

UNEQUAL TREATMENT: ADDRESSING THE DRIVERS OF UNAFFORDABILITY FOR ORAL CHEMOTHERAPY

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH CARE AND FINANCIAL SERVICES

OF THE

COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM

U.S. HOUSE OF REPRESENTATIVES

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C O N T E N T S

OPENING STATEMENTS

	Page
Hon. Glenn Grothman, U.S. Representative, Chairman	1
Hon. Emily Randall, U.S. Representative	3

WITNESSES

Mr. Ted Okon, Executive Director, Community Oncology Alliance	
Oral Statement	5
Dr. Sheetal M. Kircher, MD, Associate Professor of Medicine & Hematology Oncology Medical, Director of the Survivorship Institute of Northwestern, Clinical Practice Director, Northwestern University	
Oral Statement	7
Mr. Anthony Wright (Minority Witness), Executive Director, Families USA	
Oral Statement	9

*Written opening statements and bios are available on the U.S. House of
Representatives Document Repository at: docs.house.gov.*

INDEX OF DOCUMENTS

- * Statement from OCRA; submitted by Rep. Grothman.
- * Statement from Cancer Support Community; submitted by Rep. Grothman.
- * Statement from International Myeloma Foundation; submitted by Rep. Grothman.
- * Statement from Susan G. Komen; submitted by Rep. Grothman.
- * Article, *Protect Our Care*, “It is Only Getting Worse, Trump Admin Cuts Medicaid”; submitted by Rep. Randall.
- * Article, *The Guardian*, “TrumpRx Not A Solution For Many Patients”; submitted by Rep. Randall.
- * Statement from Families USA, Trump Admin Gives Increase to Insurers; submitted by Rep. Randall.

The documents listed above are available at: docs.house.gov.

ADDITIONAL DOCUMENTS

- * Questions for the Record: Mr. Ted Okon; submitted by Rep. Grothman.

These documents were submitted after the hearing, and may be available upon request.

UNEQUAL TREATMENT: ADDRESSING THE DRIVERS OF UNAFFORDABILITY FOR ORAL CHEMOTHERAPY

TUESDAY, SEPTEMBER 15, 2026

U.S. HOUSE OF REPRESENTATIVES
COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM
SUBCOMMITTEE ON HEALTH CARE AND FINANCIAL SERVICES
Washington, D.C.

The Subcommittee met, pursuant to notice, at 10:21 a.m., in room 2154, Rayburn House Office Building, Hon. Glenn Grothman [Chairman of the Subcommittee] presiding.

Present: Representatives Grothman, Gosar, and Randall.

Mr. GROTHMAN. The Subcommittee on Health Care and Financial Services will come to order. Without objection, the Chair may declare a recess at any time. I recognize myself for the purpose of making an opening statement.

And first of all, like I said, I apologize for being a little late here. I appreciate how some of you had to come quite a distance to be here, so.

OPENING STATEMENT OF CHAIRMAN GLENN GROTHMAN REPRESENTATIVE FROM WISCONSIN

Welcome to today's hearing of the Subcommittee on Health Care and Financial Services. Today, we are examining why cancer patients in this country are forced to pay far more for chemotherapy in a pill form than the very same class of treatment delivered through an intravenous (IV).

Chemotherapy is one of the oldest tools we have to fight cancer for decades. It was delivered almost entirely through an IV in a hospital or a clinic.

Medicine, however, has changed. The Food and Drug Administration has now approved more than 50 oral anticancer medication, and it is estimated that between one quarter and one third of the cancer drugs in development today will be available only as a pill.

For many patients, that is a breakthrough. An oral drug can be taken at home. It is less invasive, less disruptive, and just as effective as an IV infusion. For other cancers, it is the treatment the doctor prefers. In other words, it is better than an IV with an infusion. For others, it is the only option a patient has.

You would think that a less invasive, at-home treatment would also be easier on the patient's wallet, right? You do not have to go to the hospital, da, da, da. Unfortunately, the opposite is true, and

the reason has nothing to do with medicine. It has everything to do with how the drug is billed.

When chemotherapy is delivered through an IV, it is covered under a health plan's medical benefit. The patient usually pays a modest co-pay, and their out-of-pocket costs are capped for the year. When the exact same chemotherapy comes through as a pill, it gets thrown onto the pharmacy benefit specialty tier.

In other words, a flat co-pay—instead of a flat co-pay, the patient pays coinsurance, a percentage of the drug's price, and in the commercial market, that bill often has no cap at all.

One in ten patients prescribed an oral cancer drug face a co-pay of \$2,000 or more just to fill their very first prescription. Unsurprisingly, about one in ten patients never pick up their medication at all. Think about that. They got cancer and one in ten said I am not even going to pick it up.

A cancer patient walks into the pharmacy holding a prescription that could save their life only to leave empty handed because they cannot afford it.

