**ANNALS OF HEALTH LAW**
***Advance Directive***

VOLUME 20 FALL 2010 PAGES 56-67

# What New Healthcare Reforms Means for Cancer Patients

*Lindsay Kessler**

## I. INTRODUCTION

The Patient Protection and Affordable Care Act (PPACA) prescribes both immediate and gradual relief to those struggling with their health care insurance. It seeks to provide quality, affordable, and accessible coverage options for all Americans.[1] While the new legislation will have consequences for all types of beneficiaries, 160 provisions are especially relevant to the cancer community.[2] Those suffering from cancer will see sweeping changes with the new reform which includes: enhancing the role of disease prevention and early detection, providing meaningful choices in the private and public sector, and improving the quality of life for cancer afflicted individuals.[3]

Operating under a pre-determined transition schedule, implementation of the PPACA will be phased in by 2014 for the most part and the changeover raises new sets of concerns.[4] For cancer patients, these stakes are even higher and timing is crucial. A 2010 American Cancer Society (ACS) report revealed that the most frequently diagnosed type of cancer in both women and men is skin cancer.[5] Following in a close second is breast cancer (women) and prostate cancer (men) with more than 200,000 new cases

* Juris Doctor Candidate, Loyola University Chicago School of Law, Class of 2012. Ms. Kessler is a staff member of *Annals of Health Law*.

1. *See* DEMOCRATIC POLICY COMM., SECTION-BY-SECTION ANALYSIS OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT, WITH CHANGES MADE BY TITLE X AND THE HEALTH CARE AND EDUCATION RECONCILIATION ACT INCLUDED WITHIN TITLES I-IX, (Sept. 17, 2010), http://dpc.senate.gov/healthreformbill/healthbill96.pdf.

2. AM. CANCER SOC'Y - CANCER ACTION NETWORK, THE NEW HEALTH CARE REFORM LAW THROUGH THE CANCER LENS: KEY PROVISIONS AFFECTING CANCER PATIENTS AND SURVIVORS, 1 (Mar. 3, 2010), http://acscan.org/pdf/healthcare/ implementation/HCR-cancer-provisions.pdf [hereinafter KEY PROVISIONS].

3. *See id.*

4. *See* AM. CANCER SOC'Y - CANCER ACTION NETWORK, *Healthcare Reform: Timeline for Implementation*, 1 (Mar. 31, 2010), *available at* http://acscan.org/pdf/healthcare/implementation/HCR-implementation-timeline.pdf.

5. AMERICAN CANCER SOC'Y, *Cancer Facts & Figures 2010*, 10 (2010) *available at* http://www.cancer.org/acs/groups/content/@epidemiologysurveilance/documents/document/acspc-026238.pdf [hereinafter *Cancer Facts & Figures 2010*].

estimated for 2010.[6] The next most common is colorectal cancer, with more than 70,000 new cases predicted.[7] The anticipated costs of cancer in 2010 were close to 264 billion dollars, including direct medical, indirect illness, and premature death costs due to lost productivity.[8]

One of the major barriers preventing Americans from receiving optimal health care is lack of health insurance.[9] In 2008, 46 million Americans were uninsured with approximately 28 percent of Americans between the ages of 18 to 34 and 10 percent of children had no health insurance coverage.[10] Problems become even greater when these uninsured patients are not diagnosed with cancer until a later stage, at which point treatment can be more extensive and more costly.[11]

Looking at the relevant provisions of the Act will yield some insight into the future for cancer patients at every step of the process – from prevention and diagnosis, to treatment and advocacy. Patients, caregivers, and loved ones face issues affected by healthcare reform, including the differences between public and private insurance selection, premium conditions and limits, funding for drug and research developments, and combating anti-reform action.

