Impact of Health Care Reform Legislation on Uninsured and Medicaid-Insured Cancer Patients

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Abstract: The Patient Protection and Affordable Care Act of 2010 is the most important US health legislation since the creation of Medicare and Medicaid in 1965. Repeated attempts at a complete overhaul of the health care system under various administrations and 4 decades of incrementalism in our approach to health policy making paved the way for this historic legislation. Major components of the recently enacted legislation include a substantial expansion of the Medicaid program to include 17.1 million currently uninsured adults with incomes below 133% of the federal poverty line, a mandated minimum health benefits package, a renewed focus on prevention, the establishment of state health exchanges with special provisions to permit affordability by those with incomes below 400% of the federal poverty line, and the establishment of high-risk health insurance pools for patients who were previously denied coverage because of preexisting conditions. The time for change was long overdue. Although many challenges exist, particularly for the states, in the implementation phase of the Affordable Care Act, the benefit to low-income cancer patients is increased access to guideline-recommended levels of screening, diagnostic, treatment, and follow-up services.

Key Words: Medicaid, health care reform, childless adults, uninsured, federal poverty level, health exchange, affordable care act, health benefits package, preventive services

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Widespread disparities based on factors such as race, age, income, employment status, and insurance coverage benefits fueled much of the recent heated discussion regarding the need for health care reform in the United States. Access to care is severely lacking among the uninsured. Although Medicaid-insured patients have access to care, both uninsured and Medicaid-insured cancer patients tend to exhibit similarly low rates of receipt of guideline-recommended care, high rates of late stage tumors at diagnosis,[1,2] and lower survival rates.[3] For 2009, 50.7 million (16.7%) Americans of all ages were uninsured.[4] Medicaid-insured patients for 2009 were estimated at 47.8 million or 15.7% of the US population.[4] A recent American Cancer Society (ACS) Cancer Action Network poll of individuals diagnosed with cancer prior to age 65 found that 34% were uninsured or had been uninsured during some portion of the period after diagnosis. Fifty-nine percent of uninsured patients with cancer could not afford to purchase insurance. Within the past 1 to 2 years, 34% to 38% of cancer patients delayed seeking care because of cost.[5] The time for change was long overdue.

To enable understanding of the impact of the legislation on the uninsured and Medicaid insured, the article begins with a description of access to care for these groups before enactment of Affordable Care Act (ACA). The various provisions are then described along with specific examples of how patients requiring screening, treatment, or survivorship care for cancer will be impacted. Challenges to be overcome during implementation are outlined in the discussion section. The main purpose of the article is to provide an overview of the many provisions of the ACA applicable to uninsured and Medicaid-insured patients. More in-depth information regarding these provisions is available at acscan.org/healthcare/learn.

ACCESS TO CARE BEFORE ACA

Uninsured

The uninsured have historically attempted to obtain care through a system of safety net community health centers, including those specifically designed to address the needs of public housing residents, migrants, and the homeless. In addition, university-affiliated medical centers provide a sizeable amount of uncompensated care as do many not-for-profit hospitals, such as those run by religious orders. Although patients receive health care services at little or no charge, care received in this fashion tends to involve long waiting times in hospital clinics and emergency departments, and continuity of care may be suboptimal because of the lack of a designated primary care provider. Medical record keeping may not be automated because of scarce resources. The absence of a well-organized medical record-keeping system can result in unnecessary repetition of diagnostic tests. Providers may be medical students, supervised by practicing physicians, who work in the clinics as part of their training. Uninsured patients often present at emergency departments with needs that are more appropriately cared for at clinic visits. Because of the triage method of addressing the most urgent needs first, visiting the emergency department for the flu, for example, further lengthens patient waiting times to receive care.

