

Potential Favorable Impact of the Affordable Care Act of 2010 on Cancer in Young Adults in the United States

Archie Bleyer, M.D.

From the Cancer Treatment Center, St. Charles Health System, Central Oregon

Contact Dr Bleyer at the Cancer Treatment Center, St. Charles Medical Center – Bend,
2500 NE Neff Rd, Bend OR 97701, at 541-706-6998, or via ableyer@gmail.com

The Cancer Journal: The Journal of Principles & Practice of Oncology
November/December 2010

ABSTRACT

On September 23, 2010, as a result of the Affordable Care Act, health insurance companies throughout the United States were required for the first time, with few exceptions, to provide young adults under the age of 26 to have health insurance under a parent's insurance if the policy allows for dependent coverage. The Act also provides for elimination of coverage denial for having had a prior diagnosis of cancer or other pre-existing conditions as a result of the cancer and its therapy, provision of a minimum health benefits package including preventive services and professional counseling for obesity, alcohol and substance dependence, physical activity, and nutrition improvement. How these and other provisions of the Act will affect young adults over the next decade is uncertain, but they do have the potential to lead to earlier diagnosis of cancer, less invasive cancer therapy, better quality of survival, and higher cure rates. In the long run it may also help prevent cancer when young adults so benefited age and have less cancer later late in life. A realistic appraisal of the obstacles to implementation of the Act in the age group may compromise many of the desired outcomes. Nonetheless, ACA has provisions that should reduce the cancer problem in young adult Americans, some of which are now in effect and most of which will become available during the current decade.

INTRODUCTION

During the last half-century, children and older adults with cancer have been the foci of research and treatment. As a result, the outcome from cancer in children and in adults over 40 years of age has steadily improved. Meanwhile, it became apparent that progress among older adolescent and young adult cancer patients in the United States has languished in the shadow of advances achieved for younger and older persons (Fig. 1 and 2).^{1,2} Concomitantly, cancer in this age group has become the most frequent cause of death due to disease.³ During the past decade (2000-2009) deaths due to cancer declined in all age groups except young adults 20- to- 29-years of age and in 25- to 29-year-olds it increased (Fig. 1). Among 15- to 44-year-olds in the United States, cancer deaths account for 12% of all deaths and 19% of all deaths due to disease.^{ibid}

The cancer survival gap in older adolescents and young adults is exemplified by the most common pediatric cancer, acute lymphoblastic leukemia. This malignancy has a striking dependence on age of the patient at diagnosis, with a dramatic decline as a function of age beginning in late childhood, plummeting during adolescence, and declining steadily thereafter. The discontinuity in the survival-versus-age relationship between adolescents and young adults during the past decade in the U.S. is most apparent at age 18 (Fig. 3), which suggests a distinct change in the nature or provision of health services provided to young adults.

One of the major reasons for this deficit is health insurance,⁴ which America has less of for its young adults over the age of 18 than any other socioeconomically-advantaged country in the world. This review attempts to predict how in the U.S. the Affordable Care Act of 2010 (ACA) will impact young adults who are 18 and older with respect to cancer prevention, treatment, and

survival. Primary resources for this review are government websites⁵ and opinion editorials.

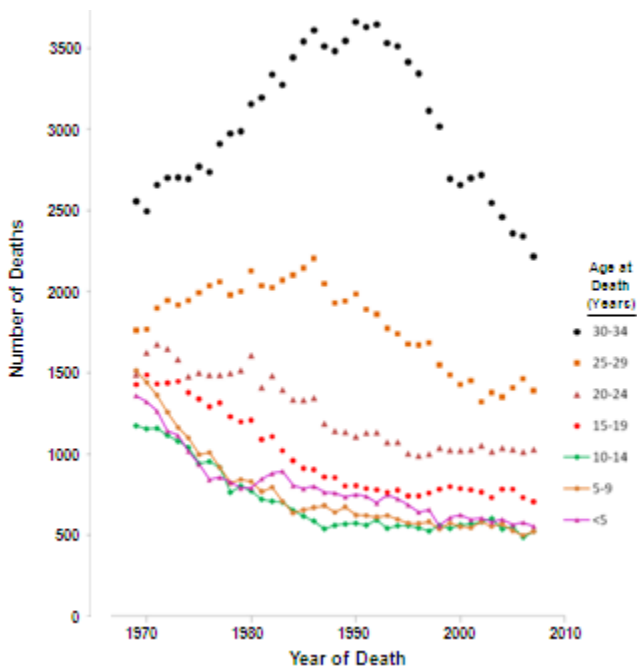


Figure 1 Number of Deaths in the U.S. Due to Cancer and Other Neoplasms, by Age and Calendar Year of Death, Age <35, 1969 to 2007.

Data from National Center for Health Statistics (www.cdc.gov/nchs) accessed Sept.13, 2010.

