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H.R. 4101, the Cancer Drug Parity Act of 2025

119th Congress

Chairman Grothman, Ranking Member Krishnamoorthi, and members of the Subcommittee:

Thank you for the opportunity to testify. My name is Sheetal Kircher. I am a practicing medical oncologist at Northwestern Medicine in Chicago, where I care for patients with gastrointestinal cancers. I am also a Professor of Medicine at Northwestern University Feinberg School of Medicine and a Fellow of the American Society of Clinical Oncology. I am appearing today in my individual capacity as a physician who routinely sees the consequences of cancer treatment costs on patients and their families.

Cancer care is changing dramatically, and so is the way we deliver cancer treatment. Intravenous therapy remains an important cornerstone of oncology care, but there has been a clear shift toward oral anticancer drugs. Increasingly, the best treatment for a patient may not be an infusion delivered in a chemotherapy chair, but a pill taken at home. Oral therapies now include conventional chemotherapy as well as many of the targeted treatments that have transformed care across leukemia, lung cancer, breast cancer, kidney cancer, prostate cancer, gastrointestinal cancers, and other malignancies. As cancer treatment becomes increasingly targeted and personalized, this movement from IV to oral therapy will continue. [2-4]

As cancer treatment has evolved, insurance benefit design has not always evolved with it. A cancer drug administered in an infusion center is generally covered under the patient's medical benefit, while an oral anticancer drug taken at home is generally covered under the prescription drug benefit. That distinction can expose the same patient, being treated for the same cancer, to very different deductibles, copayments, coinsurance, utilization-management requirements, and specialty-pharmacy restrictions based largely on how the treatment is administered. H.R. 4101 addresses this mismatch for employer-sponsored plans governed by the Employee Retirement Income Security Act (ERISA) by requiring cost-sharing for prescribed patient-administered anticancer drugs to be no less favorable than cost-sharing for anticancer medications administered by a health care provider.[1]

Oral anticancer therapy is now a core part of modern cancer care

Oral anticancer drugs should not be thought of as a small category of optional convenience medications. They are frequently the preferred therapy and, for some cancers and molecular subtypes, there is no therapeutically equivalent infused substitute. In chronic myeloid leukemia, for example, oral tyrosine kinase inhibitors transformed a once-fatal disease into one that can often be managed for years. In lung cancer, oral targeted therapies are standard treatment for tumors driven by actionable alterations such as EGFR, ALK, ROS1, RET, MET, BRAF, and others. Oral targeted agents are also standard components of treatment in breast, prostate, kidney, ovarian, and gastrointestinal cancers.

The literature also shows that patients often value oral administration when efficacy and toxicity are comparable. A review of 14 studies evaluating patient preference found that 11 of 13 studies directly comparing routes reported a preference for oral treatment; common reasons included convenience, treatment at home, scheduling, and avoidance of infusion-related burdens.[5] In a multicenter study of patients with metastatic breast or lung cancer who had experienced both oral and intravenous treatment, 77% preferred oral therapy and 70.4% reported less disruption of daily life with tablets.[6] These preferences are not absolute and patients appropriately prioritize effectiveness and toxicity over route of administration. That is precisely the point. Route should be a clinical and patient-centered consideration, not a reason for insurance design to make one evidence-based treatment substantially less affordable than another.[5-7]

The newest advances in pancreatic cancer make this issue especially tangible. On August 26, 2026, the FDA approved daraxonrasib (Rasonque), a once-daily oral RAS inhibitor, for adults with metastatic pancreatic adenocarcinoma who have received at least one prior systemic therapy or who are not candidates for multiagent systemic therapy.[25] The approval followed the phase 3

RASolute 302 trial, published in the New England Journal of Medicine, in which 500 patients with previously treated metastatic pancreatic cancer were randomized to daraxonrasib or investigator's-choice chemotherapy. Daraxonrasib improved median overall survival from 6.7 to 13.2 months in the overall population (hazard ratio, 0.40; $P < .001$) and median progression-free survival from 3.6 to 7.2 months (hazard ratio, 0.49; $P < .001$).[26] For me as a gastrointestinal oncologist, this is a particularly timely example of why benefit design must keep pace with cancer innovation. A first-in-class treatment that substantially improved survival over standard chemotherapy for one of the most difficult to treat cancers is a tablet taken at home, not a drug administered in an infusion chair. A patient's ability to receive that advance should not be disadvantaged simply because the treatment is covered through the pharmacy benefit rather than the medical benefit.

For patients, the difference between an IV drug and an oral drug is much more than the route of administration

A typical patient experience illustrates the problem. When I prescribe an intravenous anticancer drug, my office obtains authorization, the patient comes to the cancer center, the drug is administered, and the claim is processed through the medical benefit. Depending on the patient's plan, that treatment may be covered after a medical deductible and a defined copayment or coinsurance amount. The patient may have supplemental coverage or an employer plan design that limits the amount they see at the point of treatment.