A special category of safety net facility, Federally Qualified Health Centers (FQHCs), was funded under Section 330 of the Public Health Services Act in 1996 with the intent of reducing the indigent care burden on hospital emergency departments. These facilities provide free or low-cost primary care services for patients of all ages in medically underserved areas and require that individuals pay only what they can afford. An area or population may be considered underserved for a variety of reasons such as high poverty or infant mortality rates or a severe lack of primary care providers.[6] Federally Qualified Health Centers must provide preventive medical, dental, mental health, and substance

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abuse services either on site or by arrangement with another provider. Assistance with transportation to permit patients access to care must also be provided.[7,8] Access to specialists is often lacking at FQHCs, however, and out-of-pocket costs relative to income can still be prohibitive.

Medicaid Beneficiaries

Since its inception in 1965, Medicaid (Title XIX of the Social Security Act) has been a state-run, federally mandated entitlement program covering select segments of the nation's poor, primarily those younger than 65 years. Almost half (48%) of all beneficiaries are children. Although not required by law, most families who are eligible for Temporary Assistance for Needy Families are also eligible for Medicaid. The federal government provides matching funds to the states to help cover the costs of the program. For the fiscal year ending 2006, state Medicaid programs provided care for 57.8 million beneficiaries at a cost of $269.9 billion or $4762 per beneficiary. Although the blind and disabled constitute only 14% of all Medicaid beneficiaries, the cost of caring for such patients is 43% of the total cost of care for all Medicaid beneficiaries or $13,299 per beneficiary.[9]

There are minimum requirements that all states must meet in which patients have mandatory eligibility (Table 1) and the types of services provided (Table 2). Similarly, there are additional service types and patient categories that Medicaid considers optional, such as the medically needy (i.e., patients with incomes exceeding eligibility limits who are allowed by the states to incur medical expenses until they have spent down to a level sufficient to qualify for Medicaid). Thus, states may choose to provide or not provide certain services and can choose to extend or not extend coverage to certain populations.

States may also obtain waivers to extend eligibility to broader segments of the population, such as patients receiving home-based health care who might otherwise be institutionalized, or permit the provision of services beyond those considered mandatory or optional. Not only do services and eligibility vary by state, but the state can elect at any time to change eligibility, reimbursement, or covered service levels. States can also choose to impose cost-sharing requirements (i.e., deductibles, coinsurance, or co-payments) on certain categories of Medicaid beneficiaries. Cost sharing cannot be imposed on pregnant women, on children younger than 18 years, or on hospitalized or nursing home patients already devoting most of their income to their care. Most low-income Medicaid beneficiaries are automatically enrolled in managed care programs. These programs place a heavy emphasis on primary care services and cost containment.

TABLE 1. Historical Mandated Medicaid Eligibility Groups[10]

- Limited income families with children who meet the requirements for each state's Aid to Families with Dependent Children program as of July 1996;
- Children under 6 in families with incomes no greater than 133% of the FPL;
- Pregnant women with family incomes not exceeding 133% of the FPL (only pregnancy-related services are covered);
- Infants born to Medicaid-eligible women during their first year of life;
- Supplemental Security Income (SSI) recipients (or aged, blind, disabled individuals in states with restrictive eligibility requirements predating SSI);
- Recipients of adoption or foster care assistance
- Special protected groups who continue on Medicaid for a temporary period although no longer eligible, such as those who lose SSI assistance because of earnings from work exceeding maximum allowable levels;
- All children 18 years or younger in families with incomes <133% of the FPL;
- Certain categories of Medicare beneficiaries (Qualified Medicare Beneficiaries, Specified Low Income Medicare Beneficiaries, Qualifying Individuals) with incomes <135% of the FPL and limited resources

TABLE 2. Historical Minimum Basic Benefits for Medicaid Beneficiaries[10]

- Inpatient hospital care
- Outpatient hospital care
- Nursing facilities services for patients 21 years and older
- Rural health clinic services
- FQHC services
- Home health care for patients eligible for skilled nursing care
- Physician services
- Laboratory and radiography services
- Pregnancy-related services, including nurse midwife
- Family planning services and supplies
- Vaccines for children
- Pediatric and family nurse practitioner services
- Early and periodic screening, diagnostic, and treatment services for children under age 21

