in 2010, established a new, minimum standard for Medicaid coverage that was intended to be uniform across the country and fill the biggest gaps in coverage for low-income people, particularly childless adults, who generally were not covered under Medicaid. Specifically, the ACA required states by January 1, 2014, to extend Medicaid eligibility to all groups of people (including childless adults, parents, and children) under the age of 65 years with income