The ACA’s Impact on Cancer Care: What’s Ahead in 2014

The webinar will begin at 12:00 PM Eastern.
Audio: 1-866-307-6424
Please put your phone on mute!
## Agenda

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<td>Welcome and Overview of the Center for the Advancement of Cancer Survivorship, Navigation and Policy</td>
<td>Mandi Pratt-Chapman, MA GW Cancer Institute</td>
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<td>An ACA Overview</td>
<td>Mandi Pratt-Chapman, MA GW Cancer Institute</td>
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<td>The ACA’s Impact on Cancer Care: What’s Ahead in 2014</td>
<td>Juliette Forstenzer Espinosa, MA, JD, LLM</td>
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<td>Question &amp; Answer</td>
<td>All</td>
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Mandi Pratt-Chapman, MA
Center for the Advancement of Cancer Survivorship, Navigation and Policy (caSNP)

- Survivorship & Navigation Resources
  - E-news
  - caSNP listserv
- Health Policy Initiatives
  - Policy reports and white papers
- Education & Training
- Email us at casnp@gwu.edu
Center for the Advancement of Cancer Survivorship, Navigation and Policy (caSNP)

• Research Initiatives
  – Best Practices in Navigation and Survivorship
  – Social Media Survey
  – Best Practices in Survivorship Education Programming
  – Evaluating Cancer Survivorship Care Models
  – Patient Navigator Competencies
An ACA Overview

Mandi Pratt-Chapman, MA
Associate Director
The George Washington University Cancer Institute
Controversy

- Mandate
- Cancelled policies
- Bottlenecks in exchange
- Price for premiums
- High deductibles
- Access to care for those previously denied coverage
- Lower costs for seriously ill patients
- Workforce support
Key Components of the ACA

<table>
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<tr>
<th>Increased access to care</th>
<th>Expanded coverage for services</th>
<th>Shift from fee-for-service to quality</th>
<th>Engagement of patients in research</th>
<th>Support for public health workforce</th>
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THE GEORGE WASHINGTON UNIVERSITY
WASHINGTON, DC

GW Cancer Institute

Center for the Advancement of Cancer Survivorship, Navigation and Policy
Access

- Children covered up to age 26
- Temporary high-risk pools through 2013
- Exchanges (2014)
- No pre-existing condition exclusions
- No loss of coverage
Coverage

- Removes lifetime limits on plans
- Preventive services coverage
- Essential benefits
- Medicaid expansion
- Increased benefits for Medicare beneficiaries
Quality

- Accountable Care Organizations
- Patient-Centered Medical Homes
- Bundled payments
- Value-based purchasing
Research

Center for Medicare and Medicaid Innovation

Patient Centered Outcomes Research Institute
Workforce

Public health & Allied health

Nursing

Primary care

Dental health
Juliette Forstenzer Espinosa, MA, JD, LLM
The Impact of the ACA on Cancer Care: What's Ahead for 2014

Juliette Forstenzer Espinosa
Assistant Research Professor, Dept. of Health Policy
George Washington University
School of Public Health
Concerns for cancer patients

- Unable to get insurance because of pre-existing condition exclusions (children and adults)
- Unable to afford out of pocket costs associated with cancer treatment options
- Annual and lifetime dollar limits
- Lack of coverage for pain management and clinical trials participation
- Lack of coverage for screenings and other preventive measures after official surveillance ends
Affordable Care Act

• The Affordable Care Act addresses each of these issues
• Justifiable criticisms of approach, and now disappointment with implementation
• For cancer community, real and significant changes impacting survivorship and quality of life after cancer
Affordable Care Act Goals

• Repair health insurance market
  – People with money who have been sick locked out of market
  – Insurance failing when people are ill or injured

• Expand coverage
  – Millions of people with no health insurance or inadequate health insurance
  – Insurance as proxy for access to care

• Begin to address known cost and quality issues
  – Slow down the rising cost of health care which accounted for almost 18% of the Gross Domestic Product (GDP) in 2010
Consequence of broken market