So, who profits from, in essence, letting these people die? The answer far too often is the middlemen, the pharmacy benefit managers, or PBMs. The three largest of these companies are also owned by the Nation's largest health insurers. Okay. They decide which drugs a plan will cover, which the patient pays, and they collect rebates calculated as a percentage of the drug list prices.

The Federal Trade Commission has found that the largest PBMs marked up specialty drugs, including oral cancer drugs, by hundreds and even thousands of percent when they were dispensed through the pharmacies these same companies own, pocketing billions of dollars in the process. In other words, a way to make more money, not to do its best in the patient's own interest.

And I think the system, as a whole, does not save any money, and when they are not marking up the price, they are delaying the care through prior authorization, through failed first-step therapy, and forcing patients to fill their prescriptions through these same company-owned pharmacies, right?

If you just give them the drug in the first place, save a little money, but even more, save lives. And when they are not marking up the price, they are delaying the care.

Forty-three states have passed laws to fix this, including my own State of Wisconsin, requiring that oral and IV chemotherapy need to be treated the same. But those state laws cannot reach employer plans that cover most working Americans because Federal law pre-empts what the state legislatures are doing. Only Congress can close that gap.

That is why I personally have introduced the Cancer Drug Parity Act, which is bipartisan with a straightforward premise. A healthcare plan cannot charge a patient more for oral cancer than for IV treatment it is already covering.

This hearing will highlight how the problem took root, how middlemen are harming patients, and what Congress has to do to improve the lives of cancer patients across the Nation, and increase the chance that you will live through cancer.

We are honored to have expert witnesses here with us today to help us examine this crucial issue.

With that, I yield to—you do not look like Member Krishnamoorthi. With that, I yield to Congresswoman Randall for your opening remarks.

**OPENING STATEMENT OF EMILY RANDALL
REPRESENTATIVE FROM WASHINGTON**

Ms. RANDALL. Thank you, Chair Grothman.

I appreciate finally having a hearing again in this Subcommittee. It has been nine months since we have gotten together, nine months since the Majority has chosen across many committees to hold bipartisan—or to hold partisan roundtables instead of hearings. So, it is great to be back in this room for a hearing.

I am pleased to be filling in for—as the Ranking Member today, and to discuss the ways that healthcare has become unaffordable and inaccessible. Rising healthcare costs are a constant concern for me, as they are for so many millions of Americans.

Daily life is increasingly unaffordable, and the cost of healthcare is a huge driver. Choosing between healthcare and other essentials like food, rent, childcare, is keeping Americans up at night.

And I know that government can help. My younger sister, Olivia, was born with complex disabilities, and because of Medicaid expansion, my family was able to keep our home and afford her care, and she was able to live a thriving life for 19 years.

Every family should have the ability to care for their loved ones. No one should have to worry about how or even if they can afford healthcare. We should be working to bring down the costs and bring down healthcare prices and improve access to care so that quality care is available to all, including those in rural communities like mine.

The cost of healthcare can haunt families for years, and many Americans struggle to survive the crushing weight of medical debt. Because of soaring healthcare costs, medical debt is an issue that disproportionately impacts people of color, women, families, and those without insurance. Addressing these disparities is absolutely vital, if we are to have a healthcare system that is affordable, accessible, and improves outcomes for Americans regardless of where they live or how much money they have.

And the high cost of medication is a big part of the problem, including oral chemotherapy. In one recent survey, almost half of the respondents reported being underinsured for prescription medications. Even with insurance coverage, they could not afford all of the medications they need. This should concern all of us, and I am so grateful to hear the Chairman lay out some of the problem with oral chemo, especially.

The Trump Administration and my Republican colleagues, however, have only made the problem worse over these last two years. Policies that are making healthcare coverage more expensive have been passed by this Majority, and they have significantly cut funding to vital medical resources and programs across the country.

The Republicans' so-called Big Beautiful Bill Act cut Medicaid, stripping millions of their healthcare coverage. Then Congressional Republicans refused to extend the Affordable Care Act (ACA) tax credits that helped people afford their insurance premiums. These

unconscionable actions only led to skyrocketing healthcare premiums and out-of-pocket costs for families across the country.

In effect, Republicans in Washington have traded your healthcare for tax breaks for billionaires. Under Republican leadership, up to ten million people are estimated to have already lost their healthcare coverage. This means an additional ten million people struggling to see a doctor or pay for a prescription. They have created an environment where yet another person and another family are forced to choose between their health or rent.

And that is not all. The Trump Administration also canceled \$160 million in funding for Washington State that was meant to support disease monitoring and vaccine programs, and these cuts also make Americans less safe and risk their health.

At the same time the Congressional Republicans are making healthcare more expensive and harder to access, the Trump Administration is also destroying the research and innovation we rely on to cure diseases like oral cancer, improve treatments and advanced healthcare.

The Administration has terminated, suspended, or otherwise disrupted thousands of grants resulting in a loss or disruption of over \$16 billion in scientific research. These cuts have caused a major disruption in our Nation's scientific research engines and are costing lives.

