

POLICY IMPACTS ON CANCER PREVENTION AND CARE

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OUR MISSION, VISION & VALUES

MISSION

ACHI's mission is to be a catalyst for improving the health of Arkansans through evidence-based research, public issue advocacy, and collaborative program development.

VISION

ACHI's vision is to be a trusted health policy leader committed to innovations that improve the health of Arkansans.

VALUES

ACHI's values are trust, innovation, initiative, and commitment.



OUR PRIORITIES

Healthy Systems

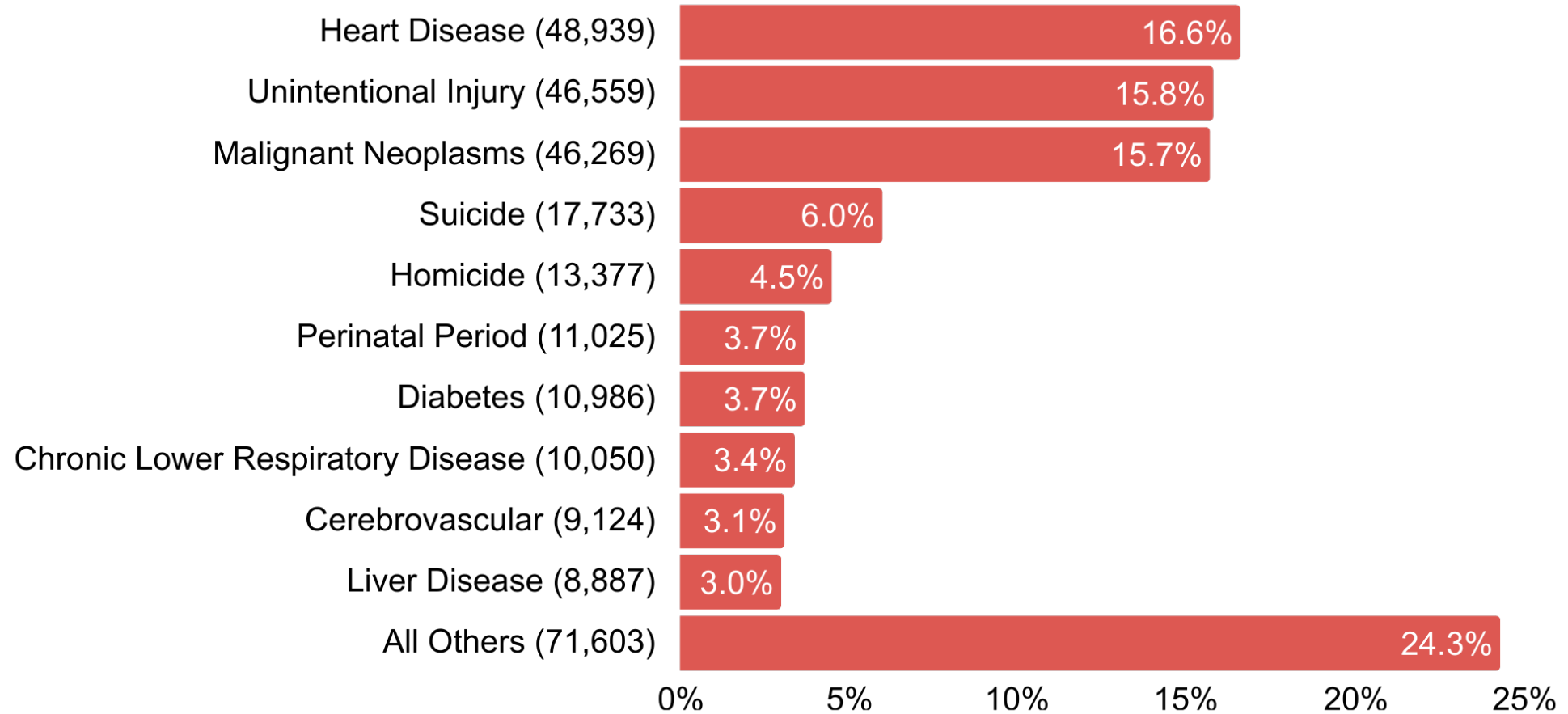
**Healthy
Communities**



**Healthy
Choices**



TOP 10 CAUSES OF PREMATURE DEATH (YEARS OF POTENTIAL LIFE LOST BEFORE AGE 75), ARKANSAS, 2023



COVERAGE CHANGES

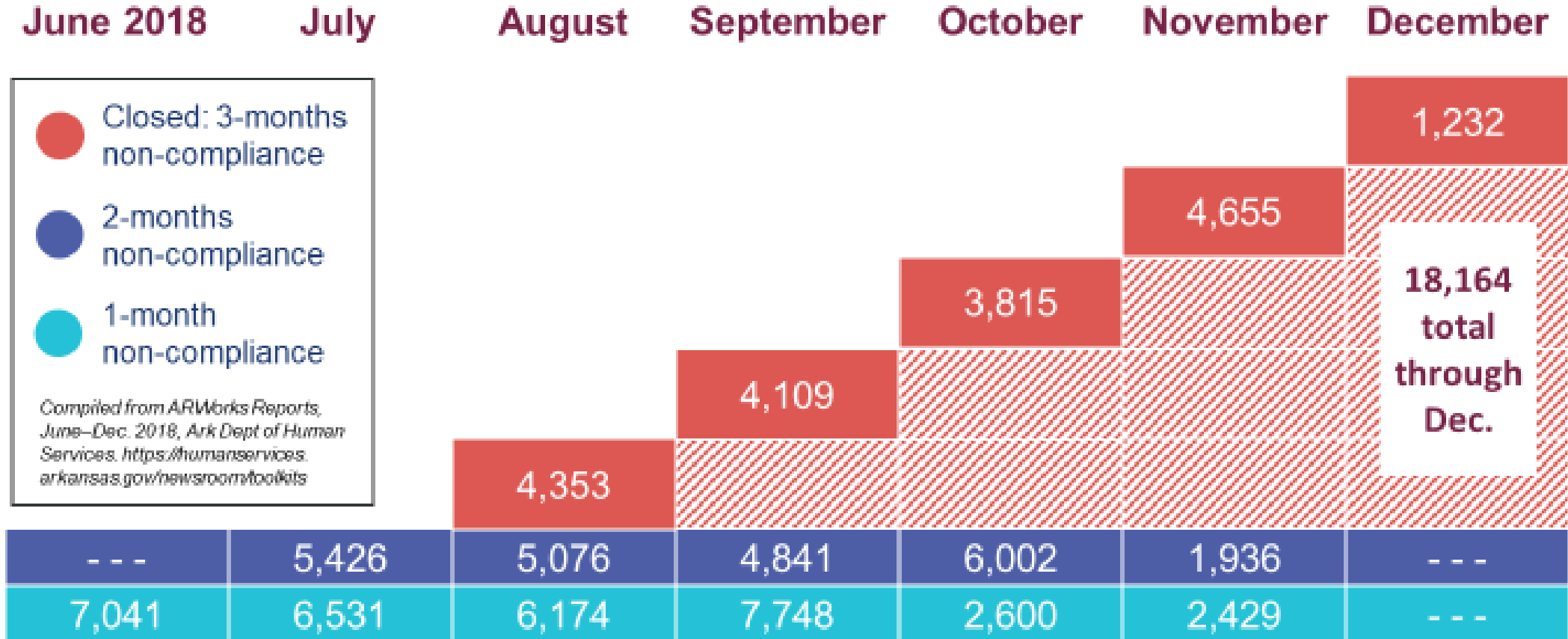


BUDGET BILL TIMELINE

- January 1, 2027: Deadline for states to implement Medicaid work requirements
 - States can seek waivers to implement work requirements earlier and can also seek extension of the deadline if they demonstrate a good faith effort toward compliance
- January 1, 2027: States must conduct eligibility redeterminations every 6 months for Medicaid expansion enrollees, currently yearly
- January 1, 2027: Retroactive coverage, previously provided for the 3 months prior to application month, is limited to 1 month for Medicaid expansion enrollees and 2 months for traditional Medicaid beneficiaries
- October 1, 2028: States must impose cost sharing of up to \$35 per service, with some exemptions, for Medicaid expansion enrollees with incomes of 100%-138% of federal poverty level



ARKANSAS WORK REQUIREMENT IN 2018



MEDICAID WORK REQUIREMENT OVERVIEW

- Applies to adults enrolled in Medicaid expansion
- 80 hours per month of one or more of the following activities: employment; participation in a work program (e.g., job training; enrollment in an educational program (at least half time), community service, or a combination of these activities
- Exemptions: Foster youth and former foster youth under age 26, caregiver of a dependent child under 14 or disabled individual, disabled veterans, individuals in SUD treatment, recently incarcerated individuals (3 months), pregnant and postpartum women, individuals with a short-term hardship (e.g., disasters, high unemployment), and individuals who are medically frail



MEDICAID WORK REQUIREMENT OVERVIEW

- Soft launch expected July 1, during which time the Department of Human Services will educate enrollees, partners, and the public and refine their processes
- States are required to use available data, such as payroll data, SNAP data, and Medicaid claims to verify compliance
- States must issue notice of noncompliance via mail and at least one other form of communication
- Enrollees have 30 days to show compliance before disenrollment
 - At application, state must “look back” to assess compliance for at least 1 month and up to 3 months
 - States must verify that current enrollees meet the requirement at least 1 month every six months of enrollment

