Medicaid Financing Changes Could Increase State Costs and Reduce Health Coverage for Cancer Patients

Medicaid is the health insurance safety-net program for lower income Americans. Currently, 64 million people[1] – many of whom are cancer patients and survivors – rely on Medicaid for affordable health care coverage.

The Medicaid program is administered by states and jointly financed by states and the federal government. Federal funding – known as the federal medical assistance percentage (FMAP) – is based on both the state's per capita (per individual) personal income and the national average per capita personal income.

Proposals to change the way Medicaid is financed are now being discussed in Congress, including changing the current payment structure from a federal-state match to either a block grant or per capita cap approach. Under a Medicaid block grant arrangement, the federal government would make fixed payments to states rather than payments based on the state's per capita income. Similarly, a Medicaid per capita cap would allow the federal government to set a cap on how much it would reimburse the state per enrollee. Both block granting and capping Medicaid reimbursement costs per enrollee raise serious issues about the impact on the program's ability to deliver affordable health care, particularly for those suffering from serious illnesses such as cancer.

Increasing Financial Risk and Unanticipated Medicaid Costs to States

The fixed payments associated with block grants are estimated in advance and based on the state's *projected* health care costs using current year expenditures. Per capita caps are based on *historical* spending per enrollee and a pre-determined growth rate. Both block grants and per capita caps would likely favor higher-income states that tend to spend more Medicaid dollars, leaving lower-income states to pay for a greater portion of program costs than under the federal match.[2] This would include states such as Utah, Virginia, Texas, and Georgia, which spend less on Medicaid than some other high-income states. Additionally, if projected costs are more than estimated in the prior year, states are left paying a greater portion of the bill than they would under a federal match, putting pressure on already tight state budgets.

Did you know?
The CBO found that block granting Medicaid or applying per capita caps would significantly **reduce revenues to states** and lead to an estimated **three quarters** of people losing Medicaid coverage.

*Congressional Budget Office. Impose caps on federal spending for Medicaid. *Budget Options*. Published December 8, 2016. https://www.cbo.gov/budget-options /2016/ 52229.

Health care costs are often greater than projected, as increases in medical expenses and health coverage needs are difficult to predict in advance. For example, a new breakthrough drug, an exciting new cancer treatment, or an unexpected health care emergency (e.g., Zika virus) could cause health care costs to increase significantly, leaving states with a larger share of unanticipated Medicaid costs. Additionally, economic downturns or major state disasters (e.g., Tennessee wildfires) could create greater need for Medicaid coverage among state residents. Currently, when these unexpected incidents occur the federal match automatically adjusts to cover additional state spending to meet state beneficiary enrollment and needs. Under a block grant arrangement, however, fixed payments remain the same, leaving the state and its beneficiaries financially vulnerable when they need help the most.

Per capita caps may be slightly more responsive to unexpected enrollment increases, but are still unable to respond to unexpected medical cost growth, which can be of particular concern to cancer patients. For example, if a Medicaid patient is diagnosed with stage III breast cancer – which studies have shown could cost between $130,000 to $160,000 per year for chemotherapy, radiation, hormone therapy, and surgery/lumpectomy[3,4] – and

the federal per capita cap for that state Medicaid enrollee is only $6,500, the state and the enrollee could be responsible for upwards of $153,000 for a year's worth of treatment (depending on prices negotiated by the state). If the federal funds are exhausted, states may simply stop providing or limit services until the next year's block grant or per capita cap money becomes available, leaving many beneficiaries – including those with cancer – uninsured, just as uninsured rates are at their lowest.

WHAT COULD STATES EXPECT FROM A BLOCK GRANT FUNDING STRUCTURE?