This hits particularly close to home. Cancer patients from across the Olympic Peninsula and across the country travel to receive treatment from the Fred Hutchinson Cancer Research Center in Seattle, a world-class research institution that has been affected by Federal funding cuts and staff reductions.

Cutting cancer research is evil, full stop. This Administration has robbed our society of new treatments and cures, and cancer patients and their loved ones will suffer.

Early career researchers are now choosing different research paths because of the instability that President Trump has created. Cancer patients and others are facing terrible and deadly diseases and are suffering more after promising clinical trials have been canceled.

Costs are rising every day, and the Trump Administration is only making things harder and more expensive for our American families. The Republican Majority in Congress could have done more to stop it, but has enabled President Trump in ripping off the American people.

I am glad that we are holding a hearing today. The high cost of oral chemotherapy needs fixing, and it sounds like we are aligned on some of those issues, but that is just one piece of our healthcare challenges. Countless medications are out of reach for far too many families.

This is the very first hearing on high drug costs in this Subcommittee, and it is the last hearing this Committee will hold before Americans go to the polls to elect a new Congress. We should remember that this is far too little and far too late.

Thank you. I yield back.

Mr. GROTHMAN. Okay. I do not exactly want to respond to that, but I will say this. This hearing is focused on oral chemo. We know

there are people who feel it would be better if the government took over the entire healthcare system.

That does not work anywhere else that I am aware of. There has been tons of fraud, and more fraud will be soon shown in the current Medicaid system, saving billions of dollars. And I am going to, from here on out, just say that, you know, having the government run anything does not seem to work very well. That is why our country is so much wealthier than other countries, and we will continue to try to work to improve the current system.

But right now, we are going to focus on community oncology. I would like to welcome today's witnesses. Mr. Ted Okon serves as Executive Director for the Community Oncology Alliance. Mr. Okon is a nationally recognized expert on the policy and politics of cancer care with an expertise in cost of cancer treatments; healthcare reforms; pharmacy benefit managers, or PBMs; and the changing landscape of cancer care delivery in the United States.

Then we have Dr. Sheetal Kircher, a practicing oncologist and associate professor of medicine at Northwestern Medicine. Dr. Kircher also serves as the Clinical Practice Director and Medical Director of the Cancer Survivorship Institute of Northwestern's Robert H. Lori Comprehensive Cancer Center. In this role, Dr. Kircher oversees the program's expanding clinical survivorship care and research and long-term effects of cancer treatment.

And finally, Dr. Anthony Wright, Executive Director of Families USA, a national healthcare consumer advocacy organization. Before joining Families USA, he spent 22 years as Executive Director of Health Access America.

Thank you all for joining us, and I am going to look forward to your testimony.

Now, pursuant to—oh, by the way, I also want to submit for the record a statement from the International Myeloma Foundation. I have currently a very loved family member with myeloma.

We have a statement from the Cancer Support Community that I want to submit for the record and a statement for the record from Susan G. Komen on "Unequal Treatment: Addressing the Drivers of Unaffordability of Oral Chemotherapy."

Now, pursuant to Committee Rule 9(g), the witnesses will please stand and raise your right hand.

Do you solemnly swear to affirm that the testimony that you are about to give us is the truth, the whole truth, and nothing but the truth, so help you God?

[Chorus of ayes.]

Mr. GROTHMAN. Let the record show that all the witnesses answered in the affirmative. Thank you.

You may now take a seat, and we will first call on Mr. Okon.

**STATEMENT OF MR. TED OKON
EXECUTIVE DIRECTOR, COMMUNITY ONCOLOGY ALLIANCE**

Mr. OKON. Thank you, Chairman Grothman, acting Ranking Member Randall, and Members of the Committee. Thank you for the opportunity to testify today.

I am the Executive Director of the Community Oncology Alliance (COA), a nonprofit organization advocating for cancer patients and

the independent practices providing the highest quality and most affordable cancer care close to home.

I want to begin with a core principle. A cancer patient should not pay more for their cancer drugs simply because the medicine that may save or extend their life comes in a pill rather than an IV bag. Yet, that happens today.

Cancer treatment has changed dramatically. Roughly, one-third of cancer therapies today are oral, and that share continues to grow. But because oral cancer drugs are generally covered under the pharmacy benefit, while infused or injectable drugs are covered under the medical benefit, patients can face very different and sometimes higher out-of-pocket costs simply because of how their cancer medicine is administered. That makes absolutely no sense.

COA supports the goal of Cancer Drug Parity Act, H.R. 4101, which requires employer-sponsored health plans to provide cost-sharing for oral cancer drugs that is no less favorable than cost-sharing for cancer drugs administered by a healthcare provider.

Importantly, the legislation also prevents plans from achieving so-called parity by simply increasing what patients pay for infused cancer drugs.

Congress must pass that protection, but I strongly urge Congress to view parity as only the beginning of the discussion, not the end. Parity is just the floor. Access and affordability are the goal.