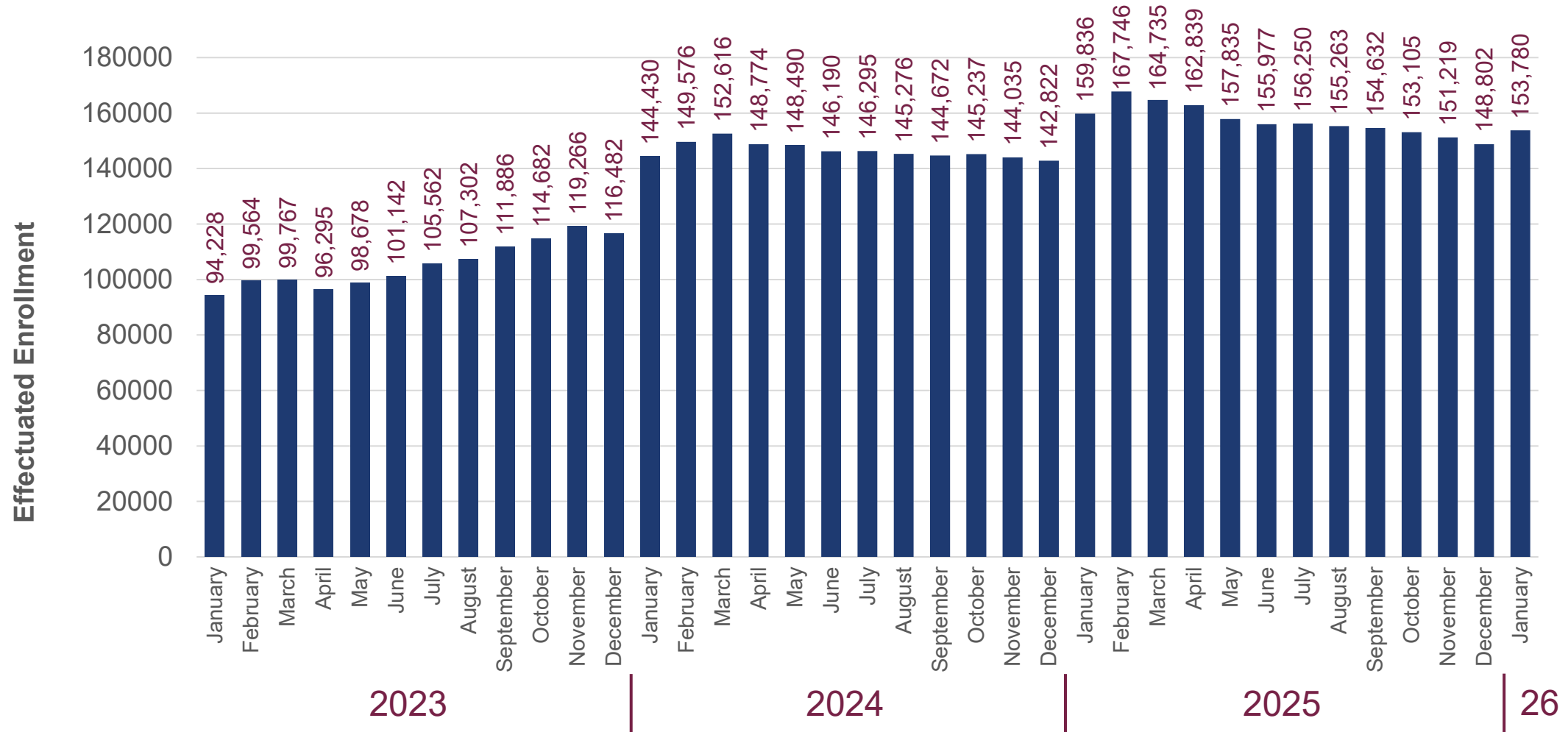


MEDICAL FRAILTY

- People who are blind or disabled, have a substance use disorder, a disabling mental disorder, a physical, intellectual, or developmental disability, or who have a serious or complex medical condition
- To date, states have had flexibility on this definition
 - Who can initiate determination of medical frailty?
 - Who can make final determination of medical frailty?
 - What information was required in determination process?
 - When is determination made?
- In 2018, Arkansas received only 904 requests for exemptions and 69 appeals, suggesting that a significant number of Arkansans who were eligible for a medical frailty exemption either did not know to apply for the exemption or could not successfully navigate the process
- What can be done? Advocate for proactive identification of patients in active cancer treatment via claims, self-identification, and provider notification



ARKANSAS MARKETPLACE ENROLLMENT



Source: Healthcare.gov, reported by carriers to Arkansas Insurance Department. | *Note: "Effectuated enrollment represents the number of unique individuals who are effectively enrolled as of the reported date and excludes those who have enrolled but coverage will begin later to the report date.

IMPACT OF LOSS OF ENHANCED SUBSIDIES ON MARKETPLACE PREMIUMS (POPE COUNTY)

Profile:

- 35-year-old single woman
- Resides in Pope County
- Based on benchmark marketplace plan (most commonly purchased plan type)

Income Level	Monthly Premium (2025)	Monthly Premium (2026)
\$25,000	\$13	\$90
\$35,000	\$96	\$240

- September 4, 2025: CMS extended availability of catastrophic coverage — which historically have had ~\$10,000 deductibles — to people newly ineligible for subsidies