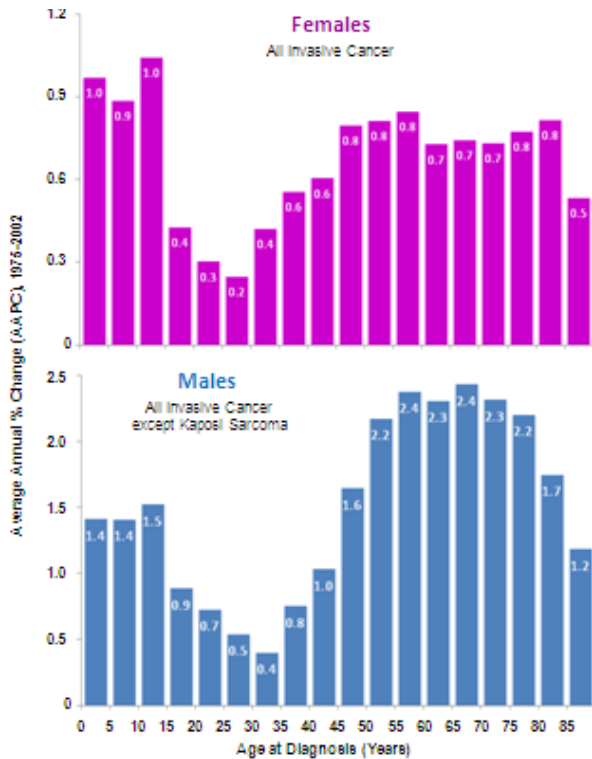


Figure 2 Average Annual Percent Change (AAPC) in 5-Year Relative Survival Rate of Cancer Patients in the U.S. from 1975 to 2002, by Age at Diagnosis and Gender.

Data from SEER17 accessed September 13, 2010. Kaposi sarcoma is excluded in males due to the HIV/AIDS epidemic that resulted in a dramatic, transient increase in this disease during the late 1980s and 1990s.

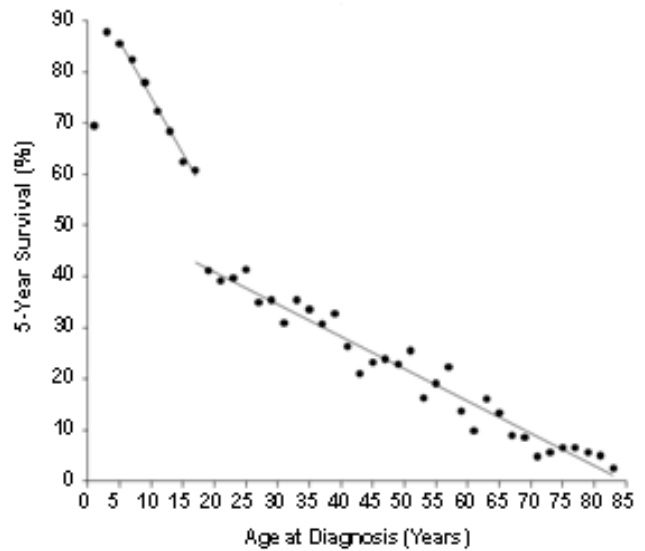


Figure 3 5-year Observed Survival Rate of Patients with Acute Lymphoblastic Leukemia Diagnosed in the U.S. between 2000 and 2007, by Age at Diagnosis of 2-Year Intervals.

Slopes are linear regressions for ages 4-17 and 18-83 years. Data from SEER17 accessed May 2, 2010. Relative survival has an essentially identical pattern.

AFFORDABLE CARE ACT IMPLICATIONS FOR YOUNG ADULTS

The ACA allows young adults to stay on their parents' health care plan until their 26th birthday. Before this landmark Act became law, nearly all health plans and issuers removed young adults from their parents' policies because of their age, leaving many college graduates and others with no health insurance. This helps to explain why in the U.S.:

- Young adults have the highest rate of uninsured of any age group. About 30% of young adults are uninsured, representing more than one in five of the uninsured. This rate is higher than any other age group and is three times higher than the uninsured rate among children.
- Young adults have the lowest rate of access to employer-based insurance. As young adults transition into the job market, they often have entry-level jobs, part-time jobs, or jobs in small businesses, and other employment that typically comes without employer-sponsored health insurance. The uninsured rate among employed young adults is one-third higher than older employed adults.

- Moreover, young adults have the highest unemployment rate, reported in the current economic climate to exceed 50% in the U.S. among those 16- to 24-year-olds not in school.⁶ This is the highest rate in the age group since the post-World War II era. Conservative forecasts predict that this rate is not likely to diminish substantively in the near future.
- The health and finances of young adults are at risk. Contrary to the myth that young people don't need health insurance, one in six young adults has a chronic illness like cancer, diabetes or asthma. Nearly half of uninsured young adults report problems paying medical bills.

PROVIDING HEALTH INSURANCE RELIEF FOR YOUNG ADULTS

The Affordable Care Act requires plans and issuers that offer coverage to children on their parents' plan to make the coverage available until the adult child reaches the age of 26. Thus, many parents and their children who worried about losing health insurance after the children moved away from home or graduated from college no longer need to worry.

Shortly after the ACA was passed, the Departments of Health and Human Services, Labor, and Treasury issued regulations implementing the ACA by expanding dependent coverage for adult children up to age 26, preventing denial of insurance coverage for pre-existing conditions, and providing plans with a minimum of healthcare benefits and affordable premiums. Key elements of relevance for older adolescents and young adults include:

Pre-Existing Conditions. Patients with pre-existing conditions who were uninsured for at least six months are now eligible for subsidized coverage (no less than 65% of medical costs) through national high risk pools.

Coverage Extended to Delay Aging Out of Parent's Health Insurance. Plans and issuers that offer dependent coverage must offer coverage to enrollees' adult children until age 26, even if the young adult no longer lives with his or her parents, is not a dependent on a parent's tax return, or is no longer a student. There is a transition for certain existing group plans that generally do not have to provide dependent coverage until 2014 if the adult child has another offer of employer-based coverage aside from coverage through the parent. The new policy providing access for young adults applies to

both married and unmarried children, although their own spouses and children do not qualify.