A common misconception is that the Medicaid program has historically provided care for all the nation's poor younger than 65 years. However, only select segments of the poor qualify for Medicaid services, as shown in Table 1. Family status has long been an indicator of Medicaid eligibility. Historical mandatory eligibility groups noticeably exclude low-income childless adults, which are defined as adults with no dependent children. Currently, uninsured low-income childless adults below 133% of the FPL constitute 17.1 million individuals.[11]

In summary, the safety net system of care for uninsured and Medicaid-insured patients is a poorly constructed system. The safety net has been in need of significant mending for decades. Patients are not "saved" by the safety net, but rather fall through large holes in the net and either go without needed health care or incur substantial debt relative to their income.

ACCESS TO CARE AFTER ACA

Patients With Preexisting Conditions

According to a recent ACS Cancer Action Network poll conducted just after the ACA became law, 16% of households affected by cancer reported that a preexisting condition precluded them from finding an insurance plan and was the reason for their uninsured status. An additional 1% had been dropped from coverage.[5] One component of the health reform legislation that took effect on August 1, 2010, addresses this problem and provides temporary assistance to cancer patients until a more permanent fix takes effect in 2014.

Effective as of August 1, 2010, adults, who had been uninsured for at least 6 months and had been denied coverage for a preexisting condition, became eligible for access to health insurance coverage through temporary high-risk health insurance pools funded entirely by the federal government. Generally, access is provided to a comprehensive major medical plan that in most cases also includes coverage for prescription drugs, HIV related

TABLE 3. Essential Health Benefits Package[12(§1302)]

- Ambulatory patient services;
- Emergency services;
- Hospitalization;
- Maternity and newborn care;
- Mental health and substance use services, including behavioral health treatment;
- Prescription drug;
- Rehabilitative services and devices;
- Laboratory services;
- Preventive[16] and wellness services and long-term disease management;
- Pediatric services, including oral and vision care

care, mental health services, and substance abuse treatment. Total co-payments, coinsurance, and deductibles cannot exceed 35% of the covered benefit cost. There is also a $5950 cap for individuals and an $11,900 cap for families, exclusive of premiums. Premiums cannot exceed 100% of the federal standard risk rate and cannot vary by age by a ratio of more than 4 to 1. For example, if the premium for a person 20 years is $400, the premium charged for a person 60 years cannot exceed $1600.[12(§1101),13]

These high-risk health insurance pools, termed *Preexisting Condition Insurance Plans* (PCIP), are an interim fix until state health exchanges become available on January 1, 2014. States have the option of running their own PCIP or having the federal government run the plan. As of September 2010, 23 states elected to have federal-government-run PCIPs.[14,15] Five billion dollars was set aside to support the PCIP program with the formula for allocating dollars to specific states similar to that used for the Children's Health Insurance Program.[14]

State Health Exchanges

Effective January 1, 2014, patients without access to qualified insurance through Medicaid, Medicare, or their employer will have the option of purchasing coverage through state or region-specific American Health Benefit Exchanges. Each state's Health Subsidy Program will use a single application form to determine a patient's eligibility for the exchange versus Medicaid or some other state-specific program. States are required to operate a Web site presenting plan options in a standardized format and an electronic calculator to permit estimation of plan costs.[12(§1302)]

All qualified health insurance plans must meet all criteria set forth by the Secretary of Health and Human Services for this designation. The state is responsible for certifying that plans meet these criteria. Plans must cover the federally mandated, but not yet fully defined, essential health benefits package (Table 3), which, unlike the Medicaid program, requires coverage of US Preventive Services Task Force (USPSTF) recommended preventive services. (USPSTF recommendations differ from those of the ACS.) Marketing of plans must not deter those with significant health needs from enrolling and plan provider networks must include those providers who typically serve low-income and medically underserved populations. The plan must also incorporate cost-sharing limits.[12(§1302)] Cost sharing is specifically prohibited for American Indians and Alaskan Natives with incomes below 300% of the FPL, and tribal benefits are exempted from gross income calculations.[12(§2901,9021),17] States must monitor premium increases inside and outside the exchanges. Insurance obtained in this fashion will be genuinely portable as it will not be tied to employment. The federal government will operate an exchange if in 2013 it seems unlikely that the state's exchange will be operational by 2014. On October 1, 2010, the governor of California signed a bill creating the nation's first state health insurance exchange. As California's population represents 10% of the total US population, their experience will be informative for the rest of the nation.[18]