COVERAGE DISRUPTION AND CANCER CARE

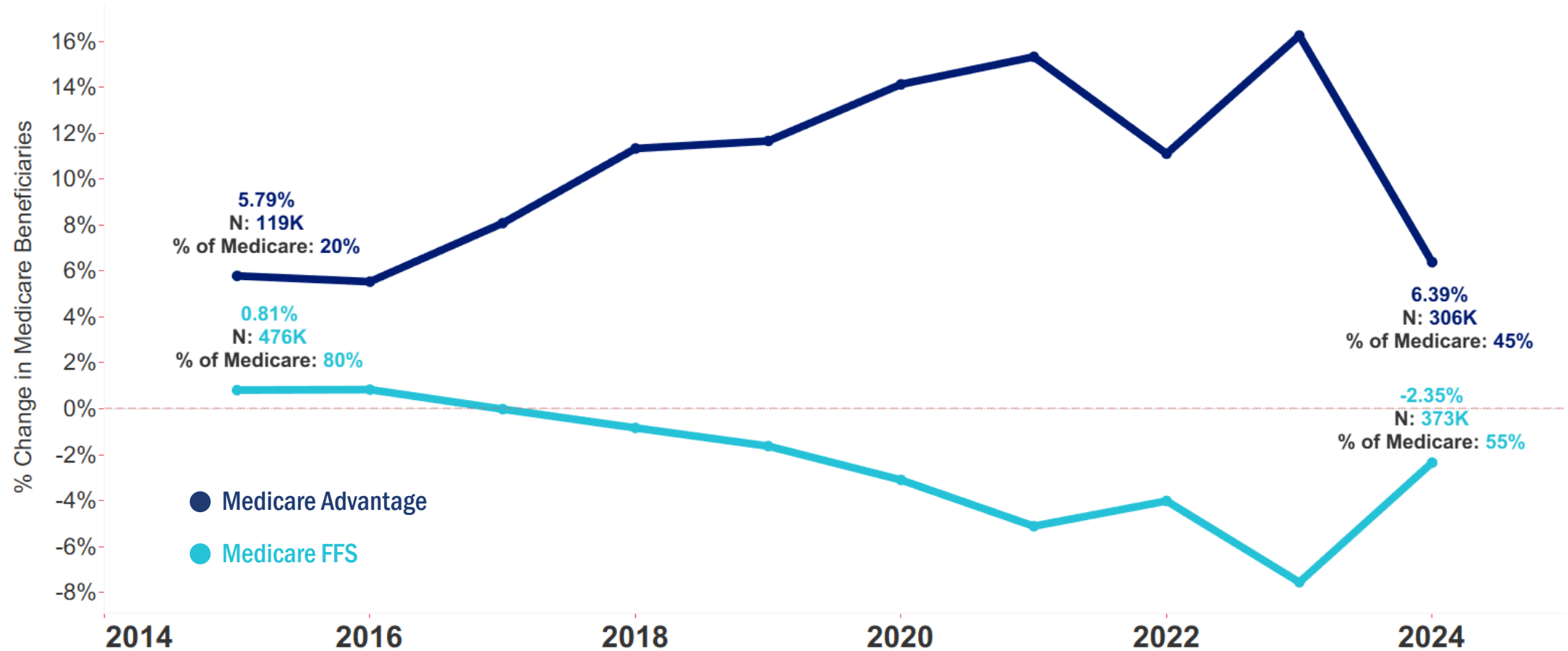
- Reduced screening and prevention
 - Uninsured adults are more than twice as likely as those with insurance to miss routine cancer screenings
- Delayed diagnoses and stage shift
 - Individuals with gaps in insurance are more likely to be diagnosed with advanced-stage cancer, reducing treatment options and survival rates
- Treatment disparities
 - Gaps in coverage are associated with lower likelihoods of receiving timely, guideline-concordant treatment
- Mortality
 - Studies have linked coverage disruptions to increased mortality and worse survival rates
- Patient burden
 - Beyond treatment, coverage gaps create financial stress, with cost being the top reason uninsured individuals fall behind on screenings