Effective for Plan or Policy Years That Began September 23, 2010. Secretary of Health Kathleen Sebelius called on leading insurance companies to begin covering young adults voluntarily before the implementation date required by the ACS (which is plan or policy years beginning on or after September 23rd). Early implementation avoided gaps in coverage for new college graduates and other young adults and save on insurance company administrative costs of dis-enrolling and re-enrolling them between May 2010 and September 23, 2010. Over 65 companies responded to this call voluntarily continued coverage for young adults who graduated or aged off their parents' insurance before the implementation deadline (Table 1).

Table 1 U.S. Insurance Companies that Began to Cover Young Adults Who Graduate or Age Off Their Parents' Insurance Before the September 23, 2010 Deadline Implementation

Coventry Healthcare, Inc.
 Blue Cross and Blue Shield of Alabama
 Blue Cross Blue Shield of Delaware
 Blue Cross and Blue Shield of Arizona, Inc.
 Blue Cross and Blue Shield of Florida
 Arkansas Blue Cross and Blue Shield
 Blue Cross and Blue Shield of Hawaii
 Blue Shield of California
 Blue Cross of Idaho Health Service
 Regence Blue Shield of Idaho
 Wellmark Blue Cross and Blue Shield of Iowa
 Health Care Service Corporation
 Blue Cross and Blue Shield of Kansas
 Blue Cross Blue Shield Association
 Blue Cross and Blue Shield of Louisiana
 WellPoint, Inc.
 CareFirst BlueCross and BlueShield
 Blue Cross and Blue Shield of Massachusetts
 Blue Cross and Blue Shield of Kansas City
 Blue Cross and Blue Shield of Michigan
 Blue Cross and Blue Shield of Montana
 Blue Cross and Blue Shield of Minnesota
 Blue Cross and Blue Shield of Nebraska
 Blue Cross & Blue Shield of Mississippi
 Horizon Blue Cross & Blue Shield of New Jersey
 HealthNow New York, Inc.
 The Regence Group
 Excellus Blue Cross and Blue Shield
 Capital BlueCross
 Blue Cross and Blue Shield of North Carolina
 Independence Blue Cross
 BlueCross BlueShield of North Dakota
 Highmark, Inc.

Blue Cross of Northeastern Pennsylvania
 BlueCross and BlueShield of Tennessee
 Blue Cross and Blue Shield of Vermont
 Blue Cross & Blue Shield of Rhode Island
 Premera Blue Cross
 Blue Cross and Blue Shield of South Carolina
 Blue Cross and Blue Shield of Wyoming
 Kaiser Permanente
 Cigna
 Aetna
 United
 WellPoint
 Humana
 Capital District Physicians' Health Plan, Albany, NY
 Capital Health Plan, Tallahassee, Florida
 Care Oregon, Portland, Oregon
 Emblem Health, New York, New York
 Fallon Community Health Plan, Worcester, MA
 Geisinger Health Plan, Danville, Pennsylvania
 Group Health, Seattle, Washington
 Group Health Cooperative Of South Central
 Health Partners, Minneapolis, Minnesota
 Independent Health, Buffalo, New York
 Kaiser Foundation Health Plan Oakland
 Martin's Point Health Care, Portland, Maine
 New West Health Services, Helena, Mt
 The Permanente Federation, Oakland, California
 Priority Health, Grand Rapids, Michigan
 Scott & White Health Plan, Temple, Texas
 Security Health Plan, Marshfield, Wisconsin
 Tufts Health Plan, Waltham, Massachusetts
 UCARE, Minneapolis, Minnesota
 UPMC Health Plan, Pittsburgh, Pennsylvania

All Eligible Young Adults Have A Special Enrollment Opportunity. For plan or policy years beginning after September 23, 2010, plans and issuers must give children who qualify an opportunity to enroll that continues for at least 30 days regardless of whether the plan or coverage offers an open enrollment period. This enrollment opportunity and a written notice must be provided not later than the first day of the first plan or policy year beginning on or after September 23, 2010. The new policy does not otherwise change the enrollment period or start of the plan or policy year.

Same Benefits/Same Price. Any qualified young adult must be offered all of the benefit packages available to similarly situated individuals who did not lose coverage because of cessation of dependent status. The qualified individual cannot be required to pay more for coverage than those similarly situated individuals. The new policy applies only to health insurance plans that offer dependent coverage in the first place: while most

insurers and employer-sponsored plans offer dependent coverage, there is no requirement to do so.

Affordable Premiums. According to an analysis of this provision, adding young adult coverage would increase average family premiums by as little as 0.7% while allowing 1.2 million young Americans coverage under their parents' plan through an employer or the individual market.

Minimum Health Benefits Package. All qualified health plans, except grandfathered plans or self-insured plans, will be required to offer at least the minimum health benefits package: ambulatory patient services, emergency services, hospitalizations, maternity and newborn care, mental health and substance use disorder services, including behavioral health, prescription drugs, rehabilitative services and devices, laboratory services, preventive services including services recommended by the Task Force on Clinical Preventive Services [mammography] and [HPV] vaccines recommended by the director of the CDC, chronic disease management, and pediatric services (including vision and oral care).

Preventive Services Covered. The ACA will help make wellness and prevention services affordable and accessible to young adults by requiring health plans to cover preventive services and by eliminating cost-sharing. According to a new regulation released by the Department of Health and Human Services, the Department of Treasury, and the Department of Labor, if a young adult or his/her family enrolls in a new health plan after September 23, 2010, that plan is required to cover recommended preventive services without charging a copay, co-insurance or deductible. Services covered include disease screening, vaccinations, and counseling to prevent or reduce obesity, sedentary life style, and use of tobacco and alcohol.