• Illness and medical bills contribute to a large share of U.S. Bankruptcies
  – 62% of bankruptcies nationwide related to medical debt
  – Most were well educated, owned homes and had middle-class occupations.
• 75% had health insurance but the limitations of their coverage (lifetime limits, benefit exclusions) caused people financial hardship
  – Those most in need of coverage could be dropped by a health insurance company or their rates could be increased significantly for using the benefits available.
• Disproportionate impact on cancer patients

Bankruptcy SOURCE: American Journal of Medicine, 2009
Some changes under the Affordable Care Act

- Changes to private insurance
  - Kids can’t be denied health coverage if they are sick
  - Young adults on parents’ policies to age 26
  - Prohibit annual and lifetime monetary caps
  - Minimum medical loss ratio

- Closes the Medicare prescription “doughnut hole”

- Expands coverage + imposes individual mandate in 2014
  - Expands Medicaid to 138%* of FPL in participating states
  - Exchanges or marketplaces open in every state
  - Large employers required to provide insurance (delayed to 2015)

*ACA 133% = 138% due to across the board income disregards
Preventive Care and the ACA

• Preventive care must be covered with no out of pocket costs (co-pays, co-insurance or deductibles)
• Includes cancer related provisions such as:
  – Breast cancer screening and preventive medications
  – Colorectal cancer screening
  – Cervical cancer screening
  – Skin cancer education/counseling
  – Smoking cessation programs
Focus on coverage

Consumer can't afford doctor

Consumer drops policy due to high price and is now uninsured

Insurers shift cost to consumer

Consumer delays care, goes to ER

Consumer can't pay

Providers shift cost to insurers

Consumer drops policy due to high price and is now uninsured

Insurers shift cost to consumer

Consumer delays care, goes to ER

Consumer can't pay
Table 8.
Coverage Rates by Type of Health Insurance: 2011 and 2012
(People as of March of the following year. For information on confidentiality protection, sampling error, nonsampling error, and definitions, see www.census.gov/prod/techdoc/cps/cpsmar13.pdf)

<table>
<thead>
<tr>
<th>Coverage type</th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any private plan</td>
<td>63.9</td>
<td>63.9</td>
</tr>
<tr>
<td>Any private plan alone</td>
<td>52.0</td>
<td>52.0</td>
</tr>
<tr>
<td>Employment-based</td>
<td>55.1</td>
<td>54.9</td>
</tr>
<tr>
<td>Employment-based alone</td>
<td>45.1</td>
<td>44.8</td>
</tr>
<tr>
<td>Direct-purchase</td>
<td>9.8</td>
<td>9.8</td>
</tr>
<tr>
<td>Direct-purchase alone</td>
<td>3.6</td>
<td>3.6</td>
</tr>
<tr>
<td>Any government plan</td>
<td>32.2</td>
<td>*32.6</td>
</tr>
<tr>
<td>Any government plan alone</td>
<td>20.4</td>
<td>*20.7</td>
</tr>
<tr>
<td>Medicare</td>
<td>15.2</td>
<td>*15.7</td>
</tr>
<tr>
<td>Medicare alone</td>
<td>4.9</td>
<td>*5.4</td>
</tr>
<tr>
<td>Medicaid</td>
<td>16.5</td>
<td>16.4</td>
</tr>
<tr>
<td>Medicaid alone</td>
<td>11.5</td>
<td>*11.3</td>
</tr>
<tr>
<td>Military health care</td>
<td>4.4</td>
<td>4.4</td>
</tr>
<tr>
<td>Military health care alone</td>
<td>1.3</td>
<td>1.3</td>
</tr>
<tr>
<td>Uninsured</td>
<td>15.7</td>
<td>*15.4</td>
</tr>
</tbody>
</table>

SOURCE: U.S. Census Data
Health insurance basics

• All insurance regulated at the state level until the ACA
• Federal and state split for employer based insurance and Medicaid
• Rules for “Direct purchase” (individual and small group market) different in every state
  – Majority of ACA insurance reforms targeting this segment of the market
Figure 9.
Uninsured Rates by Age: 1999 to 2012

SOURCE: U.S. Census Data
Exchanges (or Marketplaces)

• Intended customers:
  – “Direct purchase” (individual and small group market)
  – Uninsured

• Exchanges set up in every state

• May only sell “qualified health plans” or QHPs

• All QHPs must cover 10 essential health benefits (EHBs)
### Continuum of Exchange Options