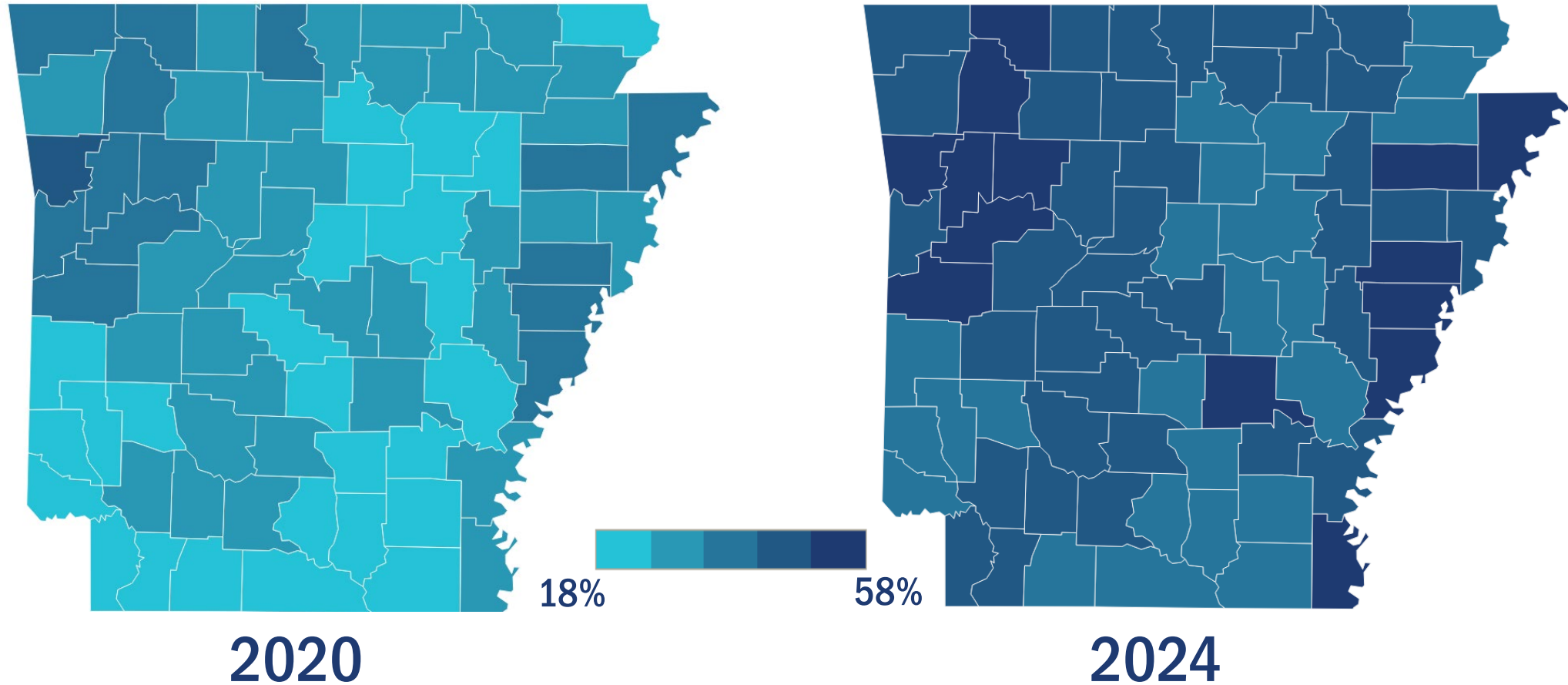
MEDICARE ADVANTAGE



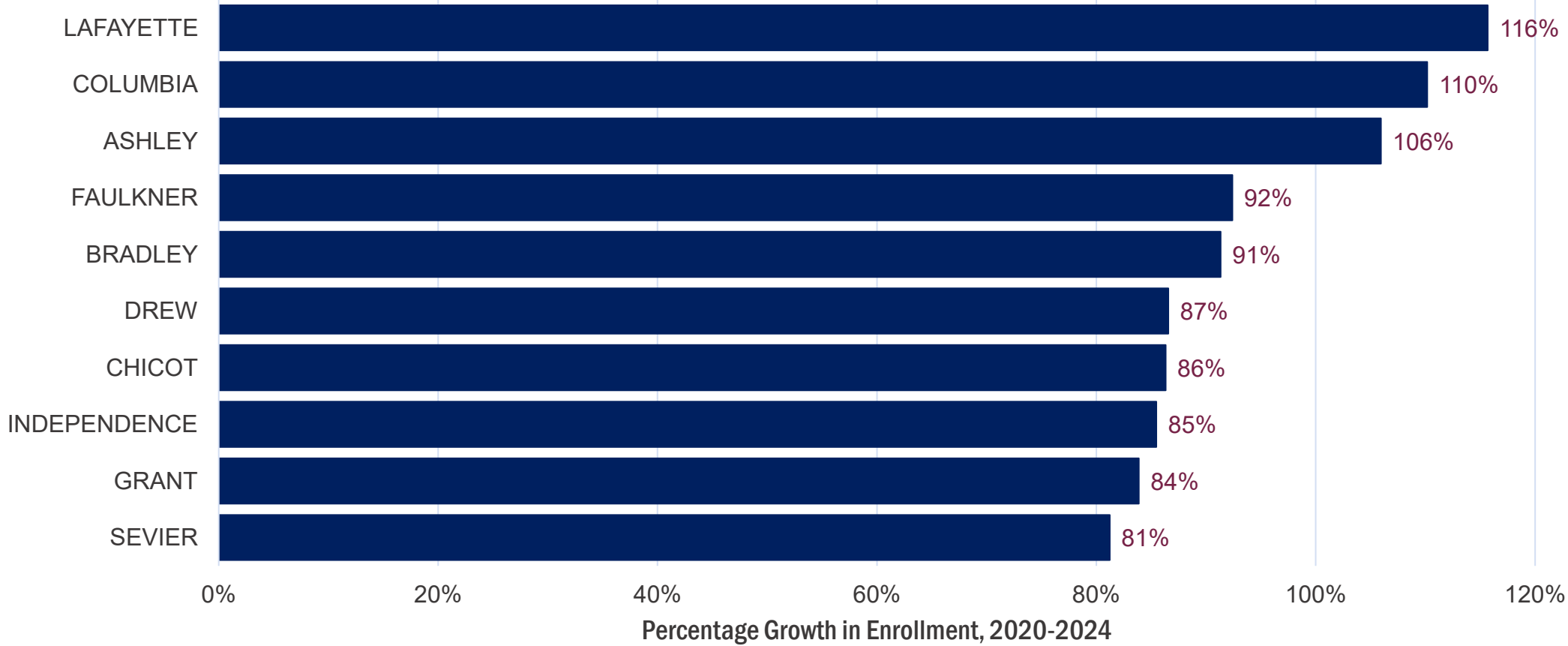
PERCENTAGE CHANGE IN MEDICARE ADVANTAGE VS. FEE-FOR-SERVICE BENEFICIARIES: 2015-24



