

Affordable Care Act May Increase Access to Colon Cancer Care for Underserved Groups

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The Affordable Care Act (ACA) has led to increased guideline-concordant care for [colon cancer](#) among non-white patients, patients from rural areas, and patients from the most deprived neighborhoods in Pennsylvania, according to results presented at the [17th AACR Conference on the Science of Cancer Health Disparities in Racial/Ethnic Minorities and the Medically Underserved](#), held September 21-24, 2024.

“The ACA was the largest change to the health insurance system in the United States since the introduction of Medicare and Medicaid in the 1960s, but there is limited evidence on how it affected cancer treatment for different patient populations,” explained Sriya Kudaravalli, a third-year medical student at the University of Pittsburgh School of Medicine, who presented the study. “We were interested in examining changes in receipt of guideline-concordant cancer treatment across various racial and socioeconomic groups after ACA insurance expansions. Understanding these changes can inform future policies to address treatment disparities.”

Kudaravalli explained that receiving guideline-concordant care is associated with improved cancer outcomes, including survival, and that insurance access is an important determinant of receiving guideline-concordant care. In the study, Kudaravalli and colleagues defined guideline-concordant care for Stage 3 colon cancer as the use of adjuvant chemotherapy and the resection of affected regional lymph nodes based on medical literature and the criteria established by the National Comprehensive Cancer Network. The retrospective study then examined data between 2010 and 2019 from the Pennsylvania Cancer Registry for 3,290 patients aged 26-64 who were diagnosed with stage 3 colon cancer. The year the main insurance expansions under the ACA were implemented, 2014, served as the cutoff between pre- and post-ACA.

They compared the receipt of guideline-concordant care over the two time periods across several socioeconomic factors including, age, sex, race/ethnicity, insurance status, community type, and area deprivation index (ADI, a measurement developed by researchers at the University of Wisconsin to rank neighborhoods by socioeconomic disadvantage based on variables related to

income, education, employment, and housing quality). In their study, Kudaravalli and colleagues grouped ADI scores into quartiles, with ADI quartile 1 representing the least disadvantaged neighborhoods and ADI quartile 4 representing the most disadvantaged neighborhoods.

About two-thirds of patients in the sample had private insurance (63.7%), 10.5% were covered by Medicare, 11.9% by Medicaid, and 13.8% were either uninsured or had an insurance status that was unknown or from another source. The study population included mostly males (54.5%), non-Hispanic whites (79.8%), and people living in urban areas (87.9%). About 4% were non-Hispanic Blacks and 3.6% were Hispanics with 7.5% living in large towns, 2.5% in small towns, and 2.1% in rural areas. Each of these variables was balanced pre- and post-ACA based on standardized mean differences.

Across the entire study period, 82.8% of patients received guideline-concordant care. However, post-ACA, the receipt of guideline-concordant care increased on average per year for non-white patients (7.8%), those in rural areas (7.7%), and those in ADI quartile 4 neighborhoods (3.5%).

“Implementation of the ACA is associated with an increase in the quality of colon cancer care for underserved groups,” Kudaravalli said. “Availability of insurance coverage is important for reducing disparities in cancer care and outcomes. States that haven’t yet expanded Medicaid are missing an opportunity to improve access to guideline-concordant treatment for cancer.”

Kudaravalli said they plan to also examine the effect of the ACA on receipt of guideline-concordant care for prostate cancer and lung cancer.

Limitations of this study include the fact that patients with missing variables who were excluded from the final results tended to be from underserved groups, which could have decreased the size of the effect. Additionally, the data comes from a single state.

The research was supported by the Agency for Healthcare Research and Quality. Kudaravalli reports no conflicts of interest.

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