Written Testimony on Hearing:

Unequal Treatment: Addressing the Drivers of Unaffordability for Oral Chemotherapy

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The opinions expressed in this testimony are mine and were prepared by me.

Opening Statement

A cancer patient should not pay more—or wait longer—for a cancer drug simply because the medicine comes in a pill rather than an IV bag.

Chairman Grothman, Ranking Member Krishnamoorthi, and Members of the Committee, thank you for the opportunity to submit this testimony on behalf of the Community Oncology Alliance ("COA"). I serve as the Executive Director of COA, which is a nonprofit organization dedicated to advocating for people with cancer and the independent, community-based oncology practices that deliver high-quality, affordable cancer care close to where patients live and work.

Cancer care has changed dramatically. Oral anticancer medicines now play a central role in treating solid tumors and blood cancers. Many are targeted therapies selected because of a patient's particular tumor biology. Others are longstanding therapies that can replace or complement infused treatment. Approximately 30 to 35 percent of newer chemotherapy drugs are available in oral form, and the share of cancer treatment delivered through patient-administered medicines continues to grow.[1]

The insurance system, however, still treats the route of drug administration as if it should determine the patient's financial burden. An infused or injected cancer drug is generally covered under the medical benefit whereas an oral cancer drug is generally covered under the pharmacy benefit. Those separate benefit structures can impose radically different deductibles, copayments, coinsurance, specialty tiers, pharmacy restrictions, and utilization-management requirements. The result is arbitrary: two clinically appropriate cancer treatments can expose the same patient to very different costs and very different obstacles solely because one is administered in a clinic and the other is swallowed at home.

COA supports H.R. 4101, the *Cancer Drug Parity Act of 2025*. The bill addresses a critical gap in federal law by requiring employer-sponsored group health plans subject to the Employee Retirement Income Security Act of 1974 ("ERISA") to provide cost-sharing for prescribed, patient-administered anticancer medicines on terms no less favorable than cost-sharing for anticancer medicines administered by a health care provider. It also prevents plans from manufacturing "parity" by increasing costs for infused drugs, reclassifying benefits to increase patient expense, or imposing more restrictive limitations on oral medicines.[2]

Congress should pass H.R. 4101. However, Congress should also understand exactly what the legislation can and cannot accomplish. Cost-sharing parity is essential, but it does not necessarily make either benefit affordable. The bill also preserves the ability of plans to use prior authorization and other appropriate utilization controls. Thus, even after parity becomes law, a patient may still face unaffordable percentage-based coinsurance, a formulary designed around rebate economics,

[1] City of Hope, "Oral Chemotherapy: Answers to Your Most Common Questions" (Sept. 15, 2025). Available Here.

[2] Cancer Drug Parity Act of 2025, H.R. 4101, 119th Cong. (introduced June 24, 2025). Available Here.

a demand to fail first on a plan-preferred drug, a mid-course non-medical switch, or mandatory use of a PBM-owned specialty pharmacy.

Parity is the floor. Access and affordability are the goal.

Executive Summary

Oral cancer drugs are not ordinary retail prescriptions. They are complex, potentially life-saving therapies that require careful selection, education, monitoring, dose adjustment, toxicity management, adherence support, and coordination with the rest of the patient's treatment plan. A policy that treats access to these drugs as a routine pharmacy transaction misses the clinical reality of cancer care.

COA's *Prescription for Health Care Reform 2.0* ("COA Prescription") identifies consolidation—particularly vertical integration among insurers, PBMs, and pharmacies—as the upstream force that magnifies the problems patients experience at the pharmacy counter. Three PBMs control 80 percent of U.S. pharmaceuticals, and those PBMs are embedded within corporations that also own major insurers, as well as specialty and mail order pharmacies. This structure creates both the incentive and the ability to favor affiliated pharmacies, shape formularies around corporate profits, and impose administrative requirements that shift patients away from the oncology practice coordinating their care.[3]

For patients, the downstream consequences of PBM and insurer market control are immediate: higher out-of-pocket costs, delayed treatment, abandoned prescriptions, treatment selected for financial rather than clinical reasons, and fragmentation of care. For independent community oncology practices, the consequences include hours of staff work fighting denials, tracking shipments, resolving pharmacy problems, and helping patients locate financial assistance—resources that should be devoted to clinical care.

