Effects of the Affordable Care Act Among Cancer Survivors: Expanded Insurance Options and Other Impacts

The webinar will begin at 1:00 p.m. Eastern. Audio: Use computer speakers or phone (1-866-307-6424)
If connecting by phone, please put your phone on mute!
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<td>Welcome and Overview of the GW Cancer Institute</td>
<td>Mandi Pratt-Chapman, MA GW Cancer Institute</td>
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<td>Effects of the Affordable Care Act Among Cancer Survivors: Expanded</td>
<td>Amy J. Davidoff, PhD Yale School of Public</td>
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<td>Insurance Options and Other Impacts</td>
<td>Health</td>
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<td>Question &amp; Answer</td>
<td>All</td>
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GW Cancer Institute

• Founded in 2003

• Vision: To set the standard for patient-centered care and eliminate cancer health disparities.

• Mission: To ensure access to quality, patient-centered care across the cancer continuum through community engagement, patient and family empowerment, health care professional education, policy advocacy, and collaborative multi-disciplinary research.
GW Cancer Institute TA Project

Online Academy

Comprehensive resource guides

Connecting CCC practitioners with experts

Supporting integration of cancer prevention with other chronic disease prevention efforts

Large-group, small-group, and one-on-one technical assistance for CCC grantees and coalitions

Creating easier ways to align local initiatives with national health priority indicators

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GW Cancer Control TAP

• Visit us at www.gwcancerinstitute.org to view previous webinars and e-newsletters.

• Subscribe to receive our monthly technical assistance e-newsletters by email cancercontrol@gwu.edu.

• Check out our FREE CME e-Learning series at www.CancerSurvivorshipCenterEducation.org.

• Join us again on August 28 at 1pm ET for our next webinar on the CCC National Partnership!
Please take a moment to complete the poll on your screen.
Amy J. Davidoff, PhD
Effects of the Affordable Care Act Among Cancer Survivors: Expanded Insurance Options and Other Impacts

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July 24, 2014
The Headlines

• The good: As of April 30, 2014:
  – 4.8M newly enrolled in Medicaid
  – 8M enrolled in private coverage
  – Uninsured rate dropped 3 percentage points.

• The not so good:
  – Various delays in implementation
    • Individual mandate
    • Small business Health Options Program (SHOP) exchanges
    • Employer mandate
    • Non-compliant non-group plans permitted
  – 23 states not planning to expand Medicaid
  – Individuals losing “grandfathered” plans; facing higher costs to purchase new plans

• The ugly: politics, politics, politics
Focus for Today’s Webinar

• Cancer survivor experience with insurance, access, cost-sharing pre-ACA
• Review of selected elements of ACA as of 2014
• Drill down – expected effects of the ACA for cancer survivors
Where did cancer survivors get coverage before the ACA?

Cancer Survivors

- Employment related/TriCare: 68%
- Medicare: 15%
- Other: 3%
- Medicaid: 11%
- Uninsured: 3%

No Cancer History

- Employment related/TriCare: 63%
- Medicare: 25%
- Other: 3%
- Medicaid: 7%
- Uninsured: 1%

Source: Medical Expenditure Panel Survey, 2008-2010
Point in time insurance estimates for non-elderly adults, Davidoff et al., unpublished.
Despite lower uninsured rates, cancer survivors faced barriers to insurance pre-ACA
Cancer history may limit offers of ESI

• Most large firms offer ESI to FT workers
  • Employment related coverage limited for PT workers, short tenure, even in large firms

• Cancer history may limit employment => reduced ESI offers

• Smaller firms may be subject to underwriting (depending on state regs)
  – High cost/high risk employee or dependent may => prohibitive premiums for group

Sources:
Davidoff A, Blumberg L, Nichols L. J Health Econ 24:725-50, 2005
Cancer history may have precluded insurance purchase in non-group market

• Non-group = individual = private purchase market

• Absent specific state regulation, insurers engage in underwriting to assess risk
  – Deny coverage if cancer history
  – Exclude coverage of cancer-related services
  – Charge exorbitant premiums

• State regulations impact of some insurer practices
  – Guaranteed issue
  – Risk rating restrictions

Even Medicare enrolled cancer survivors may experience barriers to supplemental insurance

- Medicare beneficiaries account for 2/3 of new cancer diagnoses
- 90% receive Medicaid, are enrolled in retiree health insurance, or purchase Medigap
- Supplemental coverage access limited if cancer diagnosis preceded Medicare enrollment
- Medigap enrollment subject to underwriting if permitted by state regulations
Medicaid & SCHIP not a “safety net” for most cancer survivors

• Federal-state funded programs limited to categorically eligible
  – Children, pregnant women, parents of dependent children
  – Very low income thresholds

• 35 states with medically needy programs permit “spend down”

• Some states expanded coverage to parents with higher incomes

• Few states covered non-elderly adults w/o dependent children
Large proportion of non-elderly cancer survivors faced high OOP burden

High OOP burden defined as OOP expenditure on healthcare and premiums > 20% family income.

