



**Testimony of Anthony Wright
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Before the House Oversight Health Care and Financial Services Subcommittee

"Unequal Treatment: Addressing the Drivers of Unaffordability for Oral Chemotherapy."

September 15, 2026

Chair Comer, Subcommittee Chair Grothman, Ranking Member Garcia, and Subcommittee Ranking Member Krishnamoorthi, thank you for holding this hearing on what drives unaffordability for oral chemotherapy treatments. My name is Anthony Wright, and I serve as the executive director of Families USA, the longtime national, non-partisan health care consumer advocacy organization. For 45 years, Families USA has been working to achieve the vision of a nation where the best health and health care are equally accessible and affordable to all.

Americans across the country have made it clear that they want Congress to address the high cost of health care. In a recent Families USA poll, a majority of voters said lowering health care costs was the single most important issue for Congress to address—surpassing housing, jobs, immigration, and crime—and 94% said it was important for Congress and the President to take action, including 74% who said it was very important.¹

Prescription drugs costs are, as they have been for decades, a major driver of our country's health care affordability crisis. In 2023, nearly half of families with commercial health coverage spent up to 25% of their monthly budget on health care.² These high costs have left 100 million families grappling with medical debt they may never pay off.³ And whether someone takes ten medications or none, inflated prescription drug prices impact everyone, as they contribute to rising insurance premiums (accounting for 24 cents of every premium dollar spent), higher deductibles, and stagnant wages.⁴

Oral anticancer drugs are no exception—they are, in many ways, the quintessential example of how skyrocketing drug prices force families to choose between their health and their financial security. Oral oncology drugs often carry exorbitantly high prices of tens of thousands of dollars a month.⁵ Just last month, the FDA approved a new pancreatic cancer drug that could double life expectancy for a patient compared to existing treatments.⁶ But just a single month's supply of this oral medication is priced at \$39,800.⁷ For the 13.2 months of median life expectancy the drug provides, the cost could be over half a million dollars.⁸

Even consumers with coverage face big financial barriers to getting care, depending on the type of insurance they have and the specific benefit design of their plan. An IV-administered drug treatment is usually covered under a health insurance plan's medical benefit, which carry a specific set of co-pays and deductibles. The financial hit to families can be worse for orally administered anticancer drugs, typically covered under a plan's pharmacy benefit, and thus often subject to their own significant deductibles, specialty-tier coinsurance and other forms of even higher cost sharing.⁹ As a result, patients often face substantially higher out-of-pocket costs for an oral cancer drug even when it is a medically appropriate alternative to infusion therapy, recommended by the provider, and more convenient for the patient.

Families USA appreciates the Committee's interest in this subject and supports legislation that ensures patients do not face higher cost sharing simply because an effective cancer treatment is taken as a pill rather than being administered by infusion. Specifically, we support Chairman Grothman's H.R. 4101, the Cancer Drug Parity Act,¹⁰ which would

prohibit federally-regulated ERISA plans from imposing greater cost-sharing for orally administered cancer treatments than traditional intravenous therapies.

As Congress seeks ways to make oral anticancer and chemotherapy drugs more affordable for families, we urge you to address the many drivers of unaffordability for cancer drugs beyond this specific policy concern. Equalizing cost-sharing for IV and oral chemo without accompanying reforms will ultimately lead to cost-shifting to premiums or other treatments. To keep patients—with cancer or any condition—from facing financial barriers to necessary care, Congress must also pursue broader affordability reforms: insurance benefit design, drug patents and pricing, and ensuring affordable access to coverage for everyone.

Rising prescription drug and health care costs stem from a fundamental misalignment between the business interests of the health care sector—including drug corporations, hospital systems, PBMs, and insurers—and the health and financial security of our nation's families. The unchecked growth of big health care corporations, coupled with a lack of oversight over their business practices, has led to monopolistic health care practices and prices, reduced access to care, worse health outcomes and lower wages for workers: all of which threaten the health and financial security of every American.¹¹

We implore this Committee and your colleagues in Congress to advance commonsense health care affordability reforms for a more efficient and transparent health system and lower costs for the American people and the federal government.