COA urges Congress to act on six complementary priorities:

- Pass H.R. 4101 and ensure that parity cannot be achieved by raising patient costs elsewhere.
- Move beyond technical parity by minimizing percentage-based coinsurance and making medically necessary cancer drugs affordable at the point of care.
- Ban inappropriate "fail-first" step therapy and non-medical switching in cancer care; establish meaningful exceptions and continuity-of-care protections.
- Modernize prior authorization with enforceable decision deadlines, electronic standards, transparent criteria, and review by a physician in the same specialty.
- Protect patient choice of pharmacy and stop PBM steering, discriminatory reimbursement, and mandatory use of PBM-owned mail-order or specialty pharmacies.
- Reform PBM incentives through transparency, rebate and fee delinking, pass-through pricing, fiduciary accountability, and structural limits on vertical integration.

[3] Community Oncology Alliance, COA Prescription for Health Care Reform 2.0. (2026) Available Here.

I. Oral Anticancer Medicines Are Cancer Treatment, Not a Lesser Class of Benefit

The route by which a cancer medicine enters the body is not a measure of its clinical importance. Oral therapies can be the standard of care, the preferred therapy for a biomarker-defined cancer, the only effective therapy for a particular patient, or one component of a combined regimen. Some are taken for a defined number of cycles; others must be taken every day for months or years to keep a cancer under control.

Oral administration may spare a patient repeated venous access and hours of travel to an infusion center, but it does not make the treatment clinically simple. The oncology team must confirm the diagnosis and biomarkers; evaluate drug interactions, organ function, and comorbidities; teach safe handling and dosing; monitor laboratory results and toxicities; verify adherence; arrange refills; and rapidly intervene when adverse effects emerge. If the drug is delayed, shipped to the wrong address, dispensed in the wrong quantity, or separated from the treating team, the treatment plan can fail before the first dose is taken.

Benefit design should follow clinical need, not administrative history. The distinction between the medical and pharmacy benefits was built for a different era of medicine. Route of administration should not determine whether a patient can afford the treatment the oncologist recommends. Nor should it be used to create a maze in which an oral drug must clear a separate deductible, specialty tier, pharmacy network, prior authorization vendor, and shipment process even when the same plan would cover an infused alternative under the medical benefit.

II. H.R. 4101 Is a Necessary Federal Protection

State oral anticancer parity laws have been an important response to unequal benefit design, but ERISA preemption leaves a federal gap for many workers and families enrolled in self-funded employer plans. H.R. 4101 directly addresses that gap by amending ERISA. It applies when a group health plan covers anticancer medicines administered by a health care provider and requires no-less-favorable cost-sharing for Food and Drug Administration ("FDA") approved, patient-administered cancer drugs that the treating physician determines are medically necessary or clinically appropriate.

The bill's anti-evasion protections are particularly important. Parity would be meaningless if a plan could comply by raising cost-sharing on infused and injected drugs, moving medicines between benefit classifications, or imposing tighter limitations on oral therapies. H.R. 4101 appropriately prohibits those responses. It also preserves state laws that provide greater protection and requires the Government Accountability Office to examine the law's effect on patient out-of-pocket costs and recommend further steps to reduce financial barriers.

COA recommends that Congress enact H.R. 4101 promptly and preserve these core protections through the legislative process. The effective-date language should be updated as necessary to ensure rapid implementation after enactment. Federal agencies should then be directed to issue

clear guidance, collect plan-level compliance data, provide a meaningful complaint pathway, and enforce the substance—*not merely the appearance*—of parity.