Many cancer survivors reported access barriers, although routine care rates higher

![Bar chart showing access rates for cancer survivors compared to those with no cancer history.](chart)

Key Elements of the ACA (but not every detail)
Individual Insurance Mandate

- All U.S. citizens and legal residents must have qualified insurance plan by 2014
- Failure to have coverage => tax penalty
  - Greater of $695 per year (up to three times that amount per family) or 2.5% of household income.
  - Phased in over time
- Exemptions granted for financial hardship, religious objections, undocumented immigrants, prisoners
To facilitate individual mandate, ACA improves coverage access

- Eliminates health status as barrier to coverage
- Employer mandate
- Marketplaces: New source of private coverage
  - Premium subsidies for lower income
- Public coverage expansions
Large employers mandated to offer coverage

- Employers with 50+ FT employees must offer qualified plan
- Penalty for employers that do not offer coverage and have 1+ FT employee who receives a premium tax credit
- SHOP exchanges, with tax credits for employers with < 25 employees
Buying Insurance in the New “Marketplace”

• Centralized market for purchase of private insurance plans

• Plans
  – Cover essential health benefits
  – 4 standard plans defined by actuarial value
    • Bronze (60%) – platinum (90%)
    • Varied deductibles, high deductible plans common
    • OOP caps
    • No lifetime, annual coverage limits

• Premiums vary by policy type (single, family), region, age, tobacco use
  • No health status underwriting
  • No pre-existing condition exclusions
# Federal Poverty Guidelines

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Income at 100% FPG</th>
<th>Income at 400% FPG</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$11,670</td>
<td>$46,680</td>
</tr>
<tr>
<td>3</td>
<td>19,790</td>
<td>$79,160</td>
</tr>
<tr>
<td>5</td>
<td>27,910</td>
<td>$111,640</td>
</tr>
</tbody>
</table>

Source: ASPE 2014 Poverty Guidelines
http://aspe.hhs.gov/poverty/14poverty.cfm
Subsidies, extra protections available for lower income

• For families w/ income at 100-400% FPG
  – Tax credits to subsidize premiums
  – Lower caps on OOP spending

• Eligibility for extra help
  – Not eligible for Medicaid, enrolled in Medicare, other federal plan
  – No alternative employer offer of “affordable” coverage

  • Affordable defined as OOP premium <= 9.5% of family income for individual policy
Overall Marketplace Enrollment, April 2014

- > 8 M selected plan through April 19, 2014
  - 2.2 M (28%) were young adults between the ages of 18 and 34
  - 80-90% reported to have paid premiums to effectuate coverage

- 2/3 enrolled in silver plans; 20% bronze, 9% gold, 5% platinum

- 85% receiving premium tax credits, with or w/o additional OOP protections

Medicaid Expansions for Non-Elderly Adults

Figure 4
Median Medicaid/CHIP Eligibility Thresholds as a Percent of the Federal Poverty Level, April 2014

- Children: 255%
- Pregnant Women: 201%
- Parents: 138% for Expansion States (27), 49% for Non-Expansion States (24)
- Childless Adults: 138% for Expansion States (27), 0 for Non-Expansion States (24)
- Elderly and People with Disabilities: 74%

NOTE: Thresholds reflect the standard 5 percentage point income disregard.
Figure 1

Current Status of State Medicaid Expansion Decisions, 2014

NOTES: Data as of March 26, 2014. *AR, IA and MI have approved waivers for Medicaid expansion (MI plans to implement Apr. 2014). IN and PA have pending waivers for alternative Medicaid expansions. WI amended its Medicaid program to cover adults up to 100% FPL, but did not adopt the expansion. NH has passed legislation approving the Medicaid expansion to begin in July 2014.