- **State-based Exchange**
  - State operates all exchange activities

- **State-Federal Partnership Exchange**
  - State operates plan management and/or consumer assistance activities; may determine Medicaid/CHIP eligibility

- **Federally-Facilitated Exchange**
  - HHS operates all exchange activities; state may determine Medicaid/CHIP eligibility

*SOURCE for graphic: Kaiser Family Foundation*
* In Utah, the federal government will run the marketplace for individuals while the state will run the small business, or SHOP, marketplace.
## Ten Essential Health Benefits

<table>
<thead>
<tr>
<th>1. Ambulatory services</th>
<th>6. Prescription drugs</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Emergency services</td>
<td>7. Rehabilitative and habilitative services and devices</td>
</tr>
<tr>
<td>3. Hospitalization</td>
<td>8. Laboratory services</td>
</tr>
<tr>
<td>4. Maternity and newborn care</td>
<td>9. Preventive and wellness services and chronic disease management</td>
</tr>
<tr>
<td>5. Mental health and substance use disorder services, including behavioral health treatment</td>
<td>10. Pediatric services, including oral and vision care</td>
</tr>
</tbody>
</table>
New rules about premiums

Insurers have traditionally used following factors to charge higher premiums:
- Health status
- Previous use of health services
- Gender

These are no longer allowed under the ACA
Rules about premiums

- Limited number of factors allowed as of Jan. 1, 2014
  - Individual vs. family enrollment
    (i.e., individual + spouse, individual + dependent(s), etc.)
  - Geographic area
  - Age (rate cannot vary by more than three times among adults)
  - Tobacco use (rate cannot vary by more than 1.5 to 1)
More on Exchanges (or Marketplaces)

- Minimum actuarial value for all plans (true in employer market as well)
  - Platinum (90%), Gold (80%), Silver (70%), Bronze (60%)
- For qualified individuals and businesses provides premium payment assistance
  - Premium tax credits for eligible individuals and families with incomes 100-400% of poverty ($11,490 - $45,960 for an individual in 2013) who purchase coverage in exchanges
- For qualified individuals provides cost sharing assistance
  - Cost sharing subsidies for those with incomes 100-250% FPL ($11,490 - $28,725 in 2013) to reduce out-of-pocket costs
# 2013 Federal Poverty Levels by Annual Income

<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>100%</td>
<td>$11,496</td>
<td>$19,536</td>
</tr>
<tr>
<td>133%</td>
<td>$15,288</td>
<td>$25,980</td>
</tr>
<tr>
<td>138%</td>
<td>$15,864</td>
<td>$26,952</td>
</tr>
<tr>
<td>200%</td>
<td>$22,980</td>
<td>$39,060</td>
</tr>
<tr>
<td>300%</td>
<td>$34,476</td>
<td>$58,596</td>
</tr>
<tr>
<td>400%</td>
<td>$45,960</td>
<td>$78,120</td>
</tr>
</tbody>
</table>

Source: [http://aspe.hhs.gov/poverty/13poverty.cfm](http://aspe.hhs.gov/poverty/13poverty.cfm)

Per HHS directive, after inflation adjustment, the guidelines are rounded and adjusted to standardize the differences between family sizes.
## Health Insurance Premium Tax Credit and Cost Sharing Reductions

<table>
<thead>
<tr>
<th>Income Level</th>
<th>Premium as Percent of Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to 133% FPL</td>
<td>2% of income</td>
</tr>
<tr>
<td>133-150% FPL</td>
<td>3-4% of income</td>
</tr>
<tr>
<td>150-200% FPL</td>
<td>4-6.3% of income</td>
</tr>
<tr>
<td>200-250% FPL</td>
<td>6.3-8.05% of income</td>
</tr>
<tr>
<td>250-300% FPL</td>
<td>8.05-9.5% of income</td>
</tr>
<tr>
<td>300-400% FPL</td>
<td>9.5% of income</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Income Level</th>
<th>Reduction in Out-of-Pocket Liability</th>
</tr>
</thead>
<tbody>
<tr>
<td>100-150% FPL</td>
<td>94% of the actuarial value*</td>
</tr>
<tr>
<td>150-200% FPL</td>
<td>87% of the actuarial value</td>
</tr>
<tr>
<td>200-250% FPL</td>
<td>73% of the actuarial value</td>
</tr>
</tbody>
</table>

*A Silver Metal Level plan must be purchased to qualify for Cost Sharing Reductions*
Public awareness of marketplaces

When asked “How much have you heard about the exchanges?”