Now consider that the most appropriate therapy is an oral anticancer drug. The prescription leaves my electronic medical record and enters a different system. It may require a separate pharmacy-benefit prior authorization. The plan may impose a specialty tier, coinsurance based on the drug's price, or a pharmacy deductible. The prescription may then be routed away from the cancer center to a payer- or PBM-designated specialty pharmacy. Before the patient has swallowed a single pill, the care team may be dealing with authorization, formulary rules, pharmacy network restrictions, copay assistance, foundation support, and shipment logistics. The scientific decision may have taken minutes; obtaining the drug can take days or weeks.

The patient experiences this distinction as arbitrary. From the patient's perspective, both are cancer treatments prescribed by the same oncologist for the same life-threatening disease. Yet the patient's financial obligation can change simply because one treatment is infused and the other is swallowed. The Cancer Drug Parity Act addresses that inequity directly.[1]

Oral therapy can preserve work, family time, and independence

The burden of cancer treatment is not limited to copayments. Patients also pay with time. Infusion therapy may require transportation, parking, laboratory testing, waiting-room time, hours in an infusion chair, and time away from work or caregiving. For patients who live far from a cancer center, transportation and missed work can become substantial indirect costs.

Susan G. Komen surveyed 147 people with early-stage or metastatic breast cancer about oral versus intravenous treatment. Forty-one percent of respondents receiving IV therapy reported a high impact on work or school compared with 12% receiving oral therapy. Fifty-four percent of those receiving IV therapy frequently used paid time off compared with 5% of those receiving oral therapy, and 33% frequently used unpaid time off compared with 9% receiving oral therapy. Respondents receiving IV treatment were also about three times as likely to report a high negative impact on their ability to care for family members.[8] Although this was a survey rather than a randomized trial, the direction of the findings is consistent with the broader literature showing that convenience, home administration, waiting time, and disruption of daily activities are major reasons patients prefer oral treatment.[5,6]

For working-age patients covered through an employer, these indirect costs matter. A treatment that allows a patient to remain at work, avoid repeated travel, or continue caring for children or an

older parent can preserve income and stability during cancer treatment. Insurance design should not negate those benefits by imposing substantially higher cost-sharing simply because the medicine is taken at home.

High out-of-pocket costs can determine whether an oral anticancer prescription is ever started

The cost of an oral anticancer drug can directly affect whether a patient is able to start and remain on the treatment their oncologist recommends. High deductibles, copayments, and coinsurance can create substantial financial burden at the point a prescription is filled. The American Association of Clinical Oncology (ASCO) has recognized these out-of-pocket costs as an important threat to access and adherence to recommended cancer treatment.[9]

The evidence demonstrates how consequential these costs can be. In a nationally representative analysis of 10,508 patients newly prescribed an oral oncolytic, 10% abandoned the initial prescription. Patients facing cost-sharing greater than \$500 were more than four times as likely to abandon treatment as patients whose cost-sharing was \$100 or less (odds ratio 4.46; $P < .001$).[10] Other studies and systematic reviews have likewise identified financial burden as one of multiple factors associated with adherence and persistence to oral anticancer therapy.[11,12]

For patients, these statistics translate into difficult decisions at exactly the time they should be focused on treating their cancer. Patients may delay starting therapy while they look for financial assistance, question whether they can afford to continue treatment, or ask about a less expensive alternative even when it is not the treatment I would otherwise recommend. In oncology, where treatment can be time-sensitive, a financial barrier that delays or prevents access to the recommended therapy can become a clinical barrier as well.

State oral-parity laws show both the value of parity and the need for a federal ERISA solution

The majority of states have enacted some form of oral anticancer parity requirement, but state insurance mandates generally do not reach self-funded employer health plans governed by ERISA. This creates a familiar situation in oncology: two patients can work side by side for different employers, have the same cancer, receive the same prescription, and receive different financial protection because one employer purchases fully insured coverage subject to state law while the other self-funds its plan.

The natural experiments created by state parity laws are informative. In a JAMA Oncology analysis of 63,780 adults in states that enacted parity laws, the proportion of oral anticancer prescriptions with no copayment increased from 15% to 53% in plans subject to parity, compared with a much smaller increase in self-funded plans not subject to the state law. Importantly, parity was not associated with an increase in six-month total health care spending. The authors also found that parity did not fully protect the highest spenders, demonstrating that parity is an important floor rather than a complete solution to financial toxicity.[13]

A study of patients with chronic myeloid leukemia and multiple myeloma similarly found large increases in the proportion of patients with \$0 initial out-of-pocket payments after parity, although it did not find significant improvements in adherence or discontinuation.[14] Another analysis found that state laws incorporating explicit out-of-pocket caps provided greater protection for the highest spenders; among the highest-cost prescriptions, caps were associated with substantially lower out-of-pocket spending.[15] Taken together, these studies show that benefit design matters and it can materially change what patients pay for their cancer treatment. While parity will not solve every affordability problem, it addresses a fundamental inequity that patients should not face greater financial burden simply because the cancer treatment they need is taken by mouth rather than administered in an infusion center.