Comprehensiveness of coverage of the various health insurance plans is categorized into 4 levels based on actuarial value, which is the percentage of health costs for a standard population covered by the plan: bronze (60%), silver (70%), gold (80%), and platinum (90%). Bronze is the least generous plan and platinum is the most generous plan. Each exchange must offer at least a silver- and gold-level health insurance plan. Higher actuarial value is generally correlated with higher premiums. Actuarial value does not take into consideration plan administrative performance, the quality of the plan's provider network, or optional features of a plan. Actuarial value also does not fully reflect the patient's true out-of-pocket costs. Plans with low actuarial values tend to have higher deductible and co-payment requirements.

Effective January 1, 2014, each state must also establish a Small Business Health Options Program (SHOP) Exchange for small employers with 50 to 100 employees. Typically, many small employers cannot afford to offer their employees health benefits. The SHOP Exchanges are a mechanism to assist small businesses in enrolling their employees in qualified health insurance plans within the state. After 2017, the SHOP can be opened to businesses with more than 100 employees. The states have the option of operating a single Exchange to meet both the American Health Benefit Exchange requirement and the SHOP requirement.[12(§1302)] Exchanges must be self-sustaining by 2015 and can charge assessments or user fees to participating health insurance issuers or generate funding in other ways to support operations. To encourage businesses with fewer than 25 full-time equivalent employees to offer health insurance as a benefit of employment, a new tax credit of up to 50% of the total premium cost will be available.[12(§1421)]

To make coverage through the exchanges affordable for individuals with incomes below 400% of the federal poverty line (FPL; i.e. for a family of 4, 400% of $22,050 or $88,200; Table 4), premium tax credits will be available.[20] The credit is based on a sliding scale ranging from 2% of income for those at 100% FPL (for a family of 4, 2% of $22,050 or $441) to 9.5% of income for those at 300% to 400% FPL (for a family of 4, 9.5% of $88,200 or $8379).

TABLE 4. 2010 Federal Poverty Guidelines for the 48 Contiguous States and the District of Columbia[19]

Persons in the Family	Poverty Guideline, $
1	10,830
2	14,570
3	18,310
4	22,050
5	25,790
6	29,530
7	33,270
8	37,010

For families with 9 or more persons, add $3740 per additional person. For Alaska and Hawaii, the poverty guidelines begin at $13,530 and $12,460 and are incremented by $4680 and $4300, respectively.

In order for an employee to be eligible for the premium tax credits, the cost of the insurance coverage offered by the employer to the employee must exceed 9.5% of the employee's family income. For example, an annual insurance premium of $2500 would exceed 9.5% ($2095) of an income of $22,050 for a family of 4, thus the family would qualify for the tax credit. The employee may also qualify for credits if the employer pays less than 60% of the premium. Thus, if the premium costs $2500 and the employer only covers $1000 or 40%, the employee would qualify for the credit. An individual meeting 1 of these 2 criteria would enroll in the exchange and become eligible for the credits.[12(§1401,1402)]

To further assist low-income individuals afford health insurance, the usual out-of-pocket maximums ($5950 for individuals and $11,900 for families) are reduced by 66% for those with household incomes below 200% FPL, 50% for those with incomes between 200 and 300% FPL, and 33% for those with incomes between 300% and 400% FPL. For example, for a family of 4 with an income of $35,000 (200% FPL = $44,100), the out-of-pocket maximum of $11,900 would be reduced by 66% to $3967. The usual out-of-pocket maximums pertain to the sum of the annual deductible and other annual out-of-pocket expenses for covered benefits, other than payments for premiums.