June 2013
- Nothing at all: 45%
- Only a little: 34%
- Some: 14%
- A lot: 8%

August 2013
- Nothing at all: 33%
- Only a little: 34%
- Some: 21%
- A lot: 12%
- Dk/Ref: 1%

SOURCE: Kaiser Family Foundation Health Tracking Polls
Medicaid and the ACA - Mixed Bag

- Federal government to cover majority of the cost of expansion*
- Supreme Court gave states option to **not** expand Medicaid program
- “No wrong door” rule for exchanges and Medicaid to ease enrollment
- Many cancer patients cannot afford insurance and do not qualify for Medicaid in their state
Expanding Medicaid is a Key Element in Health Reform

Universal Coverage

Medicaid Coverage For Low-Income Individuals

Health Insurance Market Reforms

Individual Mandate

Exchanges With Subsidies for Moderate Income Individuals

Employer-Sponsored Coverage

SOURCE for graphic: Kaiser Family Foundation
Medicaid Expansion Decisions (December 11, 2013)

SOURCE: Kaiser Family Foundation

Median Medicaid eligibility limits for adults as percent of FPL, Jan 2013 Jan 2014 comparison

<table>
<thead>
<tr>
<th></th>
<th>January 2013</th>
<th>January 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parents (In a family of 3)</td>
<td>106%</td>
<td>138%</td>
</tr>
<tr>
<td>Other Adults (for an individual)</td>
<td>0%</td>
<td>138%</td>
</tr>
</tbody>
</table>

States Moving Forward with the Medicaid Expansion at this Time (26 states, including DC)

States NOT Moving Forward with the Medicaid Expansion at this Time (25 states)

SOURCE: Kaiser Family Foundation Health Tracking Polls
Cancer Institute
Center for the Advancement of Cancer Survivorship, Navigation and Policy

$364 Average Annual Premium

Medicare Part D Doughnut Hole

Enrollee Pays 5%

Plan Pays 15%; Medicare Pays 80%

$3,763.75 Coverage Gap ("Doughnut Hole")

$6,733.75 plus a 52.5% brand & 21% generic discount ($4,750 out of pocket)

$2,970 in Total Drug Costs ($1,067.50 out of pocket)

Enrollee Pays 100%

Enrollee Pays 25%

Plan Pays 75%

$325 Deductible


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Clinical trial coverage

• Plans beginning January 1, 2014 will **not be allowed to limit or drop coverage** for participants in clinical trials

• Plans must pay for the **routine patient care costs** associated with participating in clinical trial

• Coverage extends to clinical trials conducted **outside the state in which the patient resides** (but does **not** require coverage for out of network services)
  • Applies to ALL commercial health insurance plans offering group or individual coverage, plans offered through the Federal Employee Health Benefit Program, employer sponsored programs, and state self-insured plans
  • Grandfathered health plans are not required to comply with this requirement.
The ACA is Significant for Cancer Patients and Providers

- Expanded access to health insurance coverage means expanded access to care when diagnosed
- Rules to make health insurance easier to understand
- New, stronger appeal rights for when care is denied
- Coverage won’t run out
- New, affordable options for insurance for young professionals and retirees under age 65
Cancer Patients after the ACA ...

- Cannot be denied coverage due to pre-existing conditions;
- Be charged more for their coverage because of health status;
- Be faced with annual or lifetime coverage limits that cause a sudden termination of care;
- Have to choose between saving their life or their life savings because they lack access to affordable coverage.
Contact Information

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Question and Answer
GWCI caSNP Resources

• Visit our new website www.gwcancerinstitute.org
• Check out our FREE CME e-Learning series at www.cancersurvivorshipcentereducation.org
• Join us again in 2014 for a new year of caSNP monthly webinars!
• Email us casnp@gwu.edu