Other Provisions Relevant to Young Adults. Other provisions are described in Table 2. They include chain restaurants and vending machines required to post calorie and nutritional information of regular menu items, reauthorization of the Children's Health Insurance Program (CHIP), an Accountable Care Organization (ACO) demonstration project, and a mandate for individuals to have health insurance.

IMPLEMENTATION TIMETABLE

Table 2 describes when, during 2011-2014, provisions applicable to young adults will be in effect.

Table 2 ACA implementation timetable.

2010

1. As of September 23, 2010, a young adult under age 26 is insurable as a dependent on his/her parent's health insurance. The only exception is if the parent(s) has an existing job-based plan and the young adult can get job-based coverage. Many plans have made a business decision to provide this coverage earlier, so if a parent has coverage with one of these plans, the young adult was insured before September 2010. Also starting as early as September 2010, new health plans must cover certain preventive services without cost sharing.

2. Children's Health Insurance Program (CHIP) is reauthorized through 2015 and prescribed it to include a 23% increase in federal medical assistance percentage rates in subsequent years.

2011

All restaurants and vending machines are required to provide calorie and nutrition information on their products.

2012

The Accountable Care Organization (ACO) demonstration project to guide formation of ACOs for pediatric and young adult patients begins and continues for four years.

2014

1. If a young adult's employer doesn't offer insurance, he/she will be able to buy insurance directly via an Insurance Exchange in his/her state. Exchanges are new transparent and competitive insurance marketplaces where individuals and small businesses will be able to buy affordable and qualified health benefit plans. Exchanges will offer a choice of health plans that meet certain benefits and cost standards.

2. If the young adult's income is less than the equivalent of about \$43,000 for a single individual and the young adult's job doesn't offer affordable coverage, he/she may get tax

credits to help pay for insurance.

3. A young adult who is unemployed with limited income up to about \$15,000 per year for a single person (higher income for couples/families with children) may be eligible for health coverage through Medicaid. The Federal government provides a portion of the funding for Medicaid and sets guidelines for the program. States also have choices in how they design their program, so Medicaid will continue to vary state by state.

4. Each citizen is required to have basic health insurance coverage or pay a fee to help offset the costs of caring for uninsured Americans. Reciprocally, each health insurance plan will have to offer the minimum yet comprehensive health benefits package.

5. All health insurance companies are required to pay for the routine patient care costs associated with participation in high-quality clinical trials, regardless of the patient's age.

NEW TAX BENEFITS FOR ADULT CHILD COVERAGE

The new regulation complements guidance issued by the Treasury Department on April 27, 2010, on the tax benefits provided for such coverage through the ACA. Under a new tax provision in the ACA and the Treasury guidance, the value of any employer-provided health coverage for an employee's child is excluded from the employee's income through the end of the taxable year in which the child turns 26. This tax benefit applies regardless of whether the plan is required by law to extend health care coverage to the adult child or the plan voluntarily extends the coverage. Key elements include:

Tax Benefit Continues Beyond Extended Coverage Requirement. While the ACA requires health care plans to cover enrollees' children up to age 26, some employers may decide to continue coverage beyond the child's 26th birthday. In such a case, the Act provides that the value of the employer-provided health coverage is excluded from the employee's income for the entire taxable year in which the child turns 26. Thus, if a child turns 26 in March but stays on the plan through December 31st (the end of most people's taxable year), all health benefits provided that year are excluded for income tax purposes.

Available Immediately. These tax benefits were effective March 30, 2010. The exclusion applies to any coverage that is provided to an adult child from that date through the end of the taxable year in which the child turns 26.

Broad Eligibility. This expanded health care tax benefit applies to various workplace and retiree health plans. It also applies to self-employed individuals who qualify for the self-employed health insurance deduction on their federal income tax return.

Both Employer and Employee Shares of Health Premium Are Excluded from Income. In addition to the exclusion from income of any employer contribution towards qualifying adult child coverage, employees can receive the same tax benefit if they contribute toward the cost of coverage through a “cafeteria plan.” This benefit is available immediately, even if the cafeteria plan document has not yet been amended to reflect the change. To reduce the burden on employers, they have until the end of 2010 to amend their cafeteria plan documents to incorporate this change.

COMPANIES RESPONDING TO CALL FOR EARLY IMPLEMENTATION:

Early implementation by the health insurance companies (Table 1) avoided gaps in coverage for new college graduates and other young adults and saved insurance company administrative costs of dis-enrolling and re-enrolling them between May 2010 and the start of the plan or policy year beginning on or after September 23, 2010. Early enrollment also enabled young, overwhelmingly healthy people who will not engender large insurance costs to stay in the insurance pool. Sixty-six companies agreed to implement this program before the September 23, 2010 deadline (Table 1).

POTENTIAL BENEFITS TO THE YOUNG ADULT CANCER BURDEN

STANDARDS OF CARE

Guidelines for standards of care to reduce the young adult cancer problem have just been published.⁷ In retrospect, implementation of, and adherence to, many of the guidelines will be facilitated by the ACA. These include having the ACO demonstration model follow the guidelines, providing access of young adults to guideline-compliant programs, enabling the insurance industry to steer policyholders to them, and potentially

requiring their minimum benefits package to include a guidelines core. Access and participation in cancer clinical trials by young adults should also be promoted by having the guidelines available to the multiple federal offices implementing the ACA and to the health insurance industry.