Parity should be paired with attention to the other access obstacles facing oral anticancer therapy

The Cancer Drug Parity Act addresses cost-sharing. It does not, by itself, eliminate every obstacle a patient may encounter when filling an oral anticancer prescription. Congress should understand the broader context because these barriers often occur simultaneously.

Prior authorization and step therapy

Utilization management can serve a legitimate purpose when it is clinically appropriate, transparent, and timely. In cancer care, however, poorly designed prior authorization and step-therapy policies can delay treatment or pressure clinicians toward a payer-preferred option that is not the therapy they believe is best for the individual patient. This is especially problematic in precision oncology, where drugs within the same broad class are not necessarily clinically interchangeable.

In a 2023 JAMA Network Open study of patients who had experienced prior authorization for cancer care, 69% reported a prior-authorization-related delay, 73% of those delayed reported waiting at least two weeks, and 22% reported that they did not receive the care recommended by their treatment team because of delay or denial.[16] A systematic review and meta-analysis across multiple cancers has shown that treatment delay is associated with increased mortality for many curative-intent indications, reinforcing why avoidable administrative delay matters in oncology.[17]

PBM and payer vertical integration and specialty-pharmacy network restrictions

Oral anticancer drugs are frequently managed by pharmacy benefit managers (PBMs), many of which are vertically integrated with health insurers and their own mail-order or specialty pharmacies. A peer-reviewed review in JCO Oncology Practice described how PBM practices in oncology can affect access through utilization management, formulary design, network restrictions, and requirements that patients use PBM-affiliated specialty pharmacies.[18]

These network restrictions are clinically relevant. Studies comparing integrated health-system specialty pharmacies with external specialty pharmacies have found shorter time to treatment and higher measured adherence when patients can obtain oral anticancer therapy through the pharmacy integrated with their cancer care team. In one study, median time to treatment was 5 days through the internal health-system specialty pharmacy versus 27 days through external specialty pharmacies.[19] A 2024 propensity-matched study across specialty medications found treatment initiation was six days faster for patients using an integrated health-system specialty pharmacy than for patients whose prescriptions were transferred externally.[20] Another cancer-center study found that 71% of new oral anticancer prescriptions required prior authorization and demonstrated improved timeliness after implementation of a hospital-based specialty pharmacy model.[21]

The Federal Trade Commission has separately documented the degree of PBM consolidation and vertical integration. Its 2024 interim staff report found that the three largest PBMs processed nearly 80% of U.S. prescriptions in 2023 and that pharmacies affiliated with those three PBMs accounted for nearly 70% of specialty-drug revenue. The FTC's 2025 report on specialty generic drugs further described substantial markups and affiliated-pharmacy revenue involving specialty drugs, including cancer drugs.[22,23] These reports are not specific to the Cancer Drug Parity Act, but they help explain why an oral prescription may encounter access issues that an infused drug administered directly by the oncology practice does not.

Why H.R. 4101 matters clinically

H.R. 4101 is narrow in an important way. It does not require a health plan to cover every anticancer drug. It applies where a group health plan provides benefits for provider-administered anticancer medications, and it requires cost-sharing for qualifying prescribed patient-administered

anticancer medications to be no less favorable than the cost-sharing for provider-administered anticancer treatment. The bill also ties the protection to the treating physician's determination regarding the medication.[1]

That structure matters because oncologists do not select treatment by route first. We select treatment based on tumor type, stage, molecular characteristics, prior therapy, expected benefit, toxicity, comorbidities, and the patient's goals and preferences. Sometimes the right treatment is intravenous. Sometimes it is oral. Sometimes the oral drug is the only evidence-based option. Insurance coverage should not create a financial penalty based on the route by which the drug reaches the patient's body.

I also want to be precise about what this legislation can and cannot do. Oral parity will not lower the underlying price of cancer drugs. It will not eliminate prior authorization. It will not solve every PBM network problem. It will not eliminate financial toxicity. The literature on state parity laws makes that clear.[13-15] What it can do is remove one unjustifiable difference in benefit design for people in federally regulated employer plans.

Conclusion

In my clinic, a prescription is not successful when I click “send.” It is successful when the patient can obtain the medicine, afford it, take it safely, and continue it for as long as it is helping. For oral anticancer therapy, too many things can happen between the prescription and the first dose.

Congress cannot remove every complexity in cancer care with one bill. It can, however, eliminate a benefit-design distinction that no longer reflects how modern cancer treatment is delivered. The Cancer Drug Parity Act would extend an important protection to patients in ERISA-regulated employer plans and help ensure that treatment decisions are driven by clinical evidence and patient needs rather than by whether a medicine is delivered through an IV line or comes in a bottle of pills.

I urge Congress to advance H.R. 4101 and its bipartisan companion legislation.[24]

Thank you for the opportunity to provide this testimony.

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