## II. MEDICAID EXPANSION FOR CANCER PATIENTS

The PPACA expands Medicaid enrollment, which provides health insurance for low-income and low-resource beneficiaries.[12] Cancer patients often qualify for Medicaid through the Aged, Blind, and Disabled Program, which provides coverage to individuals with low incomes who are over 65 or who have a disability.[13] Approximately 8.8 million disabled individuals rely on Medicaid for health insurance, which accounts for about

---

6. *Id.*
7. *Id.*
8. *Id*. at 3.
9. *Id.*
10. *Id.*
11. *Cancer Facts & Figures 2010*, *supra* note 5, at 3.
12. Joanna L. Fawzy Morales, et al., *The HCP Manual: A Legal Resource Guide for Oncology Health Care Professionals*, DISABILITY LEGAL RIGHTS CTR., 1, 36, (2010), http://www.disabilityrightslegal center.org/
about/documents/HCPManual2010Final.pdf.
13. *Id.*

fifteen percent of Medicaid enrollees.[14] Moreover, this enrollment group accounts for forty-two percent of overall Medicaid expenditures.[15] In 2007, Medicaid expenditures were about $14,500 per disabled individual.[16]

By 2014, the Act will expand Medicaid eligibility to individuals who fall below 133 percent of the poverty level, simplify enrollment, and offer incentives.[17] Health reform also means important changes for Medicaid beneficiaries with cancer as it will discourage states from discontinuing breast and cervical cancer treatment eligibility during the transition period, and it will increase access to tobacco cessation products.[18] It will also incentivize enrollees to participate in chronic disease prevention programs and other preventative services. [19]

However, increased funding will not begin until 2014, and with estimates of sixteen million additional beneficiaries, Medicaid's expanded role presents not only unprecedented opportunities, but also challenges.[20] With continual budget pressures, states are limited in their resources and federal assistance will be crucial for a smooth implementation process.

## III. MEDICARE: NON-ELDERLY DISABILITY INSURANCE

Another federal option for health insurance is Medicare, traditionally designed to provide healthcare insurance to the elderly population over the age of sixty-five.[21] But Medicare eliminated the age requirement if individuals have received Social Security Disability Insurance (SSDI) benefits for two years.[22] Currently, approximately eight million people under the age of sixty-five qualify for Medicare due to a permanent

14. *The Medicaid Program at a Glance*, THE HENRY J. KAISER FAMILY FOUND., 1 (June 2010), http://www.kff.org/medicaid/upload/7235-04.pdf [hereinafter *The Medicaid Program at a Glance*].
15. *Id.*
16. *Id.* at 2.
17. KEY PROVISIONS, *supra* note 2, at 2; Patient Protection and Affordable Care Act (PPACA), Pub. L. No. 111-148, 124 Stat. § 2001 (2010).
18. KEY PROVISIONS, *supra* note 2, at 2; Pub. L. No. 111-148, 124 Stat. § 2502 (2010).
19. KEY PROVISIONS, *supra* note 2, at 2; Pub. L. No. 111-148, 124 Stat. § 2502 (2010).
20. *The Medicaid Program at a Glance*, *supra* note 14, at 2.
21. HENRY J. KAISER FAMILY FOUND., FACT SHEET: MEDICARE AND NONELDERLY PEOPLE WITH DISABILITIES, 1 (Sept. 2010), http://www.kff.org/medicare/upload/8100.pdf [hereinafter MEDICARE AND NONELDERLY PEOPLE WITH DISABILITIES].
22. *Id.*

disability.[23] Among those eligible for SSDI in 2009, nine percent had cancer.[24]

Those qualified to receive Medicare due to their disabilities still face tough financial situations. Over one-third (35%) of nonelderly beneficiaries lived on incomes below 100% of poverty in 2008, those living on $10,400 per year and two-thirds (67%) had incomes below twice the poverty level.[25] This combination can be problematic for beneficiaries who depend on Medicare, as research shows that the nonelderly disabled demographic have had more access and cost related issues than the elderly demographic in respect to Medicare coverage.[26] These issues are attributed to the complex nature of this patient mix, paying bills, finding doctors that accept Medicare and who know how to treat their disability.[27] Considering the volume of health problems and low incomes among Medicare's nonelderly disabled beneficiaries, "the needs of this population require careful attention in ongoing Medicare policy discussions."[28]