If a patient pays thousands of dollars for a medically necessary cancer drug, it offers little comfort that the coinsurance is technically equal to another benefit. Our collective goal should be to minimize the financial burden on patients receiving potentially life-saving cancer treatment.

And there is another equally important problem with potentially lifesaving cancer drugs. A cancer drug that a patient cannot actually obtain is no more accessible than a cancer drug that the patient cannot afford.

Today, insurers and their pharmacy benefit managers place obstacle after obstacle between patients with cancer and the medications prescribed by their oncologists. Prior authorization all too often delays treatment. Fail first step therapy can require a patient to try and fail a plan preferred drug before receiving the therapy the treating oncologist believes is optimal.

Restrictive formularies often exclude drugs or place them on unfavorable tiers. Patients can be forced into insurer PBM specialty and mail order pharmacies, rather than receiving their medications directly from the oncology practice coordinating their care, and patients successfully receiving a treatment can face nonmedical switching simply because the insurer or the PBM changes its formulary.

COA's 2026 survey of community oncology practices found that more than 96 percent of respondents had observed patients with cancer struggling as a direct result of insurer-imposed step therapy. The same percentage was reported that insurance policies interfere with patients receiving the treatment their physician recommends first.

For patients with cancer, the concept of fail first is not only disturbing, but it is scary and devastating.

Cancer is a disease where you effectively lose control of your body. You should not lose control of the medication to save your life. A drug preferred on an insurer PBM formulary is not necessarily the least expensive drug for the patient, or the drug the oncologist believes is best; it is often a drug that generates the greatest rebate or financial return for the middleman.

Cancer treatment decisions should be made based on the patient's diagnosis, biomarkers, prior therapy, comorbidities, expected toxicity, and the best clinical evidence. They should not be driven by what drug generates the greatest financial return for the PBM or the insurer.

Congress should build on H.R. 4101 and other legislation intended to remove the cost, delays, and denials that prevent cancer patients from receiving their optimal cancer treatment. Congress should minimize percentage-based coinsurance for medically necessary cancer drugs. Inappropriate fail first step therapy and non-medical switching should be prohibited.

Prior authorization should be dramatically streamlined with enforceable deadlines, meaningful exceptions, and reviewed by physicians with real oncology expertise. And insurers and PBMs must be stopped from steering cancer patients to affiliated mail order and specialty pharmacy simply because it is the most profitable to the middleman, the corporate middleman.

Let me close with this: Cost parity is the floor. Access and affordability are the goal because parity without access and affordability is not really parity.

Cancer patients should not have to fight their cancer, fight unaffordable cost-sharing, and then fight an insurance company or PBM simply to receive the medicine their doctor prescribed. Congress can and must change that.

Thank you, and I look forward to your questions.

Mr. GROTHMAN. Thank you.

Now we will call on Dr. Kircher for your statement.

**STATEMENT OF DR. SHEETAL M. KIRCHER, MD
ASSOCIATE PROFESSOR OF MEDICINE &
HEMATOLOGY ONCOLOGY MEDICAL DIRECTOR OF THE
SURVIVORSHIP INSTITUTE OF NORTHWESTERN
CLINICAL PRACTICE DIRECTOR
NORTHWESTERN UNIVERSITY**

Dr. KIRCHER. Chairman Grothman, Ranking Member Randall, and Members of the Subcommittee, thank you for the opportunity to testify.

My name is Dr. Sheetal Kircher. I am a medical oncologist at Northwestern in Chicago where I treat patients with gastrointestinal cancers. I am here today because my patients are not only dealing with their cancer diagnosis, but they are trying to figure out how they are going to afford the drugs that I am prescribing them.

Cancer treatment has changed dramatically. When people think about those receiving chemotherapy, they often imagine a person in an infusion center receiving an IV. But increasingly, some of our most effective drugs are pills taken at home, and sometimes this pill is not just an alternative convenient switch. It is sometimes the

best treatment or the only treatment that is appropriate for that patient, and our insurance system has just not kept up pace with that science.

An IV drug, like we have all mentioned, covered under our medical benefits, and oral drugs covered under the pharmacy benefits, this is not just a technicality of insurance design. To a patient with cancer, it determines whether they actually get their treatment.

And so, this is what it looks like in my clinic: On Wednesday, August 26, I was walking down the hall of my clinic to see Susan, a 62-year-old schoolteacher. She is a wife, grandmother, had about eight grandkids, and also has metastatic pancreatic cancer.

I was holding the printout of her scans walking into that room, and the scans, they showed that her cancer was growing despite the IV chemotherapy I was giving.

After 17 years of doing this work, I still have to pause when I walk into those rooms. I take a deep breath knowing that the words are going to take away some of her hope and force them to, once again, confront her mortality.