Finally, cost-sharing credits are available to those with incomes at or below 250% FPL. Generally, silver plans cover 70% of health costs. However, 94% of health plan costs would be covered for those with incomes at or below 150% FPL, 87% of costs would be covered for those with incomes exceeding 150% but at or below 200% FPL, and 73% of costs would be covered for those with incomes exceeding 200% but at or below 250% FPL.[12(§1402),21(§1001)]

Medicaid Income Eligibility Expansion

In addition to 2010 being a year of historical significance owing to the passage of health reform, January 1, 2014, is a momentous date for the uninsured. The poorly woven patchwork quilt of eligibility requirements for Medicaid will finally end and Medicaid will become a program for all of the nation's poor younger than 65 years with incomes below a particular threshold. On this date, all individuals younger than 65 years, including children, parents, and nonpregnant childless adults, with family incomes up to 133% of the FPL will become eligible for Medicaid.[12(§2001)]

Approximately 17.1 million uninsured adults will become newly eligible for Medicaid,[10] 11.8 million of whom have no dependent children (childless adults). Half of the 17.1 million newly eligible adults have family incomes below 50% of the FPL and 37% represent unemployed families. Only 18% of uninsured adults are non-Hispanic black compared with 42% non-Hispanic white and 33% Hispanic. Of the 17.1 million uninsured adults, 74% are unmarried and 31% have less than a high school level of education. The characteristics of the subsample of 11.8 million childless adults are similar but slightly more exaggerated. For example, 57% have family incomes below 50% of the FPL and 45% represent unemployed families. Once again, non-Hispanic blacks represent only 19% of uninsured childless adults, compared with 47% non-Hispanic whites and 26% Hispanics. Eighty-seven percent are unmarried and 27% have less than a high school level of education. Among uninsured adults 19 to 64 years, 61% had no usual source of care (48% among those with ≥1 known chronic conditions) and 16% were in fair or poor health.[22]

For patients 19 to 64 years of age who are already on Medicaid and are at or below 133% of the FPL (excluding those on Supplementary Security Income), the prevalence rate for cancers, leukemias, and other malignancies is 2.4%. Among the uninsured at or below 133% of the FPL who would become newly eligible for Medicaid, the prevalence rate is currently 1.0% (0.9% for the subset of childless adults). Similar differences are seen between current Medicaid beneficiaries at or below 133% of the FPL and the newly Medicaid eligible for other long-term diseases, most notably hypertension (15.6% vs 7.6%), diabetes (9.7% vs 3.8%), and chronic pulmonary disease (8.6% vs 4.0%).[22]

For uninsured childless adults at or below 133% of the FPL, the rates are similar to those for all uninsured patients newly eligible for Medicaid (7.9% hypertension, 3.3% diabetes, and 4.5% chronic pulmonary disease).[22] In a worse-case scenario, prevalence rates in the uninsured population at or below 133% of the FPL would equal those in the Medicaid population at or below 133% of the FPL. Under this worse-case scenario, the level of unmet need would seem to be high. For example, if an additional 1.4% (2.4%–1.0%) of the 17.1 million uninsured patients indeed have undiagnosed cancer, 239,400 additional patients may be in need of cancer care. Conservatively, even if only half of these patients have undiagnosed cancer, that still leaves 119,700 patients with unmet cancer care needs. In addition, it is also unclear whether the 1% of the uninsured population already diagnosed with cancer (most likely late stage)[1] are currently receiving adequate survivorship care.

To help states cover the cost of this major expansion of the Medicaid program, the federal government will provide payments to states to cover Medicaid expansion starting at 100% of costs between 2014 and 2016 and gradually decreasing payments to 90% by 2020 (95% in 2017, 94% in 2018, and 93% in 2019). States were allowed to expand Medicaid eligibility levels as early as April 1, 2010. In addition to the District of Columbia, the 16 states that expanded eligibility for at least some segments of their adult populations to 100% of FPL before the enactment of ACA (expansion states) include Arizona, California, Connecticut, Delaware, Hawaii, Illinois, Maine, Maryland, Massachusetts, Minnesota, New Jersey, New York, Rhode Island, Tennessee, Vermont, and Wisconsin. States are required to maintain income eligibility levels at 133% of FPL through December 31, 2013, for adults. For children currently in Medicaid, this requirement would be extended through September 30, 2019.[23]