III. Parity Must Produce Affordability, Not Equal Hardship

Parity answers one question: whether oral and provider-administered cancer drugs receive comparable cost-sharing treatment. It does not answer the more important question for a patient: Can I afford the medicine? If a plan subjects both categories to substantial deductibles or percentage-based coinsurance, the benefits may be technically equal while both remain financially devastating.

Percentage-based coinsurance is especially problematic for high-cost specialty medicines because the patient's obligation rises with the drug's price and can be impossible to predict before treatment. A fixed copayment is at least visible and understandable. A percentage of an opaque negotiated price is neither. The patient does not negotiate the price, does not select the rebate arrangement, and usually cannot see the net cost retained or passed through by the insurer or PBM. Yet the patient may be asked to pay a percentage of a price that does not reflect the plan's ultimate net cost.

Financial toxicity is itself a real and potentially devastating cancer care problem. When a cancer patient delays filling a prescription, takes less than prescribed, interrupts treatment, or abandons therapy because of cost, benefit design becomes a clinical determinant. Oral therapy places the act of obtaining and taking the drug in the patient's hands; that makes affordability and adherence inseparable.

Congress should therefore build on parity with patient-centered affordability protections:

- Minimize or eliminate percentage-based coinsurance for medically necessary cancer medicines and favor predictable, affordable fixed-dollar cost-sharing.
- Require that negotiated rebates and other price concessions that reduce the plan's net drug cost be reflected in the price on which patient cost-sharing is calculated at the point of sale.
- Ban copay accumulator and maximizer programs that prevent legitimate patient assistance from counting toward deductibles and out-of-pocket limits.
- Require plans and PBMs to give patients and prescribers timely, drug-specific information about coverage, expected out-of-pocket cost, formulary alternatives, and available exceptions before treatment begins.
- Ensure that financial-assistance rules do not become a pretext for steering patients to a different drug, pharmacy, or site of care.

These reforms should be designed so that lower patient cost-sharing is not financed by shifting costs to another cancer benefit or by reducing access to the drugs themselves. The objective is not merely to rearrange the bill. It is to reduce the financial barrier between the patient and medically necessary treatment.

IV. A Covered Drug Is Not Accessible If the Patient Cannot Obtain It

Coverage on paper is not access in practice. After an oncologist prescribes an oral cancer drug, the patient may encounter prior authorization, a formulary exclusion, a specialty-tier requirement, step therapy, quantity limits, a mandated specialty pharmacy, and a delivery process controlled outside the treating practice. Any one of these obstacles can delay therapy. Together they can turn the period immediately following a cancer diagnosis into an administrative ordeal.

Prior Authorization

Prior authorization can serve a legitimate purpose when it is timely, transparent, based on current evidence, and focused on true questions of medical necessity. But in cancer care, prior authorization too often functions as a repetitive claims-control process rather than a clinical safeguard. Oncology practices report requests for information already present in the medical record, different rules under the medical and pharmacy benefits, approvals that cover only part of a regimen, criteria that are difficult to locate, and peer-to-peer reviews conducted by clinicians who do not practice oncology.

The consequences are measurable. An analysis of branded oral oncology therapy showed average treatment delays of 20 days for commercial patients and 18 days for traditional Medicare patients when the initial claim was rejected; roughly one in five patients waited more than four weeks for approval. The same report found that formulary exclusions among leading national commercial formularies grew to 134 oncology-product exclusion decisions in 2024.[4]

COA's 2026 survey of community oncology practices reinforces what those data mean at the point of care: more than 96 percent of respondents had observed patients struggle as a direct result of insurer-imposed step therapy, and the same share reported that insurance policies interfere with patients receiving the treatment their physician recommends first.[5]

Congress should require one clear electronic pathway for submission and status tracking; real-time acknowledgment; a 72-hour outer limit for standard decisions; a substantially shorter deadline when delay could jeopardize life, health, or the ability to regain maximum function; automatic approval when a plan misses the deadline; and continuity of an approval for the clinically appropriate duration of treatment. Adverse decisions and appeals involving cancer treatment should be reviewed by a physician in the same specialty as the treating physician—not by a clinician with only generalized or unrelated expertise. Plans should disclose their criteria and provide a specific, plain-language explanation of any denial.