Puerto Rico currently receives a block grant from the federal government for its Medicaid program and receives reimbursement rates that are nearly half those of mainland states.* Prior to increased funding levels received under the current law, federal Medicaid funds only covered 16 percent of Puerto Rico's planned annual Medicaid expenditures.^ According to Puerto Rico officials, this allotment was often exhausted during the first quarter of the federal fiscal year, leaving the territory to pay for the Medicaid program for the rest of the year.^ This has helped contribute to a breakdown of Puerto Rico's health care system, including hospital closures and physician's fleeing the territory, just as the Zika virus has wreaked havoc on their communities.*

*Rullan J. Understanding Puerto Rico's healthcare collapse. Morning Consult. Published June 20, 2016. Accessed December 2016. https://morningconsult.com/opinions/understanding-puerto-ricos-healthcare-collapse/.
^United States Government Accountability Office. Medicaid and CHIP: Increased funding in U.S. Territories merits improved program integrity efforts. Published April 2016. Accessed December 2016. http://gao.gov/assets/680/676438.pdf.

Finally, although unlikely, Congress could decide to make the Medicaid block grant or per capita cap discretionary funding; therefore, opening it to the congressional budget process. Allowing the Medicaid entitlement program to be discretionary could have devastating effects on the program, state budgets, and enrollees, including low-income residents with cancer. If Medicaid becomes discretionary, Congress could choose to tap into the block grant or per capita cap allotment to pay for other programs or activities (e.g., infrastructure or national defense), leaving the state and its low-income residents responsible for greater costs than initially anticipated.

Shifts Costs to Providers and Beneficiaries

Greatly reducing federal funding levels in Medicaid and increasing state flexibility to determine eligibility levels would not necessarily reduce underlying program costs. Instead, it is likely that reduced federal financial support through a block grant or per capita cap would result in a shift of additional costs to health systems, providers, and enrollees through uncompensated care. Many public hospitals, children's hospitals, rural providers, and federally qualified health centers (FQHC) make up the "safety net" for low-income individuals and families battling cancer. These health systems greatly rely on Medicaid revenue to provide services. For example, FQHCs serve over 24 million people nationally, the majority of whom are low-income (71 percent) and nearly 50 percent are dependent on Medicaid.[5] Medicaid makes up over 40 percent of revenue for FQHCs, the largest portion of revenue received by these safety-net centers.[6] Without current federal and state funding levels, hospital systems, FQHCs, and providers may be pressured into not accepting Medicaid or uninsured patients due to lower reimbursement rates and greater uncompensated care costs. Not only would this mean less access for Medicaid beneficiaries and the uninsured, but it could also hinder recent efforts to improve the quality of health care.

Restricting Eligibility, Enrollment, or Benefits Guaranteed by Medicaid

Under current law, the federal government sets minimum Medicaid eligibility standards to which states must adhere, but allows the states flexibility to expand beyond those minimum requirements or try innovative approaches to their Medicaid programs through a waiver process. Block grants and per capita caps claim to provide states greater flexibility in administering state Medicaid programs. Unfortunately, this flexibility with reduced federal funding will likely result in restrictions in eligibility, enrollment, and/or benefits and services for Medicaid enrollees. Because some states may see a significant reduction in their overall federal funding under a block grant or per capita cap, they may be forced to use other cost-saving measures that are otherwise prohibited

by the current Medicaid program, including enrollment freezes, waiting lists, withholding certain medical benefits, and increased cost sharing for beneficiaries. Multiple studies have shown that individuals are less likely to seek health services, including life-saving preventive screenings (e.g., mammograms and colonoscopies), when they must pay for those services out-of-pocket.[7,8,9] Deterring a low-income person from care could result in higher costs later, which the state may have to bear. For a person with cancer, enrollment freezes, waiting lists, and out-of-pocket cost sharing could mean a later-stage diagnosis when treatment costs are higher and survival is less likely. Ultimately, block grants and capping Medicaid reimbursement costs per enrollee raise serious issues about the program's ability to offer low-income Americans quality, affordable, and comprehensive health care coverage, particularly for those suffering from cancer.

The American Cancer Society Cancer Action Network's (ACS CAN) Position

The American Cancer Society Cancer Action Network (ACS CAN) has serious concerns about the potential impact of block granting Medicaid or capping federal funds per enrollee. By unraveling the "safety net," the truly vulnerable populations, such as those fighting cancer and recent cancer survivors, will be negatively impacted. We will continue to work to ensure that cancer patients, survivors, and those at risk for cancer have comprehensive, quality health insurance coverage.

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