And literally, as I am walking into that room, I step in, I receive a notification on my phone, and it is an FDA has just approved daraxonrasib, a new treatment for metastatic pancreatic cancer. And for a few minutes, that room was purely filled with hope that there was something that was going to give Susan just a little bit more time.

That hope is quickly followed by a reality I knew was coming, that prescribing the drug and getting the drug are two different things.

With her IV chemo, my infusion center obtained authorization. Patient shows up for chemotherapy. We administer the treatment, and it goes through her medical benefits. The experience is completely different for a patient receiving oral drugs.

With IV, the patient may absolutely have co-pays and coinsurances, and those costs can be significant, but most have a supplement coverage, or an employer-based plan design that limits the amount they pay at the point of treatment. The patient is not standing at our infusion center door being told, before we hang your bag of chemotherapy, you need to pay \$1,000.

And for oral drugs, that experience is really quite different. The specialty pharmacy processes a prescription, determines the out-of-pocket responsibility, which can be substantially higher than the medical benefit. That cost becomes apparent before the drug is dispensed.

Too often, our health system specialty pharmacy is out of network, even at a large institution, forcing a prescription to a PBM-owned pharmacy, separating the dispensing of these expensive, toxic drugs, and really divorcing them from the oncology team which is providing the education and the care to the patient.

And the patient can essentially receive a phone call saying we have your cancer medication. Your responsibility is \$1,000. How would you like to pay for that before we ship it? If they cannot afford that amount, the drug is not dispensed, and we are left trying to find another way to pay for it.

And we know this cost matters. In a study of over 10,000 patients prescribed these drugs, if the out-of-pocket cost was over

\$500, they were four times more likely to abandon the drug than if it was \$100 or less. And in oncology, a prescription that a patient cannot afford is not a treatment.

IVs also mean transportation, parking, waiting rooms, hours at infusion centers, not for the patient alone, but also for their loved ones. And oral drugs face additional obstacles, they require prior authorizations, formularies, step therapy changes, and really required to go through other particular PBM—often owned specialty pharmacies.

The amount of time my nurses and advanced practice providers spend doing this, in addition to myself, is extraordinary when this is time we should be spending with our patients.

And I understand that the Cancer Drug Parity Act does not solve all of these problems. It does not eliminate prior authorizations, and it does not solve our PBM issues, but it does fix something very specific that has never made sense to me clinically.

As an oncologist, I choose treatment based on biology, science, expected benefits, toxicities, and what matters to that person sitting right in front of me. Sometimes it comes through an IV and sometimes it is oral.

On August 26, Susan did not choose whether her breakthrough was going to be developed as an infusion or a pill. She should not experience a completely different financial reality because her next treatment is swallowed instead of infused.

That is why the Cancer Drug Parity Act matters to me. The science should determine the treatment.

Thank you.

Mr. GROTHMAN. Okay. Thank you.

Mr. Wright, I guess like the others, we will give you 5–1/2 minutes.

**STATEMENT OF MR. ANTHONY WRIGHT (MINORITY WITNESS)
EXECUTIVE DIRECTOR, FAMILIES USA**

Mr. WRIGHT. Thank you, Chairman Grothman, Representative Randall, and Members of this Subcommittee. Thank you for having me here on behalf of Families USA, the national, nonpartisan healthcare consumer advocacy organization.

We appreciate the Committee's interest in addressing the drivers of the unaffordability of cancer treatments and ensuring that oral chemotherapy is appropriately covered.

Cancer impacts millions of American families. More than two million cancer cases will be diagnosed this year alone, including my wife, just a few weeks ago.

As I and millions more know personally, a cancer diagnosis is frightening enough on its own. No family should have to fight a second battle over how to afford the treatment.

Even for people with private coverage, the cost of anticancer drugs can be staggering. Take Keaton Herzer, a 34-year-old from Colorado who was diagnosed with rare bile duct cancer. The day before his infusion of a targeted therapy, his health plan denied coverage despite his oncologist's recommendation and advocacy.

Rather than delay what could jeopardize a shot at a much-needed liver transplant, Keaton and his wife emptied their savings account and paid for it out of pocket. \$77,000 for a single treatment.

Take Jen Jobe, a Texas teacher who beat stage four colon cancer and is now saddled with major medical debt. The cost of a single chemotherapy treatment was enough to reach her \$8,500 annual out-of-pocket maximum. Over the course of treatment, she racked up \$40,000 in out-of-pocket costs despite her employer on-the-job benefit.

These stories illustrate the big cost of cancer care, the need to be covered, and for that coverage to be comprehensive without delays, denials, sky-high deductibles, or other cost barriers.

Health plans certainly need more oversight, especially if benefit designs develop in corporate boardrooms without public input as they seek to minimize their risk and shift the cost onto the consumer.

Congress should follow the lead of state marketplaces that standardize plans to ensure essential benefits and fair and valued-based cost-sharing. More than half the states have also passed co-pay caps for prescription drugs with eight that have specific caps for specialty drugs, like oral chemotherapy.