PERCENTAGE OF MEDICARE ADVANTAGE BENEFICIARIES BY COUNTY: 2020 VS. 2024



AR COUNTIES WITH HIGHEST PERCENTAGE CHANGE IN MEDICARE ADVANTAGE ENROLLMENT, 2020-24



Source: Data.CMS.gov, Medicare Monthly Enrollment data

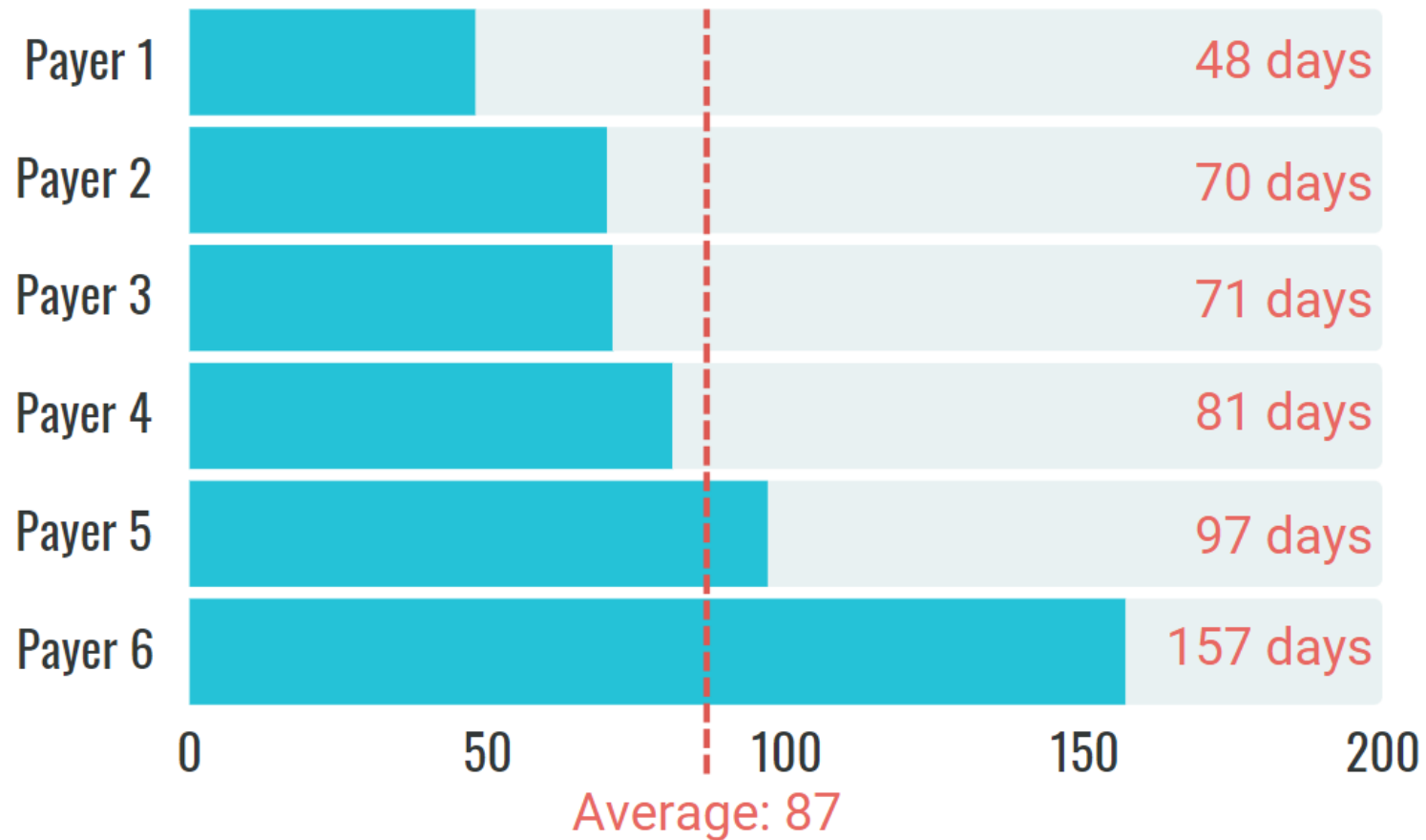


CHALLENGES POSED BY MEDICARE ADVANTAGE FOR CANCER CARE

- Many plans require prior authorization before starting treatments like radiation or chemotherapy, and there are more frequent denials of claims typically approved by Medicare
- Patients may be restricted to specific doctors and hospitals within network; may not include top-tier cancer centers
- While plans have a maximum out-of-pocket limit, they can impose higher co-payments for services such as hospital stays and specialized cancer drugs compared to traditional Medicare
- Evidence is somewhat mixed about whether Medicare Advantage enrollees experience differences in cancer diagnosis, access to clinical trials, and initiation of guideline-recommended treatments
- Opportunities to switch from Medicare Advantage to traditional Medicaid are time limited, and Medigap policies are not guaranteed issue



MEAN TIME TO PAYMENT FOR MEDICARE ADVANTAGE PLANS BY PAYER FOR INPATIENT STAYS



Data for this graphic were obtained from the Healthcare Transparency Initiative utilizing 2021 claims data. Time to payment was measured by the duration from the date of service to the final date the claim was paid.



PRIVATE EQUITY



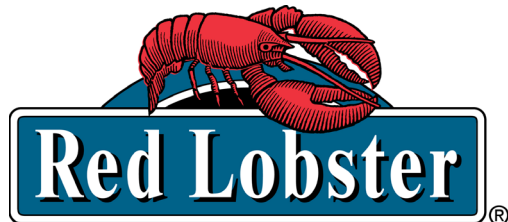
FOR-PROFIT HEALTHCARE

- Public, investor-owned: Organizations that sell shares to the public on a stock exchange and are regulated by multiple federal laws and agencies, including the U.S. Securities and Exchange Commission
 - E.g., UnitedHealth Group
- Private, investor-owned: Organizations not traded on public markets and not subject to the same regulations as public companies
 - E.g., private equity-owned firms



WHAT IS PRIVATE EQUITY?