EVOLVING MEDICAL DISCIPLINE

Now that adolescent and young adult oncology is becoming a recognized discipline,⁸ young adults will have more opportunity to take advantage of the increasing expertise, resources and referral network that is occurring as a result. Similarly, the discipline will benefit as more young adults and older adolescents are able to access healthcare, enroll in clinical trials, enable more tumor specimens for translational research, and provide long term follow-up.

PREVENTION

Since the ACA required health insurance plans to cover recommended preventive services without charging a copay, co-insurance or deductible, young adults are now more readily able to be vaccinated against human papilloma virus (HPV) and thereby eliminate their risk of cancer of the uterine cervix and lower the incidence of anal and penile cancer and of cancer of the oral cavity and pharynx. For females, improved access to HPV vaccination is particularly welcome since the incidence of oro/pharyngeal cancer is increasing quite dramatically in young women and vaccine is essentially 100% effective,⁹

Young adults can also more readily access professional counseling on quitting smoking, losing weight, eating better, and reducing alcohol use, as well as be able to read the calorie and nutritional content of foods they obtain from vending machines and at restaurants. Each of these measures has the potential to reduce the cancer incidence in young adults, and several are invariably likely to reduce the cancer burden in the age group, such as the pap smear and HPV vaccine. The calorie and nutrition information is relevant because the risk of many cancers is increased with excessive weight gain, include cancers that occur in young adults (lymphoma, leukemia, and cancer of the breast, cervix, colon, rectum, and thyroid), the required coverage of exercise and nutrition counseling to reduce and prevent obesity may thereby indirectly reduce cancer incidence in young adults. That America is currently faced with an epidemic of obesity among young adults in the U.S.

renders this provision particularly significant. The demonstration project for pediatric/young adult ACOs should also promote since one of the major aims of ACOs is to prevent chronic disease.

EARLY DETECTION

Young adults have not only been found to have longer intervals from the onset of symptoms and signs of cancer to its diagnosis,^{10,11,12,13} but also have been shown to have even longer delays if they are uninsured or under-insured.¹⁴ The ACA should enable earlier detection and diagnosis by providing health insurance access to the age group that is least insured in the U.S. Also, the Act’s requirement that insurance plans cover recommended screening tests should decrease the burden of cancer of the uterine cervix and breast in females and colorectal cancer in young adult females and males via pap smears, mammography, and colonoscopy, respectively. The demonstration project for pediatric/young adult ACOs should also promote early cancer detection since this is one of the major aims of ACOs.

CURRENT YOUNG ADULT CANCER PATIENTS AND SURVIVORS

Young adults with or after cancer who have been uninsured for at least six months can no longer be denied health insurance because of their prior condition. They are now eligible via national high risk pools for subsidized coverage of at least 65% of medical cost. This alone should allow earlier detection of recurrence or progression of their malignancy and potentially prolong survival. At a minimum it should improve the quality of life of these persons not only in allaying the anxiety and fear of being uninsurable but also in directly providing supportive care.

Components of the minimum health benefits package that are directly relevant to young adult cancer problem: mammography for early breast cancer detection and HVP vaccination for cervical, anogenital, and oral/oropharynx cancer prevention, ambulatory patient services, emergency services, hospitalizations, mental health and substance use disorder services, including behavioral health, prescription drugs, rehabilitative services and devices, laboratory services, and chronic disease management.

Also the extension of CHIP and its programmed increase in Federal contribution will assist young adult parents in assuring that their children will have access to, and likely additional coverage, for health needs. Since young cancer survivor parents are

particularly concerned about their fertility and additional potential medical and socioeconomic risks faced by their children, this provision of the Act offers benefits to the subsequent generation and their parents. That the minimum health benefits package specifies obstetric and maternal care, and pediatric services that including vision and oral care, will also be important to most young adult cancer survivors.

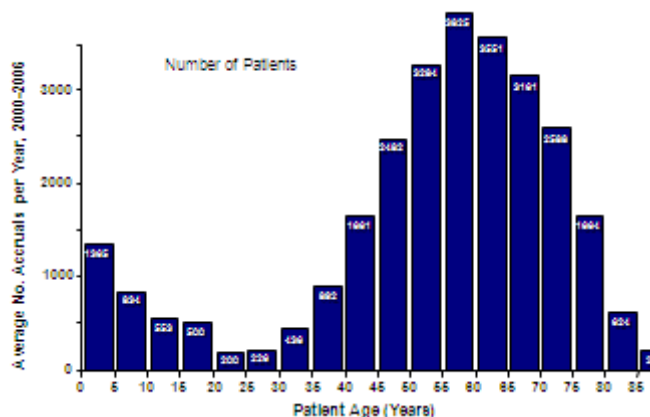


Figure 4 U.S. Cancer Patients Entered on National Treatment Trials by 5-year Age Intervals, 2001-2006. Data from Cancer Therapy Evaluation Program, National Cancer Institute, courtesy of Michael Montello, Troy Budd, and Steve Friedman