Similarly, 43 states have passed parity laws so cancer patients do not face different financial barriers for IV administered treatments versus oral chemotherapy often covered in a separate drug benefit with its own deductibles, specialty tiers, coinsurance, and other cost-sharing.

We support the Chairman's bipartisan Cancer Drug Parity Act, which covers Federally regulated employer plans that states cannot touch and other efforts to ensure that all coverage is comprehensive and cost-sharing is limited.

Yet, cancer patients with non-employer plans also need comprehensive coverage. Yet, ten million Americans are projected to lose coverage because of Congress' cuts to Medicaid and the Affordable Care Act. Just this year, four million Americans dropped their individual coverage due to the doubling of premiums resulting from the deliberate decisions to end the enhanced tax credits. A few million more dropped down to bronze plans with deductibles of \$7,000 or more.

We urge this Committee to consider the millions of nearly uninsured and underinsured, including those who will inevitably become cancer patients and face the full cost of cancer care.

For all consumers, regardless of how or whether they are covered, we must confront the inflated and irrational prices of prescription drugs. Nearly one in three adults reported not taking their medications prescribed, rationing, skipping doses, not filling their prescriptions at all. An estimated 125,000 people die each year as a result.

Drug companies have long exploited a system that lets them set a high launch price with no accountability and then raise prices faster than inflation.

Thankfully, Medicare drug price negotiation and a new \$2,000 out-of-pocket cap is starting to lower drug costs for millions of seniors and people with disabilities, but the Inflation Reduction Act's negotiating power is limited to Medicare. We must expand negotiation to more drugs and to more people, including with commercial coverage.

Congress must also shut down problematic pricing and practices, like patent gaming, and pay for delay tactics that keep cheaper generics and biosimilars out of the market.

In closing, Americans are urging action on prescription drug prices and healthcare costs in general. Our Families USA poll last month showed that 94 percent of voters said it is important that Congress and the President act on healthcare costs. Seventy-four percent said very important.

They want Congress to address affordability and hold the health industry accountable, from the drug companies to the health plans, to the providers, to the PBMs.

Cancer patients like Keaton and Jen deserve more than parity between two unaffordable treatment options. They deserve a system where the cost of staying alive also does not threaten their families' financial future.

Thank you, and I look forward to your questions.

Mr. GROTHMAN. Okay. I would like to thank you all very much. Now we are going to the question and answer.

I also want to give a little shout out before we start. As far as the overall cost of drugs, I know it is, you know, drug by drug, but TrumpRx is the first time in the 12 years that I have been here that we have really had somebody willing to stand up to the pharmaceutical industry and drop the price of drugs. And while that is not going to be as comprehensive as what we are going to talk about today, it was a great step, and I would like to thank the President for that.

Okay. Now we will start the questions. I recognize myself for 5 minutes.

Medicine has changed, more and more cancer is being treated with oral medication. The patients take it at home rather than through IV infusions. For many patients, oral chemo is the safer, easier, and more effective option, but the way these drugs are paid for has not kept pace with the change.

I would like to ask both Mr. Okon and Dr. Kircher, can you explain in plain terms how our insurance rules have failed to keep up with the science and who ends up paying the price for this failure?

Mr. OKON. So, I think, Mr. Chairman, part of the problem is you identified in your remarks that the PBMs, basically three PBMs, control 80 percent of the prescription drug market. You have to realize, each one of those PBMs is owned by an insurance company. In fact, in some cases, the insurance company owns the physicians as well, too, with United Healthcare.

So, the problem is that as these companies have seen these oral cancer drugs and upwards of 30 percent, we are going on 40 percent of cancers are treated with oral cancer drugs, you have to realize that they are gold to these PBMs. They are gold, especially when they can extract rebates and do other mechanisms to make off of these drugs, and they always push the highest-priced drugs.

So, the fact of the matter is that this has attracted them to a market that is just going to increase, and it is just going to get worse.

Dr. KIRCHER. Yes, I agree. And, you know, I think in cancer specifically, the drugs have changed so much over the last 20, 30 years

where we did use to only have IV chemotherapy. And even in the 15 years that I have been practicing, the science has evolved in a space where—not only orals. We are talking about the next level of now we are going to have, you know, a lot more immunotherapy, CAR-T therapy, different type of infusions that will need to keep up with this antiquated way that we really finance the chemotherapy, locking us into a bucket that really does not make sense for oncology anymore.

Mr. GROTHMAN. Okay.

The medical providers that are members of the Community Oncology Alliance, or COA, treat most of the cancer patients in our country. As COA's Executive Director, you have spent years fighting the industry practices, again, between patients and their prescribers.

Could you explain to us how PBMs and insurers often interfere with a patient's prescribed oral chemo treatment?

Mr. OKON. It is terrible. First of all, when the drug is prescribed, if the insurer or the PBM, with prior authorization, does not agree with that, then the oncologist basically has to make a switch, or, in some cases, the insurer will basically say, you have to fail first on this drug, and in some cases a couple of times you have to fail.