- A form of for-profit ownership in which investors pool large amounts of money to purchase companies, improve their value, and quickly sell them for a profit
- Not just limited to healthcare



WHY IS PRIVATE EQUITY IN HEALTHCARE RISKY?

- Investment typically comes from lay investors lacking professional and institutional obligations to promote higher ethical goals of healthcare
- Private equity investment is heavily debt-financed
 - Typical leveraged buy-out uses the assets of the underlying business to secure the purchase price
- Goal is to generate substantial increases in profitability in 3-7 years before exiting the investment



WHAT DOES THIS MEAN FOR THE TARGET?

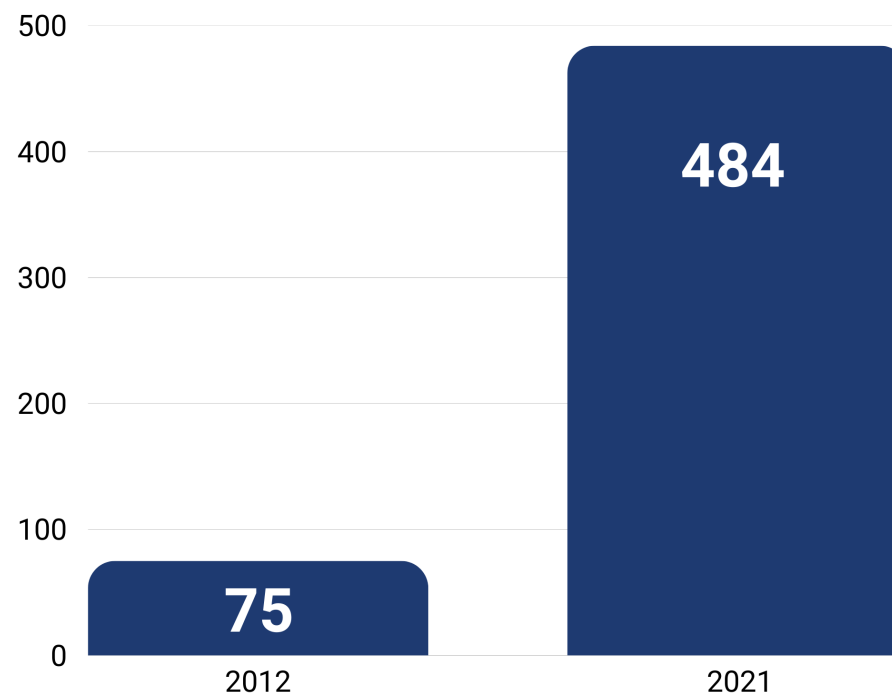
- Best case scenario:
 - Infusion of cash
 - Improved operating margins
 - Opportunities for innovation and growth
 - Maintenance of a care access point for a community
- Worst case scenario
 - Stripping of assets
 - Debt-loading
 - High management fees
 - Staffing cuts/centralization
 - Aggregation of market power
 - Clinical judgment interference
 - Compromised care quality, access, and safety
 - Potential closure



WHAT ARE THE TARGETS?

- Physician practices
 - Historically have targeted high-margin specialty practices (e.g., dermatology, oncology, cardiology, gastroenterology)
 - In 2022, PE firms controlled over 30% of the oncology market in 17 metropolitan areas and more than 50% in 9, with the highest concentrations in AR, PA, MI, GA, NM, and TX.

FIGURE: PRIVATE EQUITY ACQUISITIONS OF PHYSICIAN PRACTICES IN THE U.S., 2012 VS. 2021



WHY IS PRIVATE EQUITY TARGETING CANCER CARE?

- Oncology generates substantial revenue through integrated, high-margin services such as chemotherapy, lab testing, and advanced imaging
- Significant opportunities for "roll-up" strategies, where smaller practices are acquired and consolidated into larger, more powerful entities
- Growing prevalence of cancer and an aging population create a consistent, "recession-proof" demand for services
- Professional management, technology, data analytics, and centralized administrative services can enhance efficiency, which can allow for better negotiation with insurers and drug suppliers and participation in value-based models