Additional Medicaid Benefits

Tobacco Cessation

Effective October 1, 2010, tobacco cessation counseling and pharmacotherapy services for pregnant women are covered under Medicaid free of cost sharing. With the strong causal link between smoking and cancer incidence and mortality and the disproportionate concentration of smoking in lower socioeconomic classes, this addition to the Medicaid benefits package is major.[24–26] Diagnostic, therapy, and counseling services are now covered as recommended by the US Public Health Service clinical practice guidelines.[27] In addition, prescription and nonprescription tobacco cessation agents as approved by the Food and Drug Administration for cessation of tobacco use by pregnant women are also covered.[12(§4107)] The US Public Health Service guidelines specifically recommend that pregnant women be encouraged to quit smoking without using medications. A recent study found that only 25% of pregnant women identified at an outpatient visit as a smoker were documented as receiving counseling for tobacco cessation.[28]

In addition to the cancer risk reduction benefits of tobacco cessation for the mother, tobacco dependence interventions for pregnant women have also been shown to result in fewer low birthweight babies and perinatal deaths as well as fewer physical,

cognitive, and behavioral problems during infancy and childhood.[29] Cigarette smoking has been shown to result in stillbirths, spontaneous abortions, reduced fetal growth, premature births, low birth-weight, and sudden infant death syndrome.[27,30,31]

The cost effectiveness of tobacco cessation programs has also been demonstrated. Previous interventions with US pregnant smokers yielded net savings of approximately $8 million in direct neonatal inpatient costs for each pregnant woman who quit smoking.[32] According to 1 study, for each low-income pregnant smoker who quit, Medicaid saved $1274.[33] Simulations suggest that a 1% decrease in smoking prevalence among US pregnant women would save $21 million (1995 dollars) in direct medical costs in the first year.[27,29]

Behavior Modification Programs

Effective January 1, 2011, grants will be made available to the states to develop incentives that encourage Medicaid beneficiaries to complete evidence-based behavior modification programs. The goals to be addressed include tobacco cessation, weight control or reduction, reduced cholesterol and blood pressure levels, diabetes prevention, and appropriate diabetes management. Behavior modification programs that also address comorbidities related to any of these goals, such as depression, are also covered by these grants. States are required to establish targets for the beneficiaries in these programs and track their progress relative to the targets. States will be evaluated by an independent entity chosen by the Secretary of Health & Human Services to measure the ease with which beneficiaries can participate, patient satisfaction, the impact of these programs on health services utilization, and the costs associated with the programs.[12(§4108)]

Prescription Drugs

Effective January 1, 2014, smoking cessation drugs, barbiturates, and benzodiazepines approved by the Food and Drug Administration will be removed from Medicaid's excludable drug list.[12(§2502)] Because cigarette smoking is a major risk factor for many types of cancer and is the most common cause of preventable morbidity and mortality,[26] the availability of smoking cessation drugs to Medicaid patients is a major benefit of the ACA.

Effective January 1, 2010, the health reform legislation increased the Medicaid drug rebate percentage provided by drug manufacturers to the states for noninnovator, multiple-source drugs. In addition, effective March 23, 2010, ACA extended the prescription drug rebate to Medicaid managed care plans. Although Medicaid patients are not directly impacted by the drug rebate percentage changes, these changes do impact the cost of operating Medicaid programs and, thus, merit a brief mention here. Basically, the flat rebate for single-source and innovator multiple-source outpatient prescription drugs increased from 15.1% to 23.1%, with one exception. For clotting factors and outpatient drugs approved by the Food and Drug Administration for pediatric indications, the rebate only increased to 17.1%.

