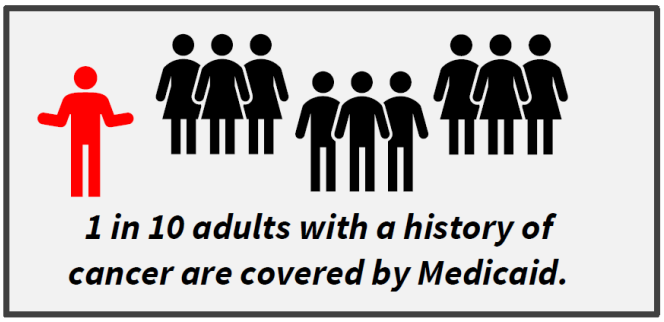
The Facts About Medicaid and Cancer

Medicaid provides essential health coverage to millions of lower income individuals in the U.S. It is funded jointly by the federal and state governments. Because access to health insurance coverage is a key factor in preventing, catching and treating cancer, the American Cancer Society Cancer Action Network (ACS CAN) encourages policymakers to ensure that this vital health coverage program is available to people who need it, particularly those with cancer or in need of cancer screenings and preventive services. As Congress and the administration consider changes to federal spending that could severely cut Medicaid funding and impact state budgets, some facts are getting lost in the debate.

Fact: Medicaid is vital health coverage to many people.

Medicaid is essential health insurance for children, seniors in nursing homes, people with disabilities, veterans and other hard-working families who can't afford health insurance and aren't offered coverage through their jobs. Medicaid covers:

- 1 in 10 adults with a history of cancer[1]
- 1 in 3 children diagnosed with cancer[2]
- 2 in 5 of all U.S. births[3]
- 2 in 5 children
- 1 in 6 non-elderly adults
- 2 in 5 non-elderly adults with a disability
- 3 in 5 nursing facility residents



Fact: Increasing access to Medicaid saves lives.

By increasing access to affordable health insurance Medicaid improves cancer outcomes in many important ways:

- **Higher uptake of cancer screenings and preventive services** – so that cancer is caught earlier when it's easier to treat, and cancer risk factors and comorbidities can be better managed
  - Colorectal and breast cancer screenings among low-income adults rose in Medicaid expansion states compared to non-expansion states.[4]
- **Earlier stage cancer diagnoses**, when prognosis is better
  - After Kentucky expanded Medicaid, fewer breast cancer patients were uninsured, and more breast cancers were caught in early stages (I and II).[5]
- **Increased likelihood that cancer patients receive timely treatment according to guidelines**
  - Medicaid expansion was associated with an increase in the 2-year survival rate for patients with HR-negative, HER2-positive breast cancer, an aggressive cancer type for which prognosis largely depends on access to effective treatment.[6]
- **Improved cancer survival rates and reduces cancer mortality**
  - Medicaid expansion was associated with an increase in survival from cancer at 2 years post diagnosis, and the increase was most prominent among non-Hispanic Blacks in rural areas, highlighting how expanding Medicaid can reduce health disparities.[7]

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Fact: Medicaid funding cuts will negatively impact people with cancer.

On February 25, 2025, the U.S. House of Representatives passed its budget blueprint, which included instructions to the committee with jurisdiction over Medicaid to find $880 billion in funding cuts over a decade. Many sources say that this will amount to cutting about *one-third* of federal spending on Medicaid.[8] The Congressional Budget Office (official, bipartisan analysts for Congress) confirmed this in a March 5th report, as reported by NBCNews.

It is not possible to cut that much spending in Medicaid without impacting the coverage and health care for the millions of people enrolled in the program, including patients with serious conditions like cancer who need treatments that are extremely difficult to afford without coverage. All of the Medicaid cuts that policymakers have discussed recently would result in states having to contribute more to the program, reduce enrollment in Medicaid and/or cut the services Medicaid provides. This would leave people uninsured and unable to access cancer treatment or lifesaving screening and preventive services. Services that would be on the chopping block are coverage for prescription drugs or preventive services like cancer screenings. Cuts to Medicaid have real consequences for cancer patients, survivors and all those at risk of developing the disease.

Fact: There is no evidence of "fraud, waste and abuse" among Medicaid beneficiaries.

Every year, the Department of Justice and the Department of Health and Human Services Office of the Inspector General publish a report on their efforts to hold to account bad actors in Medicare, Medicaid, and other Federal health care programs. The December 2024 report lists examples of the different kinds of fraud against Medicaid (and Medicare) that the agencies have identified and prosecuted. ***No enrollees are in the listing.*** For more information, please see The Truth About Fraud Against Medicaid and The Truth About Waste and Abuse in Medicaid.