"Fail-First" Step Therapy and Non-Medical Switching

The phrase "fail first" is uniquely disturbing in cancer care. Treatment choice may turn on tumor type, stage, biomarker results, prior therapy, resistance mechanisms, comorbidities, toxicity risks,

[4] IQVIA, Access Challenges in the Cancer Patient Journey: How Barriers to Oral Oncology Affect Patient Initiation and Persistency (Aug. 2024). Available Here.
[5] Community Oncology Alliance, 2026 survey of community oncology practices (data on file with COA).

and the patient's goals. Requiring a patient to use and fail a plan-preferred drug can consume time during a narrow window for effective intervention. It may also expose the patient to avoidable toxicity or allow disease progression.

Congress should prohibit "fail-first" step therapy for an FDA-approved cancer drug recommended as Category 1 or 2A by the National Comprehensive Cancer Network when the treating oncologist determines that drug is appropriate. At minimum, any step therapy policy must include a rapid and clinically meaningful exception when the required drug is contraindicated, expected to be ineffective, likely to cause harm, was previously tried, or would interfere with the patient's ability to perform daily activities.

Likewise, a stable patient should not be switched for non-medical reasons because a plan's contract or formulary economics changed. Continuity-of-care protections should apply to the entire course of therapy, and mid-year formulary changes should not remove a cancer drug or move it to a more restrictive tier except for a genuine safety issue, market withdrawal, or another narrow circumstance that protects the patient.

Formulary Design

A formulary is not neutral when its construction is shaped by rebates, fees, market-share guarantees, or the economics of an affiliated pharmacy. The plan-preferred drug may not be the least expensive drug for the patient or the most clinically appropriate drug. It may be the product that produces the most favorable financial return elsewhere in the insurer-PBM corporate structure.

Congress should require disclosure of gross and net drug prices, rebates and fees, formulary-placement rationale, spread-pricing arrangements, and benefit features that favor affiliated pharmacies. A denial based on non-formulary status should identify the specific clinical and benefit criteria, explain the financial consequences of alternatives, and provide a direct and workable path to an exception. Formulary information should be current, public, searchable, and reliable—not a snapshot that becomes obsolete after enrollment.

V. PBM Steering Fragments Cancer Care and Creates Conflicts of Interest

Independent community oncology practices have developed medically integrated drug dispensing facilities because oral therapy is part of the cancer-care plan, not an isolated transaction. When permitted to dispense the medicine, the oncology team can verify the order against the regimen, assess interactions, secure authorization, locate assistance, educate the patient, coordinate the start date with other treatment, monitor adherence and toxicity, and respond quickly to changes. The prescription and the clinical record remain connected.

Mandatory specialty and mail order rules can sever that connection. The major PBMs often require the prescription to be transferred to its own affiliated pharmacy, even when the oncology practice can dispense the medicine safely and conveniently. The practice then must chase shipment status, reconcile information from an outside pharmacy, and attempt to coordinate a treatment start it no longer controls. Patients often face delivery failures, confusing calls, refill gaps, or instructions from a pharmacy that lacks the full clinical picture.