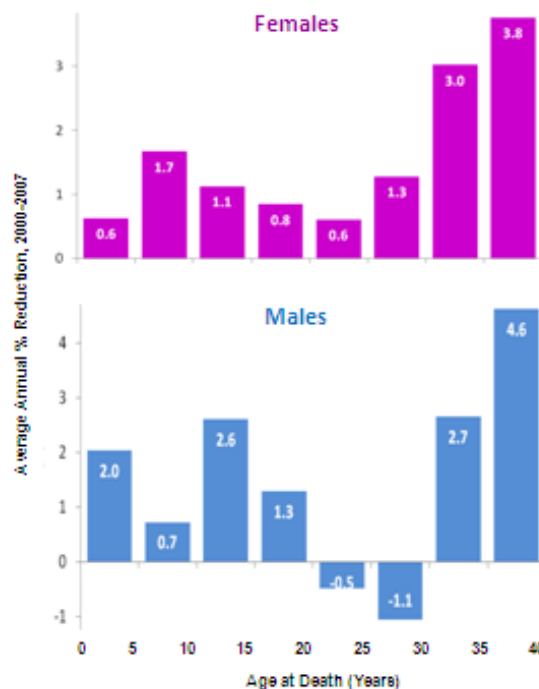


Figure 5 Average Annual Percent Reduction in Deaths from Cancer and Other Neoplasms in the U.S., 2000 to 2007, by Gender and Age at Death. Data from National Center for Health Statistics (www.cdc.gov/nchs) accessed September 13, 2010.

PARTICIPATION IN CLINICAL TRIALS

Accrual to the national treatment trials has been strikingly age dependent in the 0-to 44-year age groups, with the lowest rate in patients 15- to 39-years of age and a nadir in the 20- to 24-year age group (Fig. 4) in whom less than 2% are not entered onto a clinical trial during their cancer experience.^{15,16,17} Between 2000 and 2007, the latest year for which national mortality data are publicly available, the age-dependent rate in the reduction of deaths attributed to cancer in the U.S. (Fig. 5) was correlated with age-dependent accrual of young adults to national cancer treatment trials over the same era (Fig. 4). In females the correlation is statistically significant ($p = 0.05$).

As Medicare patients, older adults have had this protection since June 7, 2000 when the President of the United States issued an executive memorandum directing the Secretary of Health and Human Services to "explicitly authorize [Medicare] payment for routine patient care costs...and costs due to medical complications associated with participation in clinical trials." Thanks to the ACA, young adults will, for the first time in America's history, have similar access to quality clinical trials. Moreover, coverage includes clinical trials conducted outside the state in which the patient resides. It does not, however, require coverage for out of network services unless those benefits are otherwise provided under the plan.

The ACA uses Medicare's definition for routine costs to include all items and services that are typically covered for a patient who is not enrolled in a clinical trial. The ACA requires self-insured plans to submit an annual report beginning one year after enactment and a study to compare characteristics of fully insured and self-insured group health plan markets within one year.

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Given that lack of health insurance is a major reason that clinical trial participation is so low in young adults, the ACA should allow more entries onto trials in this age group. Also, the improved coverage should stimulate the development of more clinical trials for the age group since reimbursement of physicians and other care providers will be improved.

ACQUISITION OF BIOLOGIC SPECIMENS AND TRANSLATIONAL RESEARCH

The young adult age group also has the fewest specimens in malignant and corresponding normal tissues in biorepositories (tumor banks) across the country. Yet there is sufficient data to indicate that the biology of cancer in young adults differs from that in younger and older patients even for tissue that histologically and pathologically appear identical.¹⁸ In order to learn what is necessary to treat (and prevent) cancer in the age group, more specimens and the facilitated translational research may be available with ACA-mediated improvement in tissue acquisition and clinical trials.

QUALITY OF SURVIVAL DURING AND AFTER TREATMENT

In addition to the deficits in survival and mortality, the physical, emotional, social, and financial challenges of cancer faced by young adults, their families, and healthcare providers are unique and often the most difficult through the lifespan.¹⁹ Quality of life during and after treatment for cancer is thereby particularly problematic in young people with cancer who in addition to coping with the psychosocial, peer-pressure, financial, physical, sexual, spousal, fertility and parental challenges of the transition from adolescence to adulthood now must also overcome a potentially fatal disease. To the extent that health insurance and access to medical care has been denied to many young adult Americans, the ACA has the potential to significantly improve supportive care services to this vulnerable population. If for no other reason, earlier diagnosis at a more favorable stage of disease that requires

less therapy will improve quality of survival both during and after treatment. Also, formation of effective ACOs that include young adult cancer patients will also enhance survivorship.

QUANTITY OF SURVIVAL AFTER TREATMENT

The survival gaps could be narrowed with better health insurance coverage, earlier detection, increased clinical trial participation, greater access to biorepository tissues, better understanding of the biology of the malignancies of young adults, and reduced risk of cancer recurrence with improved nutrition. The improved prognosis with time after diagnosis in patients who continue to respond to therapy, known as conditional survival, has also been shown to be worse in young adults with cancer than in younger or older patients.²⁰ If the location of treatment is not constrained by health insurance, young adults are more likely to be treated by experts with the most optimum methods of staging and treatment. This is particularly important for older adolescents and young adults since those with pediatric types of cancer have had better results at pediatric cancer centers whereas those with adult types of cancer have had improved survival with care at adult-treating centers.²¹ Formation of effective ACOs for pediatric and young adult patients may blend the best of both pediatric and adult treating organizations and thereby raise cure rates of older adolescents and young adults with cancer.