SOURCES: States implementing in 2014 and not moving forward at this time are based on data from CMS [here](#). States noted as “Open Debate” are based on KCMU analysis of State of the State Addresses, recent public statements made by the Governor, issuance of waiver proposals or passage of a Medicaid expansion bill in at least one chamber of the legislature.
The ACA also attempts to fix many coverage & delivery system problems

- Mandated coverage of essential health benefits
  - Coverage of routine care for clinical trial participants
- Cost sharing caps, subsidies
- Closing the Medicare Part D coverage gap
- Focus on quality & value of care delivery
- Support for essential workforce development
- Support for research on healthcare delivery
Coverage of state-defined essential health benefits may reduce barriers to specific services

- Based on benefits offered by large employer plans offered in state, supplemented as needed
- Must be covered by new plans issued for small employers, marketplace & non-group market plans, Medicare, Medicaid
- Grandfathered plans (issued before ACA) must notify enrollees of services not covered
## Essential Health Benefits

<table>
<thead>
<tr>
<th>Ambulatory services, home health &amp; hospice</th>
<th>Rehabilitative &amp; habilitative services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency services</td>
<td>Laboratory services</td>
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<tr>
<td>Hospitalization</td>
<td>Preventive and wellness care,</td>
</tr>
<tr>
<td>Mental health and substance use disorder services</td>
<td>Chronic disease management</td>
</tr>
<tr>
<td>Prescription drugs</td>
<td>Pediatric dental &amp; vision care</td>
</tr>
</tbody>
</table>
Medicaid Benefits

• State-defined essential health benefits
• Cost sharing limited for individuals < 100% FPG
  – E.g., $4 copay for outpatient services
  – Aggregate cap on premiums and cost-sharing = 5% of income
• Premiums permitted only for income >150% FPL
Drill Down – (Expected) Effects of the ACA for Cancer Survivors
Income Eligibility for ACA Insurance Options

Medicaid expansion states

- Medicaid
- Affordable alternative coverage
- Marketplace premium tax credits
- Marketplace access w/o subsidies

States not expanding Medicaid

- Medicaid
- Affordable alternative coverage
- Marketplace premium tax credits
- Marketplace access w/o subsidies

Adjusted Income as % Federal Poverty Guideline

0% 100% 138% 400%
Simulating Adult Eligibility for Pre- & Post-ACA Insurance Options

- Data on non-elderly adult cancer survivors from Medical Expenditure Panel Survey, 2008-2010

**Link federal & state rules – Medicaid & Marketplace subsidies**
- Age
- Family structure
- Income measurement
  - Family units
  - Disregards*
  - Thresholds
- Restrictions on alternative coverage

**Construct measures from MEPS Data**
- Age
- Family structure
- Income
- ESI Offers
- Current coverage

**Eligibility indicators**
- Medicaid
- Not eligible
- Marketplace premium subsidies
- Alternative affordable coverage
- Marketplace w/o subsidies (income > 400% FPG)
Cancer Survivor Eligibility Under the ACA

Non-Elderly Adults

- Medicaid: 19%
- Not eligible: 4%
- Marketplace subsidy: 10%
- Alternative Affordable Coverage: 24%
- Income > 400% FPG: 43%

All

Eligibility Under the ACA for Uninsured Cancer Survivors

Eligibility under the ACA for uninsured cancer survivors varies dramatically by expansion status

<table>
<thead>
<tr>
<th>Expansion States</th>
<th>Non-Expansion States</th>
</tr>
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<tbody>
<tr>
<td>Medicaid</td>
<td>Medicaid</td>
</tr>
<tr>
<td>Marketplace</td>
<td>Marketplace</td>
</tr>
<tr>
<td>premium subsidies</td>
<td>premium subsidies</td>
</tr>
<tr>
<td>Income &gt;= 400%</td>
<td>Income &gt;= 400%</td>
</tr>
<tr>
<td>FPG</td>
<td>FPG</td>
</tr>
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Expected Coverage Effects for Cancer Survivors

• Dramatically reduced proportion of cancer survivors uninsured
  – Residual group of survivors w/o coverage in states not expanding Medicaid

• Medicaid to cover larger share of adults with cancer

• Shifting sources of private insurance

• Medicare, Medicaid to seek alternative patient-centered delivery systems
  – Medical home
  – Accountable Care Organizations

• Challenge: translate coverage into access
Will mandated coverage of essential health benefits have a big impact?