Among the many goals, healthcare reform aims to improve Medicare by helping people afford their drugs while making Medicare more fiscally secure.[29] Ideally, PPACA will alleviate the financial disparity faced by seventy percent of disabled Medicare beneficiaries who are enrolled in Part D, its prescription drug plan, or other stand-alone or Medicare drug plan.[30] Often times, individuals need access to costly medications but cannot afford them, falling into a gap known as the Medicare "doughnut hole."[31] Current reform aims to alleviate the out-of-pocket spending burden through phasing in coverage in the Part D coverage gap by 2020 through offering rebate checks and discounted drugs until the PPACA is fully implemented and the gap is eliminated.[32]

Other relevant provisions mandated by the healthcare reform include improving Medicare's coverage of an annual wellness visit, through a personalized prevention plan,

---

23. *Id.*
24. *Id.*
25. *Id.*
26. *Id.* at 2.
27. MEDICARE AND NONELDERLY PEOPLE WITH DISABILITIES, *supra* note 21, at 1-2.
28. *Id*. at 2.
29. FAMILIES USA, HELP IS ON THE WAY: 12 REASONS TO EMBRACE HEALTH REFORM, 6 (May 2010), http://www.familiesusa.org/assets/pdfs/health-reform/12-reasons-to-support-reform.pdf [hereinafter HELP IS ON THE WAY].
30. MEDICARE AND NONELDERLY PEOPLE WITH DISABILITIES, *supra* note 21, at 2
31. HELP IS ON THE WAY, *supra* note 29.
32. KEY PROVISIONS, *supra* note 2, at 2-3; Pub. L. No. 111-148, 124 Stat. §§ 3301-3315 (2010).

eliminating both cost-sharing, and deductibles for certain prevention services.[33]

## IV. PRE-EXISTING CONDITION INSURANCE PLAN

Included in the new healthcare reform law is a remedy for those who have been denied coverage from their private insurance due to pre-existing conditions.[34] The Pre-Existing Condition Insurance Plan (PCIP) is a nationwide program that includes a variety of available health benefits to treat a pre-existing condition, including prescription drugs, hospital, primary and specialty care.[35] Additionally, PCIP will not charge higher premiums because of medical conditions or base eligibility on income.[36] Its primary function is to act as a temporary high-risk pool serving those with pre-existing conditions until January 1, 2014.[37] Then, the Act is scheduled to officially prohibit insurers from determining coverage or pricing options based on health status.[38] At this point, a competitive marketplace called an Exchange is available, offering affordable insurance choices without pre-existing condition penalties.[39]

Each state program will vary because it has the choice to run the PCIP, or have it federally administered by the U.S. Department of Health and Human Services.[40] For example, the Illinois government elected to execute this program at the state level through the Illinois Department of Insurance and Public Health.[41] Premium prices are preset at $111 to $526, which is especially important for residents because currently there is no requirement that rate increases be actuarially justified in Illinois.[42]

Conversely, Indiana chose to let the federal government carry out their PCIP, and premiums will range from $310 to $662.[43] Unlike Illinois' state-run program, Indiana

---

33. KEY PROVISIONS, *supra* note 2, at 2-3; Pub. L. No. 111-148, 124 Stat. §§ 4103-4104 (2010).
34. *Pre-Existing Condition Insurance Plan*, HEALTHCARE.GOV (last visited Oct. 13, 2010), http://www.healthcare.gov/law/provisions/preexisting /about/index.html [hereinafter *PCIP*].
35. *Id.*
36. *Id.*
37. *See Illinois Pre-Existing Conditions Insurance Plan (IPXP)*, ILL. DEP'T OF INS. (last visited Apr. 22, 2011), http://www.insurance.illinois.gov/ipxp [hereinafter *IPXP*].
38. *Id.*
39. *PCIP*, *supra* note 34.
40. *Id.*
41. *Pre-Existing Condition Insurance Plan*: *Illinois*, HEALTHCARE.GOV (last visited Apr. 22, 2011), http://www.healthcare.gov/law/provisions/preexisting/states/il.html.
42. *Id*.
43. *Pre-Existing Condition Insurance Plan: Indiana*, HEALTHCARE.GOV (last visited Apr. 22, 2011),