There is simply no way to cut this much from Medicaid - 1/3 of the program over 10 years - without cutting critical health care services for millions. Reports show almost all of the fraud, waste and abuse in the system comes from the billing and payment processes and skyrocketing health care prices - not from those who get their health coverage with Medicaid. Rushing these cuts from Medicaid won't address these problems and it won't bring down costs for families. It's just taking health care away from people who can least afford it - like cancer patients, seniors in nursing homes, children and people with disabilities.

Fact: States have tried to implement work requirements in Medicaid in the past – and they don't work.

Empirical evidence shows that requiring Medicaid enrollees to prove they are working does not increase the number of people working, but it does take eligible people off the rolls by requiring additional paperwork and effort to remain covered.

Only two states, Arkansas and Georgia, have ever fully implemented a Medicaid work requirement, and neither state saw the success they anticipated. Arkansas instituted a work requirement from June 2018 to March 2019, and about 25% of those subject to the requirement lost coverage – some of whom were working, or should have been exempt. Research indicates that enrollees in Arkansas were unaware of or confused by the new work and reporting requirements, and they did not provide an additional incentive to work.[9] After legal challenges and high administrative costs, the state opted to stop their work requirement.

Georgia's Pathways to Coverage program launched in July 2023. This initiative imposes stringent work or community engagement requirements, mandating participants to document at least 80 hours per month of qualifying activities—such as employment, job training, education, or volunteering—to maintain their Medicaid benefits.[10] The program has

encountered significant obstacles, including high administrative costs: the program has already cost nearly $26 million to implement, with 90% of funding directed toward administrative expenses, including application processing and work requirement verification.[11] These costs divert resources from direct health care services. It is also clear that the work requirement creates a barrier to enrolling in Medicaid and accessing care. By mid-December 2023, only 2,344 of the estimated 345,000 individuals eligible were actively enrolled in the program, far short of the state's goal of 100,000 participants in its first year.[12] Participants face substantial challenges navigating the enrollment process, including technical glitches, non-functional websites, and unclear guidance on documentation. These hurdles discourage many people who are eligible and need Medicaid from applying or maintaining their benefits.

Evidence from these programs shows that work requirements not only fail to improve employment outcomes but also disproportionately harm low-income individuals by creating unnecessary barriers to critical health coverage. Several courts have ruled that Medicaid work requirements are unlawful because they decrease access to Medicaid coverage.

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[1] 2023 National Health Interview Survey data. Analysis performed by American Cancer Society Health Research Services, December 2024.
[2] Ji X, Hu X, Castellino SM, Mertens AC, Yabroff KR, Han X. Narrowing Insurance Disparities Among Children and Adolescents With Cancer Following the Affordable Care Act. JNCI Cancer Spectr. 2022 Jan 5;6(1):pkac006. doi: 10.1093/jncics/pkac006. PMID: 35699500; PMCID: PMC8877169.
[3] Source for remaining bullets in this paragraph: Center for Budget and Policy Priorities. Medicaid Threats in the Upcoming Congress. December 13, 2024. https://www.cbpp.org/research/health/medicaid-threats-in-the-upcoming-congress
[4] Fedewa SA, Yabroff KR, Smith RA, Goding Sauer A, Han X, Jemal A. Changes in Breast and Colorectal Cancer Screening After Medicaid Expansion Under the Affordable Care Act. Am J Prev Med. 2019 Jul;57(1):3-12. doi: 10.1016/j.amepre.2019.02.015. Epub 2019 May 22. PMID: 31128952.
[5] N. Ajkay *et al.* Early Impact of Medicaid expansion and quality of breast cancer care in Kentucky. J Am Coll Surg (2018)
[6] Shi KS, Ji X, Jiang C, et al. Association of Medicaid Expansion With Timely Receipt of Treatment and Survival Among Patients With HR-Negative, HER2-Positive Breast Cancer. *J Natl Compr Canc Netw*. 2024;22(9):593-599. doi:10.6004/jnccn.2024.7041.
[7] Han X, Zhao J, Yabroff KR, Johnson CJ, Jemal A. Association Between Medicaid Expansion Under the Affordable Care Act and Survival Among Newly Diagnosed Cancer Patients. *J Natl Cancer Inst*. 2022;114(8):1176-1185. doi:10.1093/jnci/djac077.
[8] Georgetown Center for Children and Families. The Truth about Waste and Abuse in Medicaid. January 27, 2025. The Truth about Waste and Abuse in Medicaid – Center For Children and Families.
[9] Sommers, Benjamin, et al. Medicaid Work Requirements in Arkansas: Two-Year Impacts on Coverage, Employment, and Affordability of Care. Health Affairs. 2020 Sep;39(9):1522-1530. doi: 10.1377/hlthaff.2020.00538.
[10] Musumeci, M., Leiser, E., & Douglas, M. (2024, September 11). Few Georgians are enrolled in the state's Medicaid work requirement program. The Commonwealth Fund. Retrieved from https://www.commonwealthfund.org/blog/2024/few-georgians-are-enrolled-states-medicaid-work-requirement-program.
[11] Id.
[12] Id.