Medicaid Funding Caps are a Barrier to Care for Cancer Patients & Survivors

Medicaid is the primary health insurance program for Americans with limited incomes, offering quality, affordable, and comprehensive health care coverage to over 84 million people[1] – a number that has increased as more people relied on this crucial program during the Covid-19-related public health emergency. Many people with cancer, those who will be diagnosed with cancer, and cancer survivors use Medicaid to access needed medical care. Having health insurance through Medicaid helps Americans stay healthy so they can maintain employment, care for their families, and pay their bills. The Medicaid program also helps communities, hospitals, schools, and the economy thrive.

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. The FMAP funding structure adjusts if a state experiences increases in Medicaid enrollment during economic downturns or natural disasters, as well as if health care costs increase. The current federal funding structure is responsive if and/or when these changes occur, which helps protect state budgets.

Proposals to change the way Medicaid is financed have been considered by the federal government for decades. Some federal policymakers view these types of structural funding changes as a way to reduce the federal budget rather than to improve the program. 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 per capita cap would allow the federal government to cap how much it would reimburse the state per enrollee or enrollee group. Both approaches would result in limited funding for Medicaid, raising serious concerns about the ability of the program to deliver quality, affordable health care, particularly for those suffering from serious illnesses such as cancer.

The previous Administration encouraged states to apply for 1115 Research and Demonstration Waivers to change the funding structure from a federal-state match to either a block grant or per capita cap. No state ultimately implemented this type of waiver. The American Cancer Society Cancer Action Network (ACS CAN) strongly opposes changing the financing for Medicaid to a block grant or per capita cap.

Did you know?
In 2017, the Congressional Budget Office estimated that block granting Medicaid or applying per capita caps would significantly reduce revenue 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.

Increasing Financial Risk and Unanticipated Medicaid Costs to States

Health care costs are often greater than projected, because medical expenses and health coverage needs are difficult to

predict. For example, a new breakthrough drug, an exciting new cancer treatment, or an unexpected health care emergency (e.g., Covid-19) 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., floods or hurricanes) could create greater need for Medicaid coverage among state residents. Currently, when these unexpected incidents occur the FMAP funding structure 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 financially vulnerable and eligible enrollees without Medicaid coverage when they need help the most.

Per capita caps are also unable to respond to unexpected medical cost growth. If the federal funds are exhausted and states do not have enough in their own budgets to adjust, states may simply stop providing or limit benefits and services until the next year's funds become available, leaving many beneficiaries – including those with cancer and cancer survivors – uninsured.

Restricting Eligibility, Enrollment, or Benefits Guaranteed by Medicaid

WHAT THE PUBLIC THINKS ABOUT BLOCK GRANTS

Seven in ten (71%) prefer keeping Medicaid funding largely as it is today while far fewer (26%) support changing Medicaid to "limit what the federal government spends over time and allowing states more flexibility in determining which groups of people and what services are covered under the program." The bottom-line is that the majority of people do not support block granting Medicaid.

*Data provided by Perry Undem Medicaid 2020 Polling for ACS CAN.

Block grants and per capita caps claim to provide states flexibility in administering state Medicaid programs. Unfortunately, this flexibility coupled with reduced federal funding will likely result in restrictions in eligibility, enrollment, and/or benefits and services for Medicaid enrollees rather than improved care. Because states may see a significant reduction in their overall federal funding under capped funding, they may be forced to use other cost-saving measures. These measures could include enrollment freezes, waiting lists, withholding certain medical benefits or services, closed prescription drug formularies, and increased cost sharing for beneficiaries. Enrollment freezes and waiting lists mean some Medicaid enrollees will not have the opportunity to receive early detection services that could prevent certain cancers from developing, diagnose cancers at an earlier stage, or provide timely and appropriate access to cancer treatments, diminishing their odds of survival. Additionally, multiple studies have shown that individuals are less likely to seek health services, including lifesaving preventive screenings when they must pay for those services out-of-pocket.[2] Deterring a low-income person from care could result in higher costs later, which the state may have to bear.

Shifts Costs to Providers and Beneficiaries

Capping funding does nothing to reduce the need for health care services. Capping funding would simply shift additional costs to health systems, providers, and enrollees through uncompensated care. Many public hospitals, children's hospitals, rural providers, and community health centers make up the "safety net" for low-income individuals and families battling cancer. These health systems greatly rely on Medicaid revenue

to provide services. Reduced federal and state funding could result in hospital systems, community health centers, and providers reducing the number of Medicaid patients or uninsured patients they treat due to lower reimbursement rates and greater uncompensated care costs. Not only would this mean less access for Medicaid enrollees and the uninsured, but it could also hinder the administration and Congress' efforts to improve the quality of health care.

The American Cancer Society Cancer Action Network's Position

ACS CAN opposes block grants and per capita caps in Medicaid. Capping funding and allowing states to impose changes that could prevent or disrupt care will seriously hinder the program's ability to serve its beneficiaries in a way that allows them to access quality, affordable, comprehensive health care. This will particularly affect people living with complex and expensive conditions like cancer. We will continue to work to ensure that people with cancer, survivors, and those at risk for cancer have quality, affordable, and comprehensive health insurance coverage.

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[1] Centers for Medicare and Medicaid Services. October 2022 Medicaid & CHIP Enrollment Data Highlights. Accessed February 2023. https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html.
[2] Solanki G, Schauffler HH, Miller LS. The direct and indirect effects of cost sharing on the use of preventive services. Health Services Research. 2000; 34:1331-50.