separately maintains high-risk pool insurance, called the Indiana Comprehensive Health Insurance Association (ICHIA).[44] The ICHIA offers coverage for those individuals who are HIPAA eligible or otherwise unable to purchase private health insurance because of their medical conditions.[45] To qualify for HIPAA, the beneficiary must have eighteen months of continuous creditable coverage, used up state continuation coverage, ineligible for Medicare or Medicaid, and have no health insurance.[46] Accordingly, to be eligible for ICHIA individuals must be uninsurable, a resident for at least twelve months, and not be eligible for any other coverage.[47]

Children, under the age of nineteen with pre-existing conditions will benefit from PPACA's new stipulation much earlier than adults, who must wait until the January 1, 2014 phasing schedule.[48] As of September 23, 2010, six months after the Act was passed, children under nineteen cannot be denied coverage based on a pre-existing condition.[49] However, some insurance companies are responding by dropping their child-only policies.[50] Instead of complying with the new federal healthcare law, Anthem Blue Cross, Aetna Inc. and others decided to no longer have this option available for new enrollees in several states.[51] These insurers have attributed their removal of child-only policies due to huge and unexpected costs for covering children.[52] Companies also worry that parents might wait until their children get sick to purchase policies which could cause insurance companies to "flee the marketplace," and consequently create even more financial burden.[53] Experts estimated that this could affect 500,000 uninsured children

---

http://www.healthcare.gov/law/provisions/preexisting/states/in.html.

44. *Indiana Comprehensive Health Insurance Association (ICHIA)*, HEALTHINSURANCEINFO.NET (last visited Oct. 13, 2010), http://healthinsuranceinfo.net/ getinsured/indiana/individual-health-plans/indiana-comprehensive-health-insurance-association-ichia.

45. *Id.*

46. *Id.*

47. *Id.*

48. *The Patients' Bill of Rights: Ensuring Coverage for Consumers with Pre-Existing Conditions*, FAMILIES USA 1, 1 (Sept. 2010), http://www.familiesusa.org/health-reform-central/september-23/Pre-Existing-Conditions.pdf.

49. *Id.*

50. Duke Helfand, *Big Health Insurers to Stop Selling New Child-Only Policies*, L.A. TIMES (Sept. 21, 2010), *available at* http://articles.latimes.com/2010/sep/21/ business/la-fi-kids-health-insurance-20100921.

51. *Id.*

52. *Id.*

53. *Id.*

nationwide.[54]

## V. INCREASED INSURANCE PREMIUMS

Anthem Blue Cross has also raised the issue of the harsh realities of increased premium rates. Especially when they are unfairly determined, cancer patients are worried about budgeting for their private insurance costs. Shortly after Anthem dropped their child-only policies, it also threatened to raise premiums in California by thirty-nine percent.[55] Widespread criticism from federal officials, regulators, and even the President, temporarily prevented the premium increase, but Anthem later announced that new rate increases would occur between fourteen percent and twenty percent, and would take effect October 1, 2010.[56] This is arguably one of the biggest concerns amidst healthcare reformers. Anticipating this issue, steps to restrain premium hikes and protect consumers are included in PPACA, but most do not occur until 2014.[57]

Depending on the state, small group and individual policies are rising as much as twenty-five percent this year in response to new required benefits under the law.[58] But "[f]ederal officials counter with industry, academic and government studies showing that the changes, which take effect four years from now, are expected to raise premiums by only about 1 to 2 percent."[59] Some suggest choosing less expensive coverage or filing a complaint with the state if this occurs.[60] But for cancer patients, opting for minimum coverage or waiting for the state to remedy the issue is not an option. Where cost and time are of the essence, this is a potential set back for private insurance companies and beneficiaries alike as they cope with the burden of rising costs.