Vertical integration turns this fragmentation into a structural conflict. As I previously related, the largest PBMs are affiliated with major insurers, as well as specialty and mail order pharmacies. The Federal Trade Commission ("FTC") reported that the three largest PBMs processed nearly 80 percent of approximately 6.6 billion prescriptions in 2023. In case studies involving abiraterone acetate and imatinib mesylate—generic cancer drugs—commercial plans paid PBM-affiliated pharmacies roughly 80 to 90 percent more than unaffiliated pharmacies in 2022, while Medicare Part D plans paid affiliated pharmacies more than 30 percent more.[6] The FTC's subsequent analysis found large markups on specialty generics and higher payments to affiliated pharmacies than to unaffiliated pharmacies.[7]

Those findings expose the fallacy that mandatory use of an affiliated pharmacy necessarily saves money. A vertically integrated corporation may set the network, reimbursement, formulary, patient cost-sharing, and dispensing destination, while profits can move among affiliated entities. The patient and employer see only the final premium and out-of-pocket obligation.

Congress should protect willing and qualified community oncology practices and independent pharmacies from exclusion and discriminatory terms. PBMs should be prohibited from mandating use of an affiliated mail-order or specialty pharmacy, imposing differential patient cost-sharing to steer prescriptions, or paying their own pharmacies more for the same drug and service. Any specialty pharmacy performance program should use evidence-based measures relevant to oncology. Dispensing reimbursement should cover the reasonable cost of dispensing and clinical coordination.

VI. PBM Incentives Must Be Reformed, Not Merely Disclosed

Transparency is necessary because policymakers, employers, patients, and even plan fiduciaries simply cannot follow the money. But disclosure alone will not correct incentives that reward higher prices, larger rebates, greater volume through affiliated pharmacies, or spread between what a plan pays and what a pharmacy receives.

COA supports delinking PBM compensation from a drug's list price and from the amount of rebates or discounts obtained. PBMs should be paid transparent, bona fide service fees—not a percentage of a price they have an incentive to increase. Congress should require pass-through pricing so the amount charged to the plan for the drug corresponds to the amount paid to the dispensing pharmacy, with transparent administrative compensation. Rebates and other concessions should pass through to the plan and, where they affect patient cost-sharing, to the patient at the point of sale.

PBMs serving ERISA plans should owe enforceable fiduciary duties to act in the best interests of the plan and its participants. That obligation should reach formulary design, pharmacy-network

[6] Federal Trade Commission, Pharmacy Benefit Managers: The Powerful Middlemen Inflating Drug Costs and Squeezing Main Street Pharmacies (July 2024). Available Here.
[7] Federal Trade Commission, Specialty Generic Drugs: A Growing Profit Center for Vertically Integrated Pharmacy Benefit Managers (Jan. 2025). Available Here.

decisions, rebate arrangements, affiliated transactions, and disclosure of conflicts. Employers cannot be prudent purchasers when the entities controlling their drug benefit are permitted to withhold the information needed to evaluate price and performance.

Congress must also confront vertical integration directly. COA's Prescription calls for prohibiting insurer and PBM parent companies from owning pharmacies and physician practices, with appropriate divestiture authority and enforcement by the Department of Health and Human Services, FTC, and Department of Justice. At an absolute minimum, Congress should establish strict safeguards against self-preferencing, require equal reimbursement for equivalent dispensing services, prohibit mandatory steering, and subject transactions among affiliates to full reporting and independent audit.

VII. Cancer Care Requires Clinical Accountability and Patient Choice

The central question in every coverage decision should be whether the treatment is clinically appropriate for the individual patient. That decision must remain with the treating oncologist and patient, guided by the FDA label, authoritative compendia, recognized clinical guidelines, and the patient's circumstances. It should not be displaced by a corporate middleman applying an undisclosed rule or a financially preferred sequence.

Patient choice also matters. A person with cancer should be able to obtain an oral therapy from any qualified pharmacy that can deliver the medication safely, promptly, and in coordination with the oncology team. Network standards should evaluate actual performance—accuracy, timeliness, oncology expertise, patient education, adherence support, and coordination—not ownership. Plans should not be permitted to label a pharmacy "specialty" and then use that label to exclude a medically integrated practice that meets or exceeds the relevant standards.