Finally, the improve information on calorie and nutrition content of vending machine and restaurant food items could help young adult reduce their risk of a worse prognosis and cancer recurrence since there is increasingly clear evidence that time to disease progression is adversely affected for a number of cancers that occur in young adults (e.g. cancers of the breast, colon, rectum, head/neck, uterine cervix, ovary) by excessive body weight and weight gain.²²

WHAT YOUNG ADULTS AND PARENTS SHOULD DO

WHAT YOUNG ADULTS AND PARENTS NEED TO ACCESS INSURANCE AND OPTIMIZE THEIR CANCER PREVENTION, EARLY DIAGNOSIS, TREATMENT AND OUTCOME

Frequently Asked Questions (FAQs).

Questions that have been most often asked since the ACA was passed are presented in Table 3, along with official answers provided by the U.S. government.

Watch for Open Enrollment. As of September 23, 2010, young adults qualify for an open enrollment period to join their parents' family plan or policy. Insurers and employers are required to provide notice for this special open enrollment period. Watch for it or ask about it.

Expect an Offer of Continued Enrollment. Insurers and employers that sponsor health plans are required to inform young adults of continued eligibility for coverage until the age of 26. To get the coverage, young adults and their parents need not do anything but sign up and pay for this option.

Utilize Calorie and Nutritional Information. Since all items in vending machines and served by chain restaurants will by 2011 required to have caloric and other nutritional information, young adults will be able to help themselves prevent and reduce obesity and otherwise reduce their risk of cancer occurrence and recurrence. \

Table 3 Frequently Asked Questions about the ACA application to young adults.*

How does the ACA help young adults?

Before the President signed the Affordable Care Act into law, many health plans and issuers could remove adult children from their parents' policies because of their age, whether or not they were a student or where they lived. The ACA requires plans and issuers that offer dependent coverage to make the coverage available until the adult child reaches the age of 26. Many parents and their children who worried about losing health insurance after they graduated from college no longer have to worry.

What plans are required to extend dependent coverage up to age 26?

The ACA requires plans and issuers that offer dependent coverage to make the coverage available until a child reaches the age of 26. Both married and unmarried children qualify for this coverage. This rule applies to all plans in the individual market and to new employer plans. It also applies to existing employer plans unless the adult child has another offer of employer-based coverage (such as through his or her job). Beginning in 2014, children up to age 26 can stay on their parent's employer plan even if they have another offer of coverage through an employer.

How can a young adult under the age of 26 who is on his/her parents plan and scheduled to lose coverage soon keep health insurance?

Watch for open enrollment. Young adults may qualify for an open enrollment period to join their parents' family plan or policy on or after September 23, 2010. Insurers and employers are required to provide notice for this special open enrollment period. Watch for it or ask about it. Expect an offer of continued enrollment for plans that begin on or after September 23, 2010. Insurers and employers that sponsor health plans will inform young adults of continued eligibility for coverage until the age of 26. Young adults and their parents need not do anything but sign up and pay for this option.

How can a young adult under the age of 26 who used to be on a parent's plan but lost this coverage because of graduation from college get coverage?

Yes. Check with your insurance company to see if they will provide that coverage to you now. If not, watch for the special open enrollment period and sign up then.

Will young adults be given a special chance to enroll after September 23, 2010?

Yes. For plan or policy years beginning on or after September 23, 2010, plans and issuers must give children who qualify an opportunity to enroll that continues for at least 30 days regardless of whether the plan or coverage offers an open enrollment period. This enrollment opportunity and a written notice must be provided not later than the first day of the first plan or policy year beginning on or after September 23, 2010. Some plans may provide the opportunity before this date

Will young adults have to pay more for coverage or accept a different benefit package?

Any qualified individual must be offered all of the benefit packages available to children who did not lose coverage because of loss of dependent status. The qualified young adult cannot be required to pay more for coverage than similarly situated individuals who did not lose coverage due to the loss of dependent status.

Can plans or issuers who offer dependent coverage continue to impose limits on who qualifies based upon financial dependency, marital status, enrollment in school, residency or other factors?

No. Plans and issuers that offer dependent coverage must provide coverage until a child reaches the age of 26. There is one exception for group plans in existence on March 23, 2010. Those group plans may exclude adult children who are eligible to enroll in an employer-sponsored health plan, unless it is the group health plan of their parent. This exception is no longer applicable for plan years beginning on or after January 1, 2014.

Does the adult child have to purchase an individual policy?

No. Eligible adult children wishing to take advantage of the new coverage will be included in the parents' family policy.

Will Medicare cover adult children in the same way that private health insurance will?

No. The provision does not apply to Medicare.

Are both married and unmarried young adults covered?

Yes

Are plans or issuers required to provide coverage for children of children receiving the extended coverage?

No

Why is there a special exception for group plans in existence on March 23, 2010?

The goal is to cover as many young adults under the age of 26 as possible with the least amount of burden. If a young adult is eligible to purchase other employer-based health insurance such as through her job, the law does not require the parent or parents' plan to enroll that child if the parents' plan is a grandfathered health plan (i.e., in existence on March 23, 2010). Of course, all group plans have the option to cover all adult children until the age of 26 or beyond. In 2014, this exception will no longer apply.

What happens if a young adult under the age of 26 is not eligible for employer-sponsored insurance and both parents have separate plans that offer dependent coverage?

Neither parent's plan can deny coverage.

Does the law apply to plans or issuers that do not provide dependent coverage?

No. There is no federal requirement compelling a plan or issuer to offer dependent coverage at this time. However, the vast majority of group health plans offer dependent coverage and many family policies exist in the individual market.

