

## Editorial

# Beyond the foundation: building on Medicaid expansion to achieve cancer equity

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## Introduction and context: The collision of two crises

The COVID-19 pandemic subjected the American health-care system to a true stress test of unprecedented scale, abruptly halting routine cancer screening and prevention. At the height of the lockdowns in April 2020, mammograms for breast cancer plummeted by 85%, colonoscopies for colorectal cancer by 75%, prostate-specific antigen (PSA) tests by 74%, and low-dose computed tomography for lung cancer by 56%.<sup>1,2</sup> These delays have already led to a shift toward later-stage diagnoses, which threatens to increase cancer morbidity and mortality for years to come.<sup>1,3</sup>

Yet the pandemic did not create cancer disparities—it exposed and magnified them. The fragmented landscape of US health policy, with Medicaid expansion varying by state, created a powerful natural experiment. Han and colleagues provide compelling evidence that a state's decision to expand Medicaid under the Patient Protection and Affordable Care Act (ACA) served as a critical determinant of its cancer care system's resilience. The study's core finding—that Medicaid expansion acted as a protective buffer, mitigating the decline in early-stage cancer diagnoses for vulnerable populations—illuminates a crucial lesson. The differential impact between expansion and nonexpansion states was not an anomaly but the logical outcome of policy choices. Prepandemic research had already established that Medicaid expansion improves screening rates, facilitates earlier diagnosis, and narrows racial disparities in timely treatment.<sup>4</sup> States that had expanded Medicaid therefore entered the crisis with a more robust safety net, making their systems inherently more resilient to the shock that followed.

## Study strengths and key findings: Evidence of a protective policy buffer

Han et al. leveraged the National Cancer Database (NCDB), which captures approximately 74% of all newly diagnosed cancer cases in the United States from more than 1500 accredited facilities.<sup>5</sup> Critically, the study's use of month-wise data allows for a precise temporal analysis, mapping the decline in diagnoses directly

onto the timeline of pandemic-related lockdowns and service suspensions. Importantly, they disaggregated data for Asian American, Native Hawaiian, and Pacific Islander (AANHPI) populations, moving beyond the harmful “model minority” myth<sup>6,7</sup> to uncover disparities that may have remained hidden.

The central finding of the analysis is the clear protective effect of Medicaid expansion. Although all states experienced a downturn in early-stage cancer diagnoses during the pandemic's initial wave, the decline was significantly less severe in states that had expanded Medicaid. This finding aligns with a large body of prepandemic evidence demonstrating the policy's power to promote health equity. Studies have consistently shown that Medicaid expansion is associated with increased colorectal cancer screening rates for low-income populations,<sup>8</sup> a significant shift toward earlier-stage diagnoses for cancers such as head and neck squamous cell carcinoma,<sup>4</sup> and significant decreases in the longstanding disparity between Black and White patients in receiving timely treatment for breast cancer.<sup>9</sup> Medicaid expansion, the evidence shows, builds a more equitable foundation for cancer care—one that proved more resilient under pressure.

## The overlooked

One of the study's most vital contributions is its illumination of the pandemic's impact on often overlooked communities. By disaggregating AANHPI data, Han and colleagues uncovered a substantial decrease in early-stage cancer diagnoses among Native Hawaiian and Pacific Islander (NHPI) populations, an effect that was particularly pronounced in states that had not expanded Medicaid. The model minority myth—the perception that Asian Americans are “problem-free” or successful minorities—may reinforce harmful hierarchies while obscuring the reality of systemic barriers faced by Asian Americans and other diverse communities. This stereotype, born from aggregated data, conceals the fact that many people from Native Hawaiian and Pacific Islander (NHPI) and some Southeast Asian populations face some of the nation's most severe cancer disparities.<sup>7,10–12</sup> By maintaining this myth, we discredit the barriers to access experienced by Asian Americans along with other Black, Indigenous, and people of

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Color communities. Disaggregated data show that NHPI women have 41% higher overall cancer mortality than non-Hispanic White women, with markedly higher death rates for breast, endometrial, stomach, and cervical cancers.<sup>13</sup> Furthermore, only about half of Samoan, Tongan, and Laotian women are diagnosed with breast cancer at an early, localized stage, compared with nearly three-quarters of Japanese women.<sup>14</sup>

The pandemic's impact on these communities is better understood in the context of the concurrent rise in anti-Asian discrimination, as harmful rhetoric surrounding the virus had measurable health consequences. During the pandemic, Asian Americans were disproportionately likely to lose health insurance coverage, which was primarily due to employment-related job losses,<sup>15</sup> and were 3 times more likely to do so than their White peers.<sup>16</sup> Many were led to alter health-seeking behaviors,<sup>17</sup> compounding existing barriers and undoubtedly contributing to the decline in cancer screenings observed in the data.<sup>16</sup>

In parallel, Han and colleagues found that women with cervical cancer in both expansion and nonexpansion states demonstrated large reductions in the proportion of early-stage diagnoses. These findings echo earlier work before (2011-2013) and after (2014-2015) Medicaid expansion suggesting that Medicaid expansion was not associated with any significant changes in cancer stage at diagnosis or timely treatment,<sup>18</sup> at least in the years immediately after expansion. Taken together, these results underscore that women with cervical cancer in the United States face substantial barriers beyond insurance coverage, including limited access to screening and diagnostic services, transportation challenges, cost-related obstacles, and disparities related to race, ethnicity, socioeconomic status, and rurality.<sup>19,20</sup> These multifactorial barriers contribute to delayed diagnosis and reduced likelihood of early-stage detection, highlighting the imperative for people-centric research targeting populations most likely to experience these disparities.