The PPACA attempts to safeguard against this possibility in many ways. While no specific limit is proscribed, several mechanisms are in place to make it difficult for companies to raise their premiums and holds insurance companies accountable for how

54. *Id.*
55. Duke Helfand, *Anthem Blue Cross is Allowed to Move Ahead with Rate Hikes*, L.A. TIMES, Aug. 26, 2010, *available at* http://www.latimes.com/business/la-fi-insure-rates-20100826,0,7225011.story.
56. *Id.*
57. Susan Jaffe, AARP, *New Health Care Law and Insurance Premiums*, HEALTH CARE LAW EXPLAINED (Sept. 27, 2010), http://www.aarp.org/health/health-care-reform/info-09-2010/hcr_explained_insurance_premiums.html.
58. *Id.*
59. *Id.*
60. *Id.*

their premium dollars are spent. First, eighty to eighty-five percent of premium dollars, depending on the market, are to be put towards medical care, with rebates to consumers if companies do not comply.[61] Next, grant money was allocated to forty-six states to "help improve the review of proposed health insurance premium increases, take action against insurers seeking unreasonable rate hikes, and ensure consumers receive value for their premium dollars."[62] Additional regulations require governmental review of "unreasonable" premium increases, and insurers with poor records will be posted publically for consumers.[63] Lastly, possible exclusion from exchanges will deter companies from raising premiums by blocking their access to millions of potential new customers.[64]

## VI. LIFETIME AND ANNUAL LIMITS ELIMINATED

The phasing out of annual and lifetime caps for all types of insurance plans began September 23, 2010, but it will be a gradual process scheduled to complete in 2014.[65] This provision ensures that individuals who are diagnosed with cancer or other costly health issues will not run out of coverage for "essential benefits," including emergency, preventive and laboratory services, chronic disease management, prescription drugs, maternity care and rehabilitative devices.[66] However, "nonessential benefits," like dental care, are still subject to annual and lifetime limits.[67] Individual plans will vary during the transition years, but, for cancer patients it is a reassuring step that they will not have to worry about maxing out their coverage options.[68] Additionally, on or before the first day of the new plan year, insurance companies must provide beneficiaries with a thirty-day grace period to reenroll if they have already reached their limit.[69] As a result, those who

61. HELP IS ON THE WAY, *supra* note 29, at 4.
62. *Health Insurance Premium Grants: Detailed State by State Summary of Proposed Activities*, HEALTHCARE.GOV (last accessed Apr. 22, 2011), http://www.healthcare.gov/news/factsheets/rateschart.html.
63. Jaffe, *supra* note 57.
64. *Id.*
65. *The Patients' Bill of Rights: Ending Annual and Lifetime Limits*, FAMILIES USA 1, 2 (last accessed Apr. 22, 2011), http://www.familiesusa.org/health-reform-central/september-23/Annual-and-Lifetime-Limits.pdf.
66. *Id.* at 1.
67. *Id.*
68. *Id.*
69. *Id.* at 2.

had their plans cancelled now have the option of rejoining their plan without being subject to annual or lifetime limits.[70]

In 2009, 14.3 million insured Americans spent twenty-five percent of their income on medical expenses.[71] In 2007, sixty-two percent of bankruptcies were attributable, in part, to medical causes.[72] Instead of being forced to pay out-of-pocket costs due to maxed out limits, cancer patients will not worry that the high costs of their chemotherapy, surgery, or treatments will end their coverage and send them into financial crisis. Nor will insurance companies be allowed to unfairly cancel coverage for patients when they need it most. Instead, "[r]escissions will be permitted only when there is clear and convincing evidence that an enrollee committed fraud, not when insurers simply want to avoid paying claims for enrollees who get sick."[73]