The Impact of High Anticancer Drug Prices on Families

For millions of American families, high drug prices serve as a constant source of stress and anxiety. A broken system allows drug manufacturers to set monopolistic prices that jeopardize families' health, financial security, and ability to earn a living wage and meet basic needs.

Cancer patients feel this acutely. More than two million new cancer cases will be diagnosed this year alone.¹² A cancer diagnosis is frightening enough without also having to fight over how to afford the medicine that offers the best shot at survival. Yet the costs of anticancer drugs can be staggering—even for the privately insured. Complex cancer care requires multiple drugs, frequent appointments, scans, and other treatments, and the combined costs can be catastrophic. Where a drug is administered, or how a plan designs its benefits, can determine whether a patient can afford to survive:

Keaton Herzer, 34, of Colorado was diagnosed with a rare bile duct cancer. The day before an infusion of a targeted therapy his oncologist recommended and fought for months to secure, his insurance denied coverage. Rather than delay treatment that could cost him his shot at a needed liver transplant, Keaton and his wife emptied their savings and paid \$77,000 out of pocket for a single treatment.¹³

Jen Jobe, a Texas teacher who beat stage 4 colon cancer, has been fighting significant medical debt for years because of the costs. A single chemotherapy

treatment was enough to hit her plan's \$8,500 out-of-pocket maximum. Despite having employer-based coverage, she has accumulated roughly \$40,000 in debt since 2021 due to the out-of-pocket costs she incurred throughout her treatment.¹⁴

These costs have significant health and financial impacts for cancer patients and healthy families alike, because high and rising drug costs don't stop at the pharmacy counter—they drive up health care premiums and deductibles, and ultimately suppress wages for our nation's workers.^{15,16,17} When a person with employer-sponsored insurance is charged a high price for a prescription drug—such as an anticancer drug—not only will the patient have higher cost sharing, that high price will be factored in when establishing future premium costs for everyone in the employer's insurance pool. As premiums increase, wage growth slows, because employers shift more of their annual budgets toward employee health costs and less toward employees' take-home pay.¹⁸ In fact, 90% of large employers now say that high and rising health care prices are a major threat to their ability to offer benefits at all.¹⁹

For a single patient, the math is untenable: an oral chemotherapy drug that can be astronomically expensive on its own, plus several other medications, doctor's appointment copays, and other out-of-pocket costs – all stacked on top of year-over-year increases to premiums and deductibles, while wages stay flat or decline.

Cancer Patients Need Comprehensive Coverage With Limits on Cost Sharing

Ultimately, such compounded costs are why comprehensive coverage with limits on cost-sharing is crucial. No one can specifically shop for coverage knowing if or when they will be diagnosed with cancer—much less which specific treatments will be appropriate.

Recent advances in oral anticancer drugs hold real promise for cancer patients—improving quality of life, reducing side effects, and offering a more convenient, less invasive treatment option than IV therapy delivered in a clinical setting.²⁰ Despite their effectiveness, oral medications often come with disproportionate out-of-pocket costs as health plan benefits fail to keep pace with drug innovation. This disparity often stems from how health plans are structured: IV treatments are typically covered under the medical benefit, while oral drugs fall under the prescription benefit.²¹ This creates unequal cost-sharing for clinically comparable treatments and shapes patient decision-making in ways that can lead them to forgo the best treatment for their disease due to affordability concerns.

Policymakers in 43 states and Washington, D.C. have worked to address this issue and to make coverage and cost-sharing more equitable by enacting parity laws requiring insurers to cover oral and intravenous anticancer drugs on comparable terms.²² Yet state parity laws do not apply to self-insured employer health plans,²³ which cover 67% of workers with employer coverage nationwide.²⁴ Thus, a majority of America's workers do not benefit from state laws providing coverage or cost-sharing parity for these anticancer drugs due to federal ERISA preemption.²⁵ This leaves a patchwork in which a patient's financial exposure can depend on the particular state or the type of health plan they have rather than the

treatment they need. This leaves a patchwork in which a patient's financial exposure depends on the particular state they live in or the type of health plan they have, rather than the treatment they need. Only a federal law can more uniformly extend these protections to millions of workers left in the gaps.