Think about that cancer patient when someone says you have to fail on that drug, meaning your cancer is growing before you basically get the drug that they want.

And, again, I go back to the issue here. When you have three entities that control 80 percent of the prescription drug market, they are in a leveraged position to extract rebates, and, therefore, they look for the most expensive drugs, the drugs that they can profit the most from as the drugs that they want the patient to get, not what the oncologist wants.

So, it is a growing problem, especially as we have more oral drugs. Why didn't we see this ten years ago? Because we did not have the oral drugs that we have now. It is just going to get worse, and it is going to get worse until we do something about these PBMs and insurers.

Mr. GROTHMAN. Thank you. We have dealt with the PBMs in other hearings.

Dr. Kircher, for some cancers, an oral drug is not just more convenient, it is the treatment that works best, and it is the only option a patient has. When a plan makes this option unaffordable but covers the IV drug cheaply, are we forcing patients toward a more dangerous alternative?

And does the doctor, who ultimately, you know, as you are relying on, do they know what is going on?

Dr. KIRCHER. Thank you for that question. And I think that is a misconception that these drugs are alternatives. They are actually completely unique identity, you know, identifiable drugs where I, as a physician, am not making a choice. I do not have a choice oftentimes for an IV alternative.

So, there are times, absolutely, where I cannot get my oral drug quick enough, fast enough, and I will need to start patients on IV therapy because I can get it approved quicker.

I absolutely agree with your question that, yes, that oftentimes does put patients in a toxicity space that I would rather not them

be in, and I am doing it mainly based on the fact that I need to treat their cancer quickly.

Mr. GROTHMAN. Thank you.

Okay. We have taken that time.

Ms. Randall.

Ms. RANDALL. Thank you, Mr. Chair, and thank you, again, to our witnesses for being here today.

As I mentioned at the start, last year, H.R. 1 was the beginning of stripping health coverage away from 15 million Americans. Rural hospitals, nursing homes, and community health centers who often are providing important, lifesaving healthcare to cancer patients, are under severe strain, forcing many to reduce services or close them altogether.

Many rural hospitals are choosing whether or not they can continue offering oncology and cancer services, or if their patients are going to travel hours farther to go to another treatment center that still provides that care, pregnant women are being forced to travel greater distances to access maternity care, seniors struggling to find long-term care, people with disabilities experiencing serious disruption to essential services.

Sarah in Takoma, Washington, wrote to me that she is a breast cancer survivor who was diagnosed with an aggressive form of a disease just before her 41st birthday. She credits decades of federally supported research with helping make her survival possible.

And now, at 44, and two years past active treatment, she continues to live with the fear of recurrence while watching for the next breakthrough. Her story is a reminder that research breakthroughs become lifesaving treatment, and Congress must protect Federal investments and cancer research and ensure that these treatments are affordable and accessible.

In the richest country in the world, as the Chair pointed out earlier, that we are, it is unacceptable that we allow high, out-of-pocket costs to stand between patients and the advances that research makes possible.

Mr. Wright, my question is for you. Oral chemotherapy can be particularly difficult to access for patients in underserved communities where lower incomes, gaps in insurance coverage, limited access to oncology care, other barriers, can compound and burden the high out-of-pocket costs.

What do you see affecting most patients in rural, low-income, and other underserved communities in preventing them from getting access to care?

Mr. WRIGHT. Obviously, the issues of access in rural healthcare is significant already. We used to say, as you mentioned, that the cuts that were made last year, the biggest cuts in the history of the Medicaid program, will make that issue worse, especially for providers where Medicaid is the primary payer, and that includes rural hospitals; that includes maternity wards; that includes community clinics and a range of other providers that will have to either scale back services or maybe even close as a result.

I also think that these cuts have an impact both on moving people off of coverage, again, estimated millions of people who will face the full force of cancer costs if they do get cancer while uninsured

or underinsured. And even if they are insured, they will have a harder time getting access to the care that they need.

And even trying to get through some of the bureaucratic burdens, you have a situation where the Trump Administration has gone further than the law that was passed by saying that, yes, we are going to exempt people who are medically frail from these requirements, but we are going to actually have to have everybody go get a doctor's note.

We are not going to blanket, say, folks with cancer have this, and we are going to put additional bureaucratic burdens even for cancer patients to get the care that they need.

Ms. RANDALL. Thank you so much for that perspective.

As we know, the cost of healthcare can lead many to putting off much-needed care. And it is not a red state versus blue state issue, right? I represent Washington State, but these huge cuts affect everyone.

Texas hospitals are facing a roughly \$9.8 billion loss in additional Medicaid funding this fiscal year, about \$27 million a day, funding that helps hospitals cover the gap between Medicaid payments and the actual cost of caring for patients who need, often expensive, treatment.

Mr. Wright, you shared so much about the patient experience with us. For oral chemotherapy in particular, how much of the financial burden patients face today is driven by the underlying price of the drug itself versus the way insurers structure coverage?