## VII. NEXT STEPS: PREVENTION AND ADVOCACY

Sixty percent of all cancer deaths are preventable with proven prevention and early detection strategies yet only four percent of allocated health care federal spending was dedicated to this cause.[74] The American Cancer Society's Cancer Action Network (ACS CAN) hopes that this investment will help to improve quality care for cancer patients and reduce cancer-associated deaths.[75] To account for these inadequacies, the PPACA has created two entities: The National Prevention, Health Promotion and Public Health Council (Council) and the Prevention and Public Health Fund (Fund).[76]

The Council will develop a strategy subject to federal review every five years beginning in March 2011 to coordinate and lead in wellness and integrating health care, establishing a nongovernmental Advisory Group to aid in policy and program recommendations, and report priorities annually to the President and Congress, beginning

70. *Id.*
71. HELP IS ON THE WAY, *supra* note 29, at 3.
72. *Id.*
73. *Id.* at 4.
74. *Affordable Care Act: Prevention Overview,* AM. CANCER SOC'Y - CANCER ACTION NETWORK (April 2010), http://www.acscan.org/pdf/healthcare/implementation/factsheets/hcr-prevention-overview.pdf [hereinafter *Prevention Overview*].
75. *Id.*
76. *Affordable Care Act: National Prevention Strategy,* AM. CANCER SOC'Y - CANCER ACTION NETWORK (April 2010), http://www.acscan.org/pdf/healthcare/implementation/factsheets/hcr-prevention-strategy.pdf.

July 2010 through January 2015.[77] Further, Congress has allocated $500 million annually to the Fund, and an additional $2 billion by 2010 and 2015, towards "prevention research, health screenings, community transformation grants, education and outreach campaigns, and immunization programs."[78] With the development of these two entities, there will hopefully be an increase in the number of people that actually receive their recommended prevention services since less than half of Americans currently take advantage of screenings and available resources.[79]

While many types of cancer are neither preventable nor predictable, there are still resources that individuals may utilize to reduce their risk with the help of PPACA. For example, being overweight and obese contributes to fourteen to twenty percent of all cancer deaths, particularly increasing the risk for several types of cancers including colon, esophagus, kidney, and breast cancer.[80] Proper nutrition is one of the easiest ways to begin a healthy lifestyle and PPACA includes a provision mandating restaurant chains with twenty or more locations to begin labeling their menus with caloric content.[81] Access to nutritional information greatly assists in making healthy food selections and efforts continue to advocate for restaurants with less than twenty locations.[82]

## VIII. FACING OPPOSITION AND REFORM CHALLENGES

Anticipating the passage of the PPACA, cancer patients quickly voiced their concerns about the possible negative impacts that could result from reform. Looking at neighboring Canadians, where cancer patients have to wait months for treatments and diagnostic scans, it is a realistic fear.[83] Widespread delays in the public health system can lead to unnecessary deaths, especially when timeliness is crucial to survival. For the eleven million people living with cancer in the United States today, healthcare reform can

77. *Id.*
78. *Id.*
79. *See Prevention Overview, supra* note 74.
80. *Affordable Care Act: Restaurant Menu Labeling,* AM. CANCER SOC'Y - CANCER ACTION NETWORK (April 2010), http://www.acscan.org/pdf/healthcare/implementation/factsheets/hcr-menu-labeling.pdf.
81. *Id.*
82. *Id.*
83. Myrna Ulfik, *Health Reform and Cancer*, THE WALL STREET JOURNAL (July 30, 2009), *available at* http://online.wsj.com/article/SB10001424052970204886304574306693989102298.html.

be "a matter of life and death" for afflicted individuals.[84]

The PPACA created a new non-governmental entity called the Patient-Centered Outcomes Research Institute that oversees comparative effectiveness research, in an effort to understand which health services accomplish the most benefits for the general population.[85] Yet, patients worry that the "patient-as-person" concept threatens to subside if treatments are now based on what is best for the majority instead of the individual.[86] There is also a concern that the expensive costs to develop new cancer techniques might deter cancer research if they do not meet the Institute's cost-benefit analysis. Consequently, funding and time for medical advancement might take a back seat to other items that are covered under the health bill, like preventative care.[87]