This confluence of factors underscores why the methodological choice to disaggregate data is not a mere technicality but an act of health justice.<sup>7</sup> When commonly overlooked groups are statistically erased, they are also erased from policy agendas and resource allocation and will eventually be left behind in the push for expanded accessibility to care.

## COVID-19's broader impact on cancer care

The disruption to cancer care was a global phenomenon. Research from Kim and colleagues, using nationally representative US registry data, quantified a cumulative deficit of more than 127 000 expected cancer diagnoses in 2020 and 2021 alone.<sup>21</sup> This deficit reflects a worldwide pattern of suspended screening programs and delayed care that will have long-term consequences for cancer outcomes globally.<sup>1</sup>

Even in Medicaid expansion states, screening rates fell. Insurance coverage, although foundational, is not sufficient when there are other powerful barriers to care—such as fear of infection, transportation challenges, lack of culturally appropriate outreach, and systemic mistrust. Out-of-pocket costs are just one of several obstacles.<sup>22</sup> Recognizing this reality is the critical bridge from identifying the problem to architecting effective, multilevel solutions.

## An evidence-based blueprint for action

The clear evidence of Medicaid expansion's protective effect during the pandemic demands a decisive policy response. Yet, to

build a truly resilient system, we must recognize that a policy foundation alone is insufficient. Achieving cancer equity requires a coordinated, multilevel strategy that moves from broad structural reform to targeted, community-level action, while also leveraging an intersectional approach to care.

## Structural reform, policy reinforcement, community-level interventions

First, the 10 remaining states should expand their Medicaid programs without delay. The evidence supports that failure to do so leaves millions exposed in times of crisis. Second, insurance alone is not enough. Protections such as the ACA's requirement for no-cost-sharing on preventive services<sup>23</sup> must be shielded from legal challenges, and federal funding for safety-net programs like the CDC's National Breast and Cervical Cancer Early Detection Program (NBCCEDP) must be maintained for those who still fall through the cracks.<sup>24</sup> Third, community solutions are vital, because insurance coverage only opens the door. Mobile health vans, as shown by the UK "Man Van" program, can bring screening directly to high-risk neighborhoods, boosting diagnosis and equity for marginalized groups.<sup>25-27</sup> Additionally, trusted patient navigators and community health workers break down cultural, language, and logistical barriers. These two evidence-based models have been proven to raise screening rates and are highly cost-effective.<sup>28,29</sup>

### Exemplar 1: Mobile health units—taking screening to the people

The "Man Van" program in the United Kingdom offers a powerful model for overcoming geographic and awareness barriers. Recognizing that prostate cancer disproportionately affects Black men<sup>25</sup> and those in deprived areas who often present with later-stage disease, the program deployed a nurse-led mobile clinic to these high-risk communities.<sup>26</sup> The results were promising. The program successfully recruited its target demographic (36.4% non-White, including 16.7% Black men) and achieved a high diagnostic rate of clinically significant prostate cancer (2.8% of all attendees), with no cases of metastatic disease detected.<sup>27</sup> Crucially, Black men were nearly 4 times more likely to be diagnosed than White men (7.1% vs 1.8%), proving the intervention reached those most at risk.<sup>26</sup> This model is directly translatable for addressing numerous cancer screening disparities in the United States.

### Exemplar 2: Human-centered navigation—the power of trusted messengers

For many underserved communities, the greatest barriers are not financial but are rooted in language, culture, and a justifiable mistrust of the health-care system.<sup>28</sup> Patient navigators and community health workers (CHWs) are proven to be a uniquely effective solution. Patient navigators are health-care professionals or trained volunteers who guide patients through the complex health-care system, helping them overcome barriers to care from initial screening through treatment and follow-up. They coordinate appointments, facilitate communication between patients and providers, and ensure continuity of care throughout the cancer journey. Community health workers are trained lay individuals who come from the communities they serve, acting as a trusted bridge to the health-care system by providing culturally competent education, one-on-one support, and assistance

overcoming logistical hurdles such as transportation and translation. Together, these complementary roles create a comprehensive support system that addresses both systemic navigation challenges and community-specific barriers to care.<sup>29</sup>

The evidence for their effectiveness is quite profound. The Community Preventive Services Task Force (CPSTF) issues strong recommendations for CHW-led interventions to increase screening for breast, cervical, and colorectal cancer.<sup>29</sup> Meta-analyses and systematic reviews confirm that these programs significantly increase screening uptake—by a median of 10.5 percentage points for colorectal cancer and 12.8 percentage points for cervical cancer—and are highly cost-effective.<sup>29</sup>

## Conclusion: From insight to implementation

The COVID-19 pandemic taught us that the foundation of cancer equity is broad, stable insurance, but that is only the start. To achieve true equity, we must build on that foundation with policy protections and decisive, community-driven action. Inaction is a choice with real, measurable consequences. As we recover from one public health crisis, we must translate these hard-won lessons into immediate action to build a cancer care system that is truly just and effective for all.

## Author contributions

Milit S. Patel (Conceptualization, Formal analysis, Investigation, Methodology, Validation, Writing—original draft, Writing—review & editing), Miranda B. Lam (Writing—review & editing), Erin Jay G. Feliciano (Writing—review & editing), and Edward Christopher Dee (Writing—review & editing)

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## Conflicts of interest

All authors have no conflicts to declare.

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No new data were generated or analyzed for this editorial.

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