Nothing in this testimony argues against responsible utilization management. Cancer drugs are powerful, costly, and sometimes toxic. Evidence-based review can protect patients and the health care system. However, the test is whether the process improves care. A process that duplicates work, ignores recognized guidelines, relies on the wrong specialist, hides its criteria, misses treatment deadlines, or channels a prescription to an affiliated company is not responsible management. *It is a serious access barrier.*

VIII. A Practical Congressional Action Plan

Congress does not need to choose between immediate patient protections and longer-term market reform. It should do both. COA recommends the following sequence:

1. **Enact oral anticancer parity.** Pass H.R. 4101 with its anti-evasion and state-law savings provisions intact, update the effective date, and require meaningful federal enforcement.
2. **Make the benefit affordable.** Limit percentage-based coinsurance for medically necessary cancer drugs, require point-of-sale benefit from negotiated price concessions, and prohibit PBM and insurer drug accumulator and maximizer practices that undermine patient assistance.

3. **Stop clinically inappropriate delay.** Create enforceable prior-authorization deadlines, same-specialty review, transparent criteria, electronic transactions, automatic approval for missed deadlines, and approval that lasts for the clinically appropriate treatment course.
4. **Protect the oncologist's treatment plan.** Ban inappropriate "fail-first" requirements and non-medical switching for guideline-supported cancer therapies; guarantee rapid exceptions and continuity of care.
5. **Restore pharmacy choice.** Prohibit mandatory steering to PBM-owned pharmacies, discriminatory patient cost-sharing and reimbursement, and network standards unrelated to oncology performance.
6. **Expose and realign PBM economics.** Require reporting of gross and net prices, rebates, fees, spreads, formulary rationale, and affiliated transactions; delink compensation from drug prices and rebates; require pass-through pricing.
7. **Impose accountability for conflicts.** Apply enforceable fiduciary duties to PBMs serving ERISA plans and empower federal agencies to police self-preferencing and anticompetitive conduct.
8. **Address structural consolidation.** Examine and restrict insurer/PBM ownership of pharmacies and physician practices; provide divestiture and disgorgement authority where vertical integration harms competition and patients.
9. **Measure what patients experience.** Require public reporting on authorization turnaround times, denials and reversals, treatment abandonment, pharmacy transfers, shipping delays, patient cost-sharing, and complaints, with cancer-specific data where feasible.

These policies should apply across the medical and pharmacy benefits so that plans cannot move burdens from one silo to another. They should also be enforced with civil penalties, corrective-action authority, accessible complaint processes, and data sufficient for Congress and regulators to identify repeat offenders.

IX. Conclusion

Cost parity is the floor. Access and affordability are the goal, because parity without access and affordability is not really parity.

Cancer is a disease in which patients can feel that they have lost control of their bodies and their futures. They should not also lose control of the medicine intended to save or extend their lives. They should not have to fight their cancer, fight unaffordable cost-sharing, and then fight an insurance company or PBM simply to receive the treatment their physician prescribed.

H.R. 4101 would correct an indefensible inequity: charging patients more because their cancer medicine comes in a pill instead of an IV bag. Congress should pass it. Then, Congress should finish the job by confronting the utilization-management barriers, distorted PBM incentives, pharmacy steering, and vertical integration that can make an apparently covered drug inaccessible in practice.

The policy principle is straightforward. Cancer treatment should be selected according to the patient's diagnosis, biomarkers, prior therapy, comorbidities, expected toxicity, goals, and the

best available evidence. It should not be selected according to which benefit silo applies, which drug generates the largest financial return, or which affiliated pharmacy a corporate middleman owns.

COA appreciates the Committee's attention to these issues and stands ready to work with Congress on reforms that ensure every person with cancer can obtain the right medicine, at the right time, from the care team and pharmacy best positioned to serve that patient.

Thank you for the opportunity to testify in person and to provide this written testimony.