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Editorial

A First Look at Medicaid Expansion's Impact on Cancer Mortality Rates

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The Affordable Care Act was passed in 2010 with the goal of improving access to health care in the United States (1). A key provision was expanding states' Medicaid programs to every adult with household incomes up to 138% of the federal poverty level in 2014, and the federal government provided initial funds to do so. There were 6 states that jump-started the Medicaid expansion in 2010-2011 to some or all low-income populations (2). In 2012, the tides turned, and the Supreme Court issued a decision giving states the option to expand their Medicaid programs. In 2014, 21 additional states chose to expand their Medicaid eligibility, and 10 more states did so between the years 2015 and 2020. As of 2021, there are 14 states that have not yet implemented Medicaid expansion. We know that when someone has insurance their chances of being diagnosed at an early stage and surviving cancer are improved (3), but how does a sweeping policy such as Medicaid expansion affect an ultimate cancer endpoint: death?

In this issue of the Journal, Barnes and colleagues (4) examine trends in cancer mortality rates among the 6 jump-starter states (California, Connecticut, Washington DC, Minnesota, New Jersey, and Washington) compared with the 19 states that had not expanded Medicaid as of December 2016. Most states that expanded Medicaid in 2014 were set aside from the primary analyses to assure sufficient power to detect changes because only mortality data through 2016 were available. The authors used death certificate data to compare cancer mortality rates among non-elderly adults (20-64 years) in these 2 groups of states (6 jump-starting and 19 nonexpansion states) across 2 time periods. Data from 2007-2009 were used to measure the preexpansion period, and data from 2012-2016 were used to measure the postexpansion period. Cancer mortality rates declined in both groups of states, but the decline among jump-starting states was steeper at 7.7% (from 72.5 to 64.8 per 100 000) compared with the 6.3% (from 85.7 to 79.4 per 100 000) decline in nonexpansion states. This translated to a 1.4% difference-in-differences, indicating the net decrease associated with the early Medicaid expansion, in unadjusted analyses and 3.1% in adjusted analyses.

What makes this study (4) important is that it provides the first look at Medicaid expansion's influence on cancer mortality rates, a key summary measure of the progress against cancer. Cancer mortality rates are a measure of the number of people who die from cancer within a given population per year (eg, per 100 000 person-years), and they are a function of incidence and survival (5). A growing number of studies examine the influence of Medicaid expansion along the cancer continuum, including risk factors (eg, smoking), screening, early detection, stage at diagnosis, receipt of treatment, and survival among people diagnosed with cancer (6,7). Previous research has shown that Medicaid expansion was associated with a faster increase of insurance coverage and shifts to early stage at diagnosis among people newly diagnosed with cancer. Survival has improved at a faster pace too (8-10). For example, among people diagnosed with cancer who lived in Medicaid expansion states, 1-year survival rates improved by 0.4% more than in nonexpansion states, with greater improvements observed among patients living in the poorest areas (10). There have also been improvements in care affordability among cancer survivors, which may be linked to lower stress and better outcomes (11).

The Barnes et al. article (4) examines Medicaid expansion's influence on mortality by cancer types. Medicaid expansion was associated with greater declines for pancreatic cancer, which has poor prognosis, so policy changes may be more readily evident. Mortality rates in cancers (breast, cervical, and colorectal) with recommended screening tests and higher survival rates changed at a comparable pace in Medicaid expansion and nonexpansion states. There is some previously reported evidence that Medicaid expansion is related to improved colorectal and cervical cancer screening use (12), with less evidence for breast cancer screening (12,13). Potential impacts of Medicaid expansion for these cancers could be diluted by important initiatives and programs. Specifically, the National Breast and Cervical Cancer Early Detection Program provides cancer screening and treatment services for women without insurance and lower incomes regardless of a state's Medicaid expansion status (14).

The overall steeper declines in cancer mortality rates in expansion states vs nonexpansion states in this report (4) are in line with previous findings for all-cause mortality rates, which are also declining faster in expansion states than in nonexpansion states (15). Additionally, another study observed that

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increases in cardiovascular mortality rates were smaller among states that expanded Medicaid compared with states that did not (16). These studies were conducted before the COVID-19 pandemic, and it is unclear whether Medicaid expansion differentially affected mortality rates overall or for cancer specifically during the pandemic with large swings in unemployment rates, health insurance churn, and care disruptions (17-19).

In this early look at the data, Barnes and colleagues (4) computed that there were 5276 deaths averted between 2012 and 2016 among the 6 jump-starting states that are home to nearly 20% nonelderly adults in the United States (20). Measuring potential changes in the 21 states that expanded Medicaid in 2014 will be important, because they are home to one-third of the US population. Another side of the coin to measure is the number of deaths that could have been prevented but were not in the 14 states that have not yet expanded Medicaid. Collectively, these nonexpansion states are home to approximately 40% of the US population.

Future study of the nexus of Medicaid expansion, cancer mortality, and socioeconomic and racial inequities are also warranted. Previous studies have found narrowing socioeconomic and racial inequities in uninsured rate and stage at diagnosis among cancer patients and care affordability among cancer survivors in states that have expanded Medicaid (11,21,22). Among states that have not expanded Medicaid, racial and social inequities in cancer care have not narrowed as much, and this issue is especially concerning because nonexpansion states have a greater proportion of residents who are Black (16.2%) and Hispanic (18.2%) than the national average (11.4% are Black and 14.2% are Hispanic) (23).

This study (4) and other studies demonstrate the promising role of Medicaid expansion in improving cancer outcomes and reducing health disparities and highlight the importance of expanding Medicaid eligibility in all states.

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