* Modified from www.hhs.gov/ociio/regulations/adult_child_fa.html, accessed September 13, 2010

LIMITATIONS OF THE IMPACT OF ACA ON YOUNG ADULTS AND CANCER

Despite all of the potential cancer benefits of the ACA for older adolescents and young adults, it is unlikely the Act will be as successful as intended. A pragmatic perspective tempers the optimism, given the obstacles that lie ahead. First, extending coverage of parents' health insurance plans to the age of 26 is a minimalist action. More than a dozen states had already enacted similar legislation and several had an age limit above 26, as high as 30. Since these are the healthiest of adults and the incidence of cancer among adolescents and adults is exponentially proportional to age, insurers had to least to lose in covering this age group. There should be little surprise in the number of companies that agreed to raise the age limit before this provision of the ACA took effect. That the incidence of cancer in adults increases exponentially with age, doubling every seven years, the 26-year age limit will in effect have relatively limited impact on the young adult cancer burden.

Second, there is the essence of adolescence and early adulthood itself, which is to develop independence and overcome reliance on parental and authoritarian resources. Regardless of the comprehensiveness of the law and the structure it creates may be, this age population is the least likely to adhere to the rules and utilize resources (you can lead a horse to water but can't ...), with estimates of therapy non-compliance ranging in 15- to 24-year-olds from 27% to 60%.²³ There appears to be nothing in the ACA that deals with

this limitation head-on. Also the mandate requiring each American to have health insurance or pay a fee to defray medical costs of uninsured Americans will likely be most resisted by young adults, particularly by those who are unemployed and those not only have to insure themselves but also their children.

Third, disease prevention and early detection are not inherent interests of the young adult population. Their self-perceived invincibility and their primary lack of awareness of cancer and other chronic diseases as a real risk for their generation will not endear them to the ACA. On the contrary, the majority will continue to deny their vulnerability, as evidenced by the failure of prior legislation to reduce the young adult smoking rate below one in every five persons. Another caveat regarding cancer prevention in young adults is the many years it takes for most interventions to have an impact. Most known effective interventions applicable to young adults, including those that reduce obesity, tobacco exposure, and sexually transmitted infections, will not have a substantial effect until middle or late adulthood. With the exception of HPV vaccination, they also require a lifestyle that must be maintained for years if not a lifetime. Thus the known effective methods of cancer prevention are not only difficult to implement in young adults, the desired outcome will not, in general, be realized for decades.

Fourth, the health insurance industry will find and utilize loopholes in the legislation that will prevent full implementation of the intended effects. This has already become apparent in the initial confrontation between the government and insurance companies over the requirement that each company must either spend 85% of the money collected in premiums on medical care or refund the difference to policyholders. The companies are claiming administrative costs to be necessary expenses, including fraud prevention and detection, utilization management, provider credentialing and network development, and the start-up costs of implementing the International Classification of Diseases 10th Revision codes by 2013, as required by law.²⁴

Fifth, healthcare reform will continue to be a political medicine ball, with the Act likely to undergo amendments as the ball is thrown back and forth with each switch of political party dominance in Congress. Also, the cost of covering clinical trial costs for enrolled subjects and developing cures for cancer will challenge health insurance companies,

self-insuring employers, reinsurers, stop-loss carriers, biotech firms, and the pharmaceutical companies to find loopholes in the legislation and lobby for ACA amendments and appeal. Also, the cost of covering clinical trial costs for enrolled subjects and developing cures for cancer will challenge health insurance companies, self-insuring employers, reinsurers, stop-loss carriers, biotech firms, and the pharmaceutical companies to find loopholes in the legislation and lobby for ACA amendments and appeal. Given that young adults in their life phase of seeking stability, the political pendulum will not enfranchise them to full ACA support and utilization.

Finally, young adults are faced with an myriad of psychosocial, educational, vocational, employment, financial, and spiritual challenges that are unique to the age group and in aggregate impose greater conflict than they will experience at any other time in life. To expect young adults to have the time and where-with-all to jump through all the hoops of the ACA and access and utilize its health insurance exchanges, national high risk pools, open enrollment process, “cafeteria” plans, and tax credits is unrealistic, especially since the Act does not provide adequate mechanisms to educate and facilitate its implementation and use among the young adult population. This same limitation occurred when the Children’s Health Insurance Program (CHIP) was rolled out during the late 1990s. CHIP required young adult parents to register with the state offices and to this date has been undersubscribed in nearly all states.

SUMMARY

Provisions of the ACA have multiple potential beneficial applications to young adult cancer patients/survivors and their families. The gains include delaying the aging out of insurance coverage under parents’ plans to the age of 26, elimination of coverage denial for having had a prior diagnosis of cancer or other pre-existing conditions and its therapy, provision of a minimum health benefits package including preventive services and professional counseling for obesity, alcohol and substance dependence, physical activity, and nutrition improvement. How these changes and the multiple other provisions of the Act will affect young adults over the next decade is uncertain, but it is likely to lead to earlier diagnosis of cancer, less invasive cancer therapy, better quality of survival, and quite possibly higher cure

rates. In the long run it may also help prevent cancer in later adulthood. As the ACA is implemented, however, many obstacles will be encountered and the desired impact on America’s young adult cancer problem will undoubtedly be less than intended by the legislation.

Grant Support

Supported in part by a Community Program grant from the Lance Armstrong Foundation (DEFEATcancer, Archie Bleyer, M.D., Program Director).

Acknowledgments

I am indebted to Otis Brawley, M.D., for asking me to contribute to this special issue of The Cancer Journal, and to the many young adults and older adolescents with cancer from whom I have had the privilege to learn how their plight merits national attention and changes in federal and state laws.

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