Beyond coverage parity, some states have adopted broader measures that place caps on prescription drug cost-sharing in general, including of high-priced specialty drugs, so patients don't face bills totaling thousands of dollars for one month—or even just one dose—of treatment.²⁶

Laws enacting coverage parity and co-pay caps are responses to a system in which we largely let insurance companies design benefits in a corporate boardroom, where the focus is to limit their risk and shift cost onto consumers. In contrast, some state insurance marketplaces, like Covered California, set standardized benefit designs through a public stakeholder process, with medical providers, plans, and patient advocates weighing in on tradeoffs and best approaches to new treatments.²⁷ Such a process can address disparities and skewed incentives related to cost-sharing between different types of cancer treatments, or decide on value-based benefit designs, like reducing cost-sharing for preventive services and treatments for chronic conditions. Ultimately, we need a health system that ensures all plans cover essential health benefits which are regularly updated based on evolving patient needs and innovative new treatments. Standardized plans would go further, allowing patients to make transparent, apples-to-apples comparisons without fear that the plan they select won't ultimately cover the benefits they might need, as in the case of oral chemotherapy.

More Uninsured and Underinsured Cancer Patients Mean Much Worse Medical Debt

Of course, the underlying premise of improving health benefit designs and parity between treatment, is that coverage for every family is fundamental to maintain health and economic security. While millions of families, regardless of insurance type, struggle every day to afford their medication, we know that those without insurance usually pay the highest costs.

Without insurance, a person often pays the “usual and customary” price (the full retail price of the drug) which does not have any insurer or pharmacy benefit manager (PBM) negotiation or discount, and therefore uninsured patients tend to pay higher costs than those with insurance.²⁸ Uninsured families are far more likely to not take their medications as prescribed due to cost. Survey research shows 33% of uninsured adults were likely to forgo medications as prescribed, more than double those with Medicaid coverage (12%) and four times the rate reported by people with private insurance (8%).²⁹

For people facing cancer, the reality is even more stark. An uninsured cancer patient often faces 100% of the costs of their care. Access to insurance is one of the most important factors to a cancer patient's health outcome: people without health insurance are more

likely to be diagnosed with cancer at a late stage, when the disease is harder and more costly to treat, and more difficult to survive. And once diagnosed, uninsured patients at earlier stages are less likely to survive than patients with insurance who are diagnosed at a later stage.³⁰

However, after record annual gains in coverage since 2021, Congress passed H.R. 1 last year which made significant cuts to Medicaid, while simultaneously failing to extend the enhanced premium tax credits for those that buy insurance through the individual marketplaces. The Congressional Budget Office (CBO) estimates that the implementation of H.R. 1's cuts to Medicaid and CHIP will increase the number of uninsured people by 7.5 million by 2034.³¹ Of those, a projected 5.3 million people are expected to lose coverage because of the law's Medicaid work reporting requirements.³² Other independent analyses project even greater coverage losses, estimating up to 10.1 million Americans could lose coverage – over half of the approximately 20 million low-income Americans who access health insurance through the ACA Medicaid expansion.³³

The deliberate decision to end the enhanced premium tax credits in the individual insurance marketplaces increased enrollees' 2026 premiums by more than 58% and has already led to significant drop-offs in coverage.³⁴ Some 4.2 million fewer people were enrolled in marketplace coverage as of February 2026 compared to February 2025. And those who maintained coverage despite the premium hikes are getting less for their money. In 2026, enrollment shifted significantly from silver-level plans to bronze plans, which have lower-premiums than silver plans, but higher-deductibles and cost sharing. As a result, the average marketplace enrollee's deductible has grown by over a thousand dollars per person, from \$2,759 to \$3,786.³⁵ These shifts to uninsurance and to less generous plans leave people more exposed to high out-of-pocket costs and potentially long-term medical debt or financial ruin.