For multisource noninnovator drugs, the rebate increased from 11% to 13%. Total rebate liability is limited to 100% of the average manufacturer price. Additional revenue generated by these increases must be remitted by the states to the federal government.[12(§2501)]

Optional Medicaid Benefits

Effective January 1, 2011, states will have the option of allowing Medicaid beneficiaries with long-term conditions to designate a specific provider as a health home from among those determined to be qualified by the state and approved by the Secretary of Health & Human Services. The provider serving as a health home can be a health team or a single designated provider with or without assistance from a team of health professionals. Services provided are to include comprehensive care management, coordination of services, health promotion, transitional care, patient and family support, and referral to community support resources.[12(§2703)] The focus is on the whole person, and the goal is to improve quality and continuity of care as well as increase patient satisfaction. In this issue of *The Cancer Journal*, Collins et al,[34] in their article on the impact of health reform on primary care providers and cancer patients, provide more extensive details on the health home.

Effective January 1, 2013, states have the option to include in their Medicaid program preventive services graded "A" or "B" by the USPSTF,[16] vaccines recommended by the Advisory Committee on Immunization Practices,[35] and any medical or remedial services deemed necessary to restore the patient to the best possible functional status. As mentioned previously, preventive services recommended by the USPSTF differ from those recommended by the ACS. The reward for providing these optional services and prohibiting cost sharing is a 1% increase in the Federal Medical Assistance Percentage (i.e., the federal government's contribution to cover the state's costs of providing Medicaid services).[12(§4106)] As pertains to cancer, examples of services graded "A" or "B" include breast, cervical, and colorectal cancer screening; chemoprevention among women at high risk for breast cancer; and tobacco use counseling.[36] Because coverage of preventive services is optional, patients will need to be aware that states will continue to vary in their coverage of these services.

Changes to Medicaid Reimbursement

Effective July 1, 2011, federal payments to states will be prohibited for Medicaid services related to health care–acquired conditions. Beneficiaries cannot be denied access to care for needed services related to such conditions. Health care–acquired conditions are only generally defined at present as secondary diagnoses codes (complications or comorbidities) that affect classification under the diagnosis-related groups system. It is assumed this would include conditions such as air embolisms, severe pressure ulcers, and surgical site infections. Although not spelled out, it is assumed states would similarly refuse to reimburse providers for such conditions rather than absorb the reimbursement shortfall at the state level.[12(§2702)]

DISCUSSION

Although the passage of health care reform promises to have major positive benefits for the uninsured and Medicaid-insured populations, there are many hurdles yet to be crossed as few provisions have been implemented to date. The ACA is comprehensive yet leaves much to be done to permit implementation of the many provisions. The often quoted phrase, "The devil is in the details," clearly applies here. The task of fleshing out the details at both the state and federal levels over the coming years provides an opportunity for working out problematic details, but may seem daunting to many states in the face of the current recession.

States are already in a budget crisis and have been cutting benefits in an attempt to balance their budgets. Budget shortfalls for 2010 approached $194 billion, whereas Medicaid spending growth averaged 8.8% across all states. Growth in Medicaid spending for 2011 is predicted to slow to 6.1%. Twenty states implemented budget restrictions in 2010, and an additional 14 states plan to do so in 2011.[37]

States received some fiscal relief from the federal government in 2009 with passage of the American Recovery and

Reinvestment Act. This act provided a temporary increase in the Federal Medical Assistance Percentage from October 2008 through December 2010. In August 2010, legislation was enacted to extend a scaled back version of this increase until June 2011. However, the legislation was passed too late in the budget deliberation process for many states that had already decided to cut services.[37]

Many states lack adequate staffing levels in the wake of employee layoffs and furloughs to process the current level of Medicaid applications in a timely fashion. Yet they must begin to prepare for an even greater volume of applications while concurrently planning for the establishment of health exchanges. The reporting aspects associated with many of the provisions represent another major challenge for the states. As new programs roll out, states must develop methods to measure and demonstrate effectiveness, quality of care, patient satisfaction, and ease of consumer access. Concurrently, the states are also preparing for major information technology upgrades in preparation for the change to International Classification of Diseases version 10 reporting of diagnoses and procedures.