Also uneasy about possible consequences of PPACA, forty states have proposed anti-reform legislation that would counteract at least some portion of the new law.[88] Most of these attempt to challenge, modify, or repeal reform based on a variety of claims: constitutionality, unfair penalties, and mandatory enrollment.[89] However, ACS CAN continues to support PPACA because it will allow cancer patients, survivors, and their families to have full access to quality, affordable health care coverage.[90] Accordingly, ACS, ACS CAN, and other leading organizations jointly filed an amicus brief in federal appellate court to support those provisions of PPACA that are critical for patients with chronic diseases.[91] The amici curiae filed accompanied a case where a U.S. District Court Judge ruled the PPACA's "individual responsibility" or "individual mandate" requirement to be constitutional.[92]

---

84. *Id.*, Morales, *supra* note 13, at 6.

85. John Donnelly, *Comparative Effectiveness Research*, HEALTH AFFAIRS 1, 2 (Oct. 5, 2010), *available at* http://www.rwjf.org/healthpolicy/product.jsp?id=70208.

86. Ulfik, *supra* note 83.

87. *Id.*

88. Richard Cauchi, *State Legislation and Actions Challenging Certain Health Reforms, 2010*, NCSL (last accessed Apr. 21, 2011), http://www.ncsl.org/?tabid=18906.

89. *Id.*

90. *Delaware U.S. House Candidates Asked to State Positions on Cancer Issues*, AM. CANCER SOC'Y - CANCER ACTION NETWORK (last accessed Apr. 22, 2011), http://www.acscan.org/mediacenter/view/id/345.

91. Statement, AM. CANCER SOC'Y, *National Patient Groups File Amicus Brief in Federal Appellate Court Defending Patient Protections in the Affordable Care Act* (Jan. 21, 2011), *available at* www.ascan.org/mediacenter/view/id/370/.

92. *Id.*

## IX. OUTLOOK AND RESOURCES

Ultimately, organizations like the ACS hope that PPACA will improve the quality, cost, availability, and treatment for at-risk and cancer-afflicted individuals.[93] While cancer patients anxiously watch PPACA progress through the transition schedule, it is difficult to predict the end result with some provisions of the Act not scheduled to complete until 2020.[94] To help navigate through reform, the ACS developed a handbook outlining key provisions and how the PPACA may enhance the healthcare system for cancer patients.[95]

The ACS urges that implementation of the PPACA will ensure that beneficiaries no longer have to deal with the insurance issues prompted by a cancer diagnosis.[96] Among the 160 relevant provisions for cancer patients, PPACA is structured to prevent individuals from being denied coverage, charged more due to health status, facing annual or lifetime limits, or being forced to choose between "saving their life or their life savings because they lack access to affordable coverage."[97] While uncertainty and challenges lie ahead for both PPACCA support and cancer patients overall, it is undeniable that healthcare reform will have profound effects on the health and economic well being of every American.[98]

93. *What Does the Affordable Care Act Mean for People With Cancer?* AM. CANCER SOC'Y (last accessed Apr. 7, 2011), http://www.cancer.org/InYourArea/Eastern/AreaHighlights/cancernynj-news-aca-guide [hereinafter *What Does the Affordable Care Act Mean?*].

94. HELP IS ON THE WAY, *supra* note 30, at 1.

95. *See* AM. CANCER SOC'Y, THE AFFORDABLE CARE ACT: HOW IT HELPS PEOPLE WITH CANCER AND THEIR FAMILIES, 1 (2010), http://bit.ly/ckX0Qu.

96. *Id.*; *What Does the Affordable Care Act Mean?*, supra note 93.

97. *What Does the Affordable Care Act Mean?*, supra note 93.

98. HELP IS ON THE WAY, *supra* note 29, at 1.