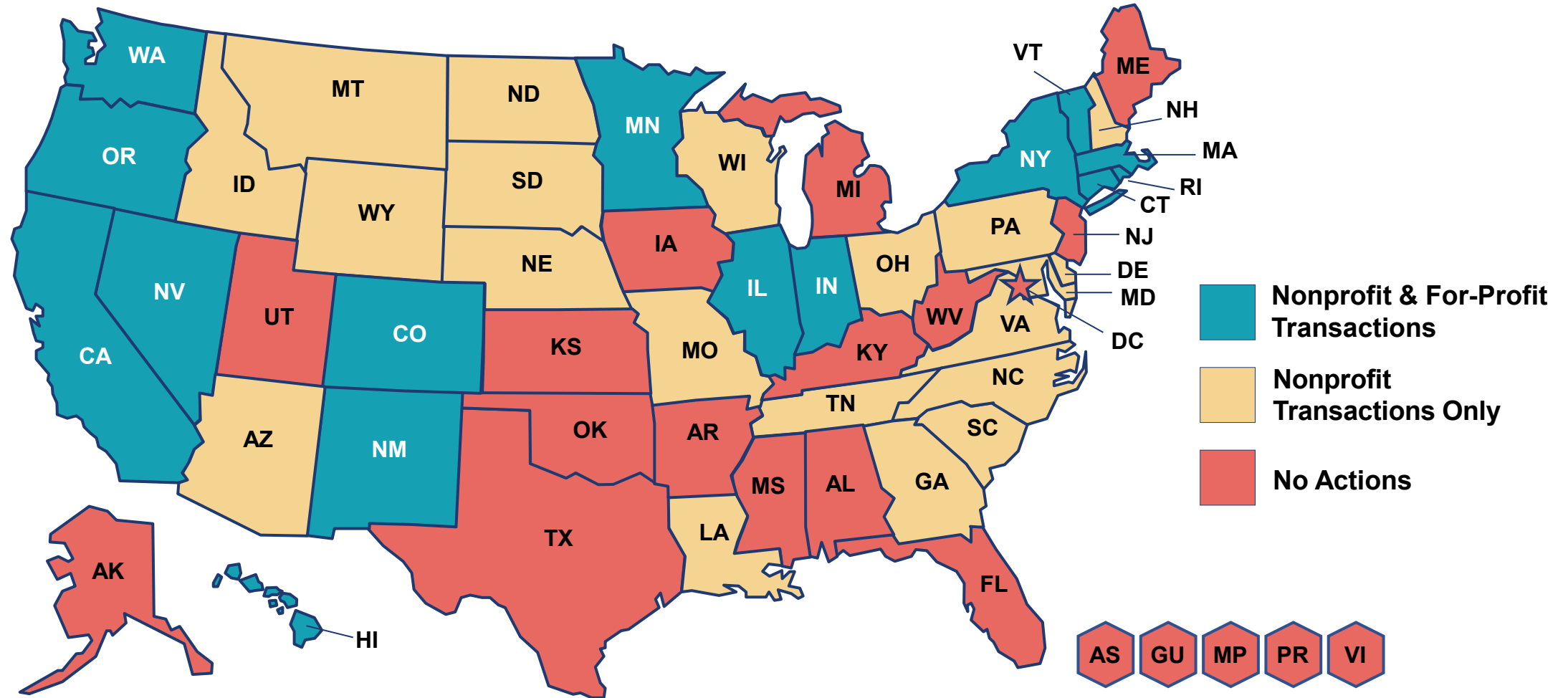


IMPACT ON CANCER CARE: THE EVIDENCE

- Private equity acquisition of oncology practices was associated with increase in local market share, with private equity-acquired practices having 5.3% higher office visit prices and 50% higher radiation therapy spending. (*International Journal of Radiation Oncology, January 2026*)
- In an observational study of Medicare beneficiaries, private equity ownership was not associated with profitable but low-value cancer treatments. (*JCO Oncology Practice, 2025*)
- Patients who underwent an esophagectomy at private-equity acquired hospitals significantly higher rates of 30-day mortality (8.1% vs 4.9%), any complications (36.6% vs 30.1%), serious complications (17.5% vs 14.3%), and failure to rescue (5.9% vs 3.4%). (*JAMA Surgery, 2025*)
- Among gastrointestinal cancer patients, private equity ownership of the treating hospital was correlated with reduced clinical staffing, fewer Medicaid patients, lower surgical costs, and increased infection risks post-acquisition. (*Journal of Gastrointestinal Oncology, 2026*)



REGULATION OF PRIVATE EQUITY TRANSACTIONS



TYPICAL PROVISIONS IN STATE LAW

- **Authorized State Entity:** Office or agency appointed to receive notice of transactions and, if applicable, review or approve the transaction (typically the attorney general or state health department)
- **Types of Regulated Transactions:** Types of healthcare transactions regulated (e.g., mergers, acquisitions, affiliations) and any monetary threshold that results in regulation
- **Extent of Review Authority:** 1) notice, 2) notice and review, or 3) notice, review, and approval
- **Types of Healthcare Entities:** Types of healthcare entities regulated (e.g., hospitals, nursing homes, pharmacies, group practices)
- **Notice and/or Review Criteria:** Notice required from parties entering a qualifying transaction (e.g., type of information that must be submitted, timeframe for submission); and metrics the authorized state entity may consider when conducting their review and, if applicable, approval or disapproval of given transaction



MODEL LEGISLATION

- National Academy for State Health Policy issued updated model legislation in 2024
- Model updates recognize increasingly sophisticated business relationships through joint ventures, affiliations, staffing agencies
- Model extends reach for oversight of smaller transactions
- Model includes provisions to review contraction in addition to consolidation or acquisition
- Model provides language to strengthen state corporate practice of medicine laws
- Model offers comprehensive reporting and review guidelines, expanding the look-back period for covered transactions



Arkansas All-Payer Claims Database

COMMERCIAL
FULLY INSURED

PUBLIC
SELF-INSURED

MEDICAID

MEDICARE

Master Social
Determinants

Hospital/ED
Discharge

Longitudinal
Child BMI

 **ENCRYPTED
ID***

Cancer
Registry

Medical
Marijuana
Cardholders

Workers'
Comp

Medical
Marijuana
Point of Sale

Birth
Certificate

Death
Certificate

State Police
Crash



**Encrypted, concatenated member/patient last name and date of birth. Used with gender.*

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