Unfortunately, some of those millions of newly uninsured and underinsured Americans will also receive cancer diagnoses, facing thousands of dollars in treatment costs. They need Congress' focus and attention to undo misguided policies that cut off access to high quality, comprehensive insurance. To more fully improve affordable access to cancer treatments including oral chemotherapy drugs, Congress must reverse the cuts to Medicaid and reinstate the enhanced premium tax credits in the individual insurance market.

Big Drug Companies Are Ultimately Responsible for High Drug Costs

Regardless of one's insurance status, families are frustrated by the price of prescription drugs, often reminded monthly when they pay their premiums and then pay again at the pharmacy counter.

Big drug companies routinely and abusively increase the price for both new and existing prescription drugs far faster than inflation.³⁶ Between 2022 and 2024, median annual launch prices increased 51% even *after* adjusting for inflation.³⁷ Prices continue to increase at staggering rates after their initial launch, leaving families and individuals paying more

every year for their needed medications. The same report showing outlandish launch price increases also found a 24% increase in regular list prices over the same 2022-2024 timeframe.³⁸

The entire business model of big drug companies is rooted in maximizing a monopoly and abusing it for exorbitant profit through price-gouging, anticompetitive behavior to extend drug exclusivity, and increasing profits on old drugs rather than investing in new and innovative treatments to help our nation's families.³⁹ Big drug companies employ many different tactics to extend exclusivity, including "patent thickets," "product hopping," and reducing competition through "pay-for-delay" schemes. When big drug companies are able to block competition, they are free to raise prices year after year at shocking rates, long after a drug's release. These price increases are not justified by additional benefits or effectiveness of the drug. In fact, one study of high-spend drugs showed that seven of the 10 drugs reviewed provided no additional clinical benefit relative to other available drugs.⁴⁰

Drug companies demonstrate again and again that it is easier and more profitable for them to abuse patent law, limit competition, and raise prices rather than investing in new, innovative treatments that will help people live longer, healthier lives.⁴¹

Congress holds the power to finally put an end to these abusive behaviors. The Inflation Reduction Act passed in 2022 is tackling high and rising drug costs by allowing the federal government to negotiate directly with drug companies for a lower price on some of the most expensive medications in Medicare.⁴² The Medicare Drug Price Negotiation Program has already negotiated lower prices for 25 drugs, with 15 more to be announced later this fall. Of those 40 drugs, four are oral cancer drugs whose prices are already lower due to negotiation and an additional four are currently being negotiated. For the already negotiated drugs – treating prostate, breast, and blood cancers – the negotiated prices are 38-50% lower than original list price.⁴³

In addition to lowering the cost of some drugs, Medicare also caps out-of-pocket drug costs at \$2,000 a year. Eighteen months after the redesign took effect, 1.5 million beneficiaries have hit the \$2,000 out-of-pocket cap, saving an average of \$1,500 per year.⁴⁴ These savings help individual patients and taxpayers broadly: The new negotiated prices for the first 25 drugs will save Medicare an estimated \$18 billion and, when combined with the new \$2,000 annual out-of-pocket cap, are estimated to save beneficiaries over \$2 billion in costs at the pharmacy counter.⁴⁵

Finally, to stop drug prices from being raised irrationally high, Medicare has the power to take action against companies that raise prices faster than inflation. While public data hasn't been released since 2024, the first two years of these rebates netted over \$1.3 billion in savings across Medicare Part B and D drugs.⁴⁶

Now implemented by presidents of both parties, Inflation Reduction Act's drug pricing reforms are an effective foundation to build on. The negotiation program is proof that policy aimed at curing the actual drivers of high drug costs, not just tinkering with the symptoms,

delivers real results. The task now is to take that model further, to more drugs and to more patients.

Pharmacy Benefit Managers Play a Role in High Drug Costs

In the absence of federal drug price regulation and prior to recent Medicare price negotiation authority, public and private payers turned to pharmacy benefit managers (PBMs) to negotiate for better prices. As third-party administrators designed to serve as intermediaries between health insurance providers and drug manufacturers, the key function of a PBM is to negotiate drug price concessions to lower prescription drug costs for health plans and employers.⁴⁷ For a long time, PBMs were one of the only tools that employers and insurers had to negotiate for rebates and discounts that ultimately ensure families can access prescription drugs at a price they might be able to afford.