• Most large employer groups already covered these services

• Impact huge for those with non-group, or previously uninsured

• But plans may still limit quantity of services

• Prescription drugs – subject to formulary restrictions, prior authorization, step therapy

• Plan cost sharing requirements may still be deterrent
Concerns About Specialist Access

• Qualified plan to ensure “adequate” provider networks, contract with essential community providers
  – Network adequacy difficult to define, regs don’t tackle
  – Narrow networks may exclude higher cost academic medical centers

• Medicaid enrolled may face limited provider participation, difficulty with referral to specialists
  – ACA increases Medicaid payments to primary care providers, not specialists
ACA eliminates cost sharing for USPSTF recommended cancer screenings

- **Objective** = increased screening => early stage diagnosis => improved outcomes

- **How likely is a big impact?**
  - Many plans already provided screening w/o cost sharing
  - Copay may still be required if other services provided during visit

- **Lack of insurance not only barrier to screening**
  - Lack of knowledge, not recommended by physician
  - Discomfort
  - Fear

- **Challenge** – education, outreach to overcome other barriers

ACA mandates coverage of routine care for clinical trials

• Goal = reduced financial barriers to clinical trial participation

• How likely is the impact?
  – Very low rates of clinical trial participation (<5%)
  – 18 states already had similar mandates
  – Financial barriers play relatively small role in limiting participation

• Challenge – how to improve recruitment rates to take advantage of insurance coverage

Reduced cost sharing may protect survivors from financial “toxicity” of cancer treatments

• By 2014, lifetime & annual $ coverage limits eliminated

• Cost sharing capped, but can still be substantial.
  – Bronze plan: $5,950 for individuals and $11,900 for families in 2010
  – Means-tested reductions in OOP spending caps
  – E.g., 100-200% FPL: $1,983/individual and $3,967/family
Closing the Part D coverage gap will smooth spending

• Part D coverage gap may discourage initiation, encourage discontinuation of oral chemotherapy, supportive care medications

• What is the likely impact?
  – Reduces cost shock associated with coverage gap
  – More common oral chemotherapy agents less expensive => closing gap may facilitate continuity of drug use
  – High $$$ copayment or coinsurance for newer oral chemotherapy agents will continue to be deterrent
Downstream availability of biosimilars likely to impact cost of cancer therapy

- ACA authorized FDA to approve generic biologic agents
- European Union experience suggests development of both:
  - “me too” biologics, slightly less expensive
  - truly interchangeable biosimilars much less expensive
- Ultimately U.S. implementation regulatory process for biosimilars => reduced cost sharing to individuals with cancer

The ACA initiated selected value-focused reimbursement changes

- Penalties to hospitals for readmissions, hospital acquired conditions, e.g. infections, common in cancer patients
- CMMI project to develop & simulate strategies to reimburse providers for outpatient oncology care
  - Oncology specific Accountable Care Organizations
  - Bundled payments

Source: http://www2.mitre.org/public/payment_models/
Will the ACA reduce disparities in receipt of cancer therapy?

• Potential to level the field by providing subsidized coverage to poor, lower income adults
  – In states not expanding Medicaid, 22% of uninsured cancer survivors are poor, yet not eligible for Medicaid or marketplace subsidies.

• Increased access to primary care, screening => earlier detection, potential for definitive therapy

• Outreach, education activities related to Wellness & Prevention may improve access, health literacy
Policy issues not addressed by ACA

- Lack of catastrophic coverage or OOP caps under Medicare Parts A & B
- Poor coordination between Part B & Part D drug coverage creates perverse incentives
- Oral-parenteral cancer drug parity
- Reimbursement for screening, off-label therapies not supported by evidence
  - “Choosing Wisely” services to be avoided
Research on ACA Impacts for Cancer Survivors

• Mostly baseline estimates related to coverage, access, OOP burden
• Some smaller surveys assessing coverage impacts, early experience
• Nationally representative estimates of early effects too limited to focus on cancer survivors
  – Enrollment, access for adult dependent children
  – Enrollment of individuals with poor health history
  – Reduced cost sharing for preventive services
• Data lags will delay larger scale evaluations until 2015
Summary

• ACA designed to address many barriers to coverage, access for vulnerable adults
  – Lower income
  – Health problems, including cancer
• Cancer survivors likely to benefit along multiple dimensions
• Not a panacea. Ongoing evaluation & refinements needed over time.
• Lots of change – in who pays, what is paid for, and how is care provided
Questions?
GW Cancer Control TAP

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