To relieve some of the financial burden of preparing for the establishment of the exchanges, the ACA has provided grants to states. One such grant under §2793 of the ACA supports offices of health insurance consumer assistance or health insurance ombudsman programs.[12] The tasks of such offices include assisting with the filing of appeals, educating patients regarding their rights and responsibilities regarding health insurance coverage, assisting consumers with the process of enrolling in a health plan, and resolving problems consumers experience in obtaining premium tax credits. Although these grants may not cover all related costs, they provide significant monies and incentive to work toward the goal of establishing the exchanges.

Safety net facilities will experience an influx of new patients and new funding with the major expansion of Medicaid in 2014. Similar to the budget constraints facing the states at present, safety net facilities are already seeing an influx of new patients due to the record high unemployment rate of 9.6% (14.9 million unemployed). These figures do not include the 8.9 million underemployed (working part-time, but seeking full-time employment) and the 2.4 million discouraged and marginally attached workers.[38] Many patients who traditionally had insurance coverage through their place of employment lost that coverage and sought Medicaid assistance for the first time. Whether these facilities will have sufficient manpower to handle the influx of patients, even with substantially increased funding (including additional funds for FQHC provided under the ACA),[12] is unclear.

The government mandate requiring that all US citizens have health insurance, to avoid paying a penalty, has attracted particular criticism in the press. Some have criticized the constitutional validity of the requirement. The government mandate impacts many stakeholder groups in the health care arena (not just the currently uninsured) and is crucial to the success of the health exchanges. If only the very sick enroll in the health exchanges (adverse selection), the health exchanges are doomed to failure. Health exchanges cannot hope to break even or achieve slim profit margins if only the very sick enroll, particularly within the cost-sharing limits under which they must operate. A balance of the very healthy and the very sick is required for the health exchanges to remain viable. Analysts have suggested that the exchanges must attract employers as well as individuals if they are to succeed.[39] Employers represent large groups of exactly those basically healthy individuals that the exchanges seek.

The proposed method of enrolling in Medicaid and the exchanges poses yet another threat. As mentioned previously, the ACA requires that each state's Health Subsidy Program use a single application form to determine a patient's eligibility for the exchange versus Medicaid or some other state-specific program. There is currently no precedent for this type of seamless operation. Considerable testing will be required to develop a workable system that is accurate in assessment of eligibility and not fraught with long delays between application and enrollment. The system will also require flexibility for those Medicaid eligible patients who choose to enroll in their state's health exchange instead.

Not discussed in this article thus far, is how health reform will impact the underinsured. According to the most recent estimates (2007), 25.2 million adults in the United States (42% of all adults) were underinsured, 24% of which had incomes below 200% of the FPL. Underinsured is defined as having out-of-pocket costs equaling 10% or more of income (≥5% if below 200% of the FPL) or deductibles of at least 5% of income.[40] Fifty-three percent of underinsured adults went without needed care because of cost. Such individuals have both high premiums and high deductibles. Those individuals with incomes below 133% of the FPL will become eligible for Medicaid. Those with incomes between 133% and 400% of FPL will benefit from the new health exchanges and reduced out-of-pocket maximums and premium tax credits for low-income individuals. No firm estimates are available at this time of the percentage of underinsured patients with cancer and other long-term diseases to permit comparison with current Medicaid beneficiaries to determine potential unmet needs.

Irrespective of the potential threats to health reform over the coming years and the imperfection of the ACA, what is clear is the major benefit of the ACA for cancer patients. For the estimated 11.7 million cancer survivors[41] and the estimated 1.5 million patients newly diagnosed with cancer in the United States each year, ACA has a very positive side.[42] The new legislation should permit low income cancer patients to celebrate more birthdays through increased access to USPSTF-recommended levels of screening[16] (through the exchanges), diagnostic, treatment, and follow-up services. As mentioned in the introduction, the goal of this article was to provide an overview of the impact of the ACA on the uninsured and Medicaid-insured populations. More in-depth information is available at acscan.org/healthcare/learn.

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