Yet this solution has become part of the problem, as PBM practices also began to play a role in driving up unaffordable drug prices.⁴⁸ They hold the power to determine what drugs people have access to, what they will pay for those drugs, and even which pharmacies people can use.⁴⁹ Yet many PBM operations are opaque, leaving patients and plans wondering if they are actually negotiating for the best cost, quality, and overall value, or simply trying to get the biggest rebate even if that means others pay more as a result. Put simply, many of the practices that are good for PBMs have the potential to be misused and ultimately bad for families' access to affordable prescription drugs.

We appreciate the action taken by Congress to advance key reforms that strengthen PBM transparency including those passed as part of H.R.7148, Consolidated Appropriations Act of 2026. We encourage Congress to continue to build on this progress, not just with PBMs, but with the drug manufacturers themselves, to address the root causes of unaffordable prescription drugs.

Congress Must Act Urgently to Lower the Cost of Drugs

In addition to advancing legislation to ensure coverage and cost parity between oral and IV anticancer drugs, to truly deliver affordability to people undergoing cancer treatment, Congress must take on systemic abuses across the drug supply chain that lead to high prices in the first place. These are the most impactful cost-saving reforms that could end the devastating effects of drug companies' greed at the expense of American families' economic stability and health:

- **End patent abuses:** For decades, drug makers have systematically abused patent and market exclusivity rules to block competition. One common abuse is to make minor tweaks to existing drugs that typically confer no additional clinical benefit but allow for extended patent protections. Marketers of the 12 best-selling drugs in the U.S. filed, on average, 125 patent applications per drug for the sole purpose of extending their monopolies and blocking competition for up to four decades.⁵⁰ Practices like “pay for delay” and patent thickets should be eliminated. Reining in these patent abuses, coupled with other drug price reforms, is estimated to save \$4.6 billion over 10 years.⁵¹

- **Extend the Inflation Reduction Act’s Medicare inflation rebate to the commercial market:** The IRA requires that drug manufacturers pay a rebate when they increase prices faster than the rate of inflation for some drugs covered under Medicare Part B and almost all covered drugs under Medicare Part D. Drug manufacturers that do not pay the rebate face a significant monetary penalty. CBO estimates a net \$63.2 billion reduction in the federal deficit over 10 years resulting from this provision alone.⁵² Inflation rebates should be extended to include drugs covered in the commercial market to better protect individuals in employer-sponsored plans and other private plans from drug manufacturers’ high prices and exorbitant yearly increases.
- **Expand the number of drugs subject to negotiation and allow commercial health insurance to voluntarily adopt the negotiated rate:** The IRA limits the number of drugs that may be subject to government negotiation each year, starting with ten drugs in 2026. These prices are not automatically available to consumers with private health insurance, which drives up prescription drug costs for hundreds of millions of families. The Secretary of Health and Human Services should be authorized and required to expand this list of drugs subject to negotiation (e.g., to at least 50 drugs per year) and to extend all negotiated prices to private sector health insurance, on a voluntary basis.

Thank you again for holding this hearing today. Families across the country are feeling the negative impacts of our nation’s affordability crisis—and cancer patients are facing these challenges first and foremost. All are eager for Congress to pass an actual affordability agenda that provides relief and reaffirms that their representatives are doing all they can to deliver on their promises to lower costs and improve health care.

Toward these goals, we support the Cancer Drug Parity Act, alongside other efforts at capping out-of-pocket cost-sharing, and standardizing health plan benefits; securing and expanding coverage, including reinstating the enhanced premium tax credits for individual insurance coverage, and undoing the H.R. 1 Medicaid cuts; and further expanding efforts to address prescription prices, including cracking down on patent abuses and expanding Medicare negotiation—which has already brought down some costs for some oral cancer medications—to more drugs to more people. To provide real relief for patients like Keaton and Jen, Families USA stands ready to support you in this essential and urgently needed work.

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