Overview

Medicaid is a critical source of coverage for people living with and at risk for HIV and hepatitis. As the single largest payer for HIV care, Medicaid provides coverage for 42% of people living with HIV, a significant increase since the Affordable Care Act’s (ACA’s) Medicaid expansion went into effect.1 As Congress debates potential changes to the ACA and the Medicaid program, it is critical to ensure people living with HIV and hepatitis have continued access to affordable and comprehensive insurance coverage.

Recent proposals to change federal Medicaid funding to a block grant or per capita cap would reduce state Medicaid programs’ ability to continue current coverage levels, much less expand or respond to emerging public health threats. This brief outlines the impact such proposals would have on HIV and hepatitis.

This issue brief is part of a series NASTAD is publishing highlighting the impact of emerging health policy proposals on HIV and hepatitis prevention, care, and treatment. For questions, please contact Amy Killelea or Sean Dickson.


Block Grants and Per Capita Caps Would Hamper States’ Abilities to Respond to Public Health Emergencies, Including:

- The opioid epidemic and expansion of access to substance use treatment and naloxone
- Advances in treatment, including direct acting anti-viral curative treatment for hepatitis C and emerging HIV treatment breakthroughs

Proposed Cuts to Medicaid

Block Grant

Under a block grant, states would receive a pre-defined, fixed amount of federal Medicaid funding. Since the federal funds available to states would be fixed amounts, they would grow at a predictable, formula-driven rate from one year to the next.2

2 Rosenbaum, S., Schmucker, S., Rothenburg, S., Gunsalus, R., What Would Block Grants or Limits on Per Capita Spending Mean for Medicaid?, The
If Congress does not appropriate funding increases, the fixed amount of funding would stay the same, as a block grant formula does not automatically consider population growth or actual health care costs for Medicaid recipients.3

With fixed federal funding, states will be responsible for all Medicaid costs in excess of the cap, accomplished by either increasing their Medicaid spending, making considerable cutbacks, or both. Cutbacks would mean reduced access to care by limiting eligibility, offering fewer covered services, lowering provider payments, or increasing cost-sharing for patients.4 Additionally, some states may be forced to freeze new enrollment, preventing some individuals who meet eligibility criteria from enrolling in Medicaid. According to a 2012 Urban Institute analysis of a previous block grant proposal, the block granting of Medicaid could lead to 14 million to 20 million Medicaid beneficiaries losing coverage.5

**Per Capita Cap**

Like a block grant, a per capita cap is intended to provide considerable federal budgetary savings over time. This is achieved by capping federal funding at a specific amount per person instead of a specific amount for the overall state. Per enrollee caps could be calculated for all enrollees or varying caps could be determined based on broad Medicaid coverage groups (i.e., children, elderly, people with disabilities, and other adults).6 To achieve further budgetary savings, funding levels for per enrollee spending would increase at a reduced and slower rate than anticipated under current Medicaid law. Additionally, even though this method adjusts for increases in enrollment, it would still not address increases in health costs or new medical breakthroughs which would cause spending per enrollee to increase.7 States would have to bear 100% of the medical costs for beneficiaries once those costs exceeded the per-beneficiary caps.8

**Block Grants and Per Capita Caps Limit Access and Coverage and Hinder States’ Ability to Respond to Public Health Emergencies**

Under a block grant and per capita cap, federal funding does not adjust to account for economic downturns, the cost of a disease outbreak, or the discovery of a new treatment – leaving states responsible for the cost and forced to cut benefits and eligibility. Given current budget realities at the state level, commencement of either of these

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3 Rosenbaum, supra note 2.
4 Rosenbaum, supra note 2.
7 Rosenbaum, supra note 2.
federal Medicaid funding structures will leave states with little choice but to make painful cuts to their programs, harming vulnerable populations who depend on Medicaid, including people living with HIV and hepatitis.

**Benefits Cuts**

If a state were to cut back on benefits, people living with HIV and hepatitis in both the Medicaid expansion and traditional eligibility categories could lose access to a comprehensive set of benefits that limit out-of-pocket burdens. Instituting a block grant or per capita caps would likely leave people living with HIV and hepatitis facing large financial burdens because state governments may select benefit designs that limit access to expensive HIV and HCV treatments, resulting in increased cost sharing and utilization management. Additionally, cuts to optional Medicaid services will hurt people living with HIV, hepatitis, and other chronic conditions the most as these populations depend on additional care and support services, such as case management, to help manage their conditions.

**Public Health Emergencies**

The loss of federal matching funds would create a significant strain on state budgets in years when overall or per beneficiary costs rise faster than expected. For states at risk of an HIV outbreak because of the opioid epidemic, similar to that experienced by Indiana in 2015, the state would bear these costs once they exceeded the cap amount.9

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9 Park, supra note 6.


The map below depicts the 26 states that have at least one of the 220 counties that the Centers for Disease Control and Prevention (CDC) identified as at-risk or vulnerable to an HIV/HCV outbreak due to injection drug use.10

**States at High Risk of HIV/HCV Outbreak due to Injection Drug Use**

In addition, the ability of states to respond to new health innovations, including the recent curative treatments for hepatitis C, would be severely limited under a block grant or per capita cap structure.11

**Eligibility Cuts**

It is very likely that as federal Medicaid support is reduced, states would be allowed to make cuts to eligibility and coverage. People living with HIV and hepatitis who gained access to Medicaid through expansion or 1115 waivers are at greatest risk for losing coverage, particularly when per capita caps

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and block grants are coupled with phasing out Medicaid expansion for enrollees who experience a break in coverage.

In short, changes to the structure of the Medicaid program would be devastating to people living with HIV and hepatitis and would curb or even reverse the progress and momentum behind plans to end the HIV and hepatitis epidemics.

Rolling Back Medicaid Access Will Have a Devastating Impact on Progress to End the HIV and Hepatitis Epidemics

Over the past several years, states and cities have launched ambitious – but ultimately achievable – campaigns to end new HIV and hepatitis infections. These “Ending the Epidemic” plans marshal public health tools and infrastructure and scientific and technological advances to scale up prevention and treatment, particularly for populations most impacted by HIV and hepatitis. Importantly, these plans have relied on partnerships with Medicaid, with the recognition that we cannot end an epidemic with safety net programs and resources alone. Moving to a block grant or per capita cap would hinder our ability to end HIV and hepatitis by:

- Reducing coverage and benefits that help PLWH achieve viral suppression and thereby reduce HIV transmission
- Reducing the opportunity to cure hepatitis C among Medicaid beneficiaries
- Weakening states’ capacity to respond to public health emergencies
- Leaving states with tied hands when health care cost rise due to new drugs and treatments