Mr. WRIGHT. I think it is both. I think the drugs are very expensive. And, again, we give them a monopoly, but, in many cases, they abuse that monopoly, that patent, with games to try to extend that monopoly to have more time to charge the monopoly price. And then the insurers pass that cost on to consumers and try to limit their risk with the types of benefit designs.

And that is why we need to have oversight over benefit designs. Cancer parity is one example, but there are other ways to put caps or other ways to make sure that we have standardized plans so people have assurance that essential benefits are covered, and they can do apples-to-apples comparison.

Ms. RANDALL. Just a unanimous consent—I am done with my questioning. Thank you.

I ask for unanimous consent to enter into the record an article from *The Guardian* which shows how TrumpRx is not a solution for the majority of patients dealing with high drug prices. And also, for unanimous consent, to enter into the record a report from *Protect Our Care*, which found that the Trump Administration's actions threaten the closure of over 1,200 hospitals, clinics, and nursing homes, jeopardizing access to care.

Mr. GROTHMAN. Okay. Without objection.

I will say right now, we will see how many more people show up for this Subcommittee, but we are going to have two rounds of questioning, so if you want to hang around.

Now we will go to the great Paul Gosar.

Mr. GOSAR. Well, you both—all of you may not know I was a dentist for 25 years, okay. So, I was looking at marketplaces.

So, Mr. Wright, I am going to ask you this question. How has the patent process really affected this? Because once upon a time, it used to be first to discover instead of first to file.

Mr. WRIGHT. Again, I think we have a drug development process where those who file the patent get the benefit of several years of charging monopoly price.

I do think that the opportunity for Congress is to take a look at ways that that patent has been gamed, whether from patent gaming, trying to extend the patent, pay for delay settlements where they actually do settlements to the potential generic competitor to keep competition from the market.

Mr. GOSAR. I think as a preliminary force, and we have to go back and address this because there once was a law called McCarran-Ferguson that gave limited liability to insurers for that monopoly rule, but they were running a freight train through that thing. It was my legislation that repealed that. Now, I think we ought to be looking back at that one. Do you agree?

Mr. WRIGHT. I would be happy to take a look at it.

Mr. GOSAR. Great, great, great.

So, what if I told you that part of this is the Federal Government's problem, Mr. Okon? So, back in 2007, we knew that with cancer drugs, that the IL-15 was a marker that actually exposed the tumor, and then you could use your own genetics in your immune system to kill it off. That was known in 2007.

Why do we have this? As we see now, Keytruda is an I-2 drug. It does not do that. And yet, Anktiva is the one that exposes those tumors and lets your immune system take care of it. This has been known since 2007 in the FDA.

What is the problem? Why isn't this being directed, and why is it so expensive?

Mr. OKON. I cannot really explain that, Congressman. I mean, the fact of the matter is that in the—and Dr. Kircher could talk about this.

Mr. GOSAR. I will come back to her.

Mr. OKON. We have more drugs, and more novel drugs. She talked about CAR-T and talked about not just the immuno agents that we see in terms of Keytruda and Opdivo, but we are seeing cellular therapies come out that are using the body's own mechanism to heal.

And I think that, basically, you are going to see a lot more of this, and they are very novel. And how we pay for those and the mechanism has to be looked at as well, too, because it is not just, as the Chairman said, going from, you know, injectable chemotherapy that you think of traditionally to oral drugs. It is now cellular therapies and different things, and we have a payment mechanism that is archaic and not keeping pace.

Mr. GOSAR. I am glad you said that, because, you know, bringing in the Ranking Member's comments, I agree with her. The lady with breast cancer, why she was not given Abraxane, I do not know. You know, it is criminal what is going on here, absolutely criminal what is going on here.

So, you know, I think we ought to start from the very bottom, increasing competition so that nobody can look. Do not allow any

limited liability for the insurance companies. Make them compete. Make them compete.

And we are so far behind. There are 34 countries, 35 countries I believe now, that give the exemption to insurers that they have Abraxane and then you have this Keytruda.

Doc, what do you see in your practice?

Dr. KIRCHER. I mean, really just echoing the sentiment up here, is that we need innovation in cancer treatment. We need these types of treatments to move forward, and they are expensive, and they take a lot of research and development. So, you know, comprehensive healthcare reform and price reform. Drug parity is just one piece of this very complicated puzzle. Knowing that stifling innovation is not what our cancer patients need, but leaving behind a legacy of financial devastation also cannot be, and how do we find the middle ground?

Mr. GOSAR. Exactly. I want to come back to that.

I want to talk about, you know, the opportunity for the right to try. Why isn't it getting the vestige that it should be? Because I think there is a lot more to the story than meets the eye.

I will yield back, and I will look forward to the second round.

Mr. GROTHMAN. I ask unanimous consent for a second round of questions for the Members. Without objection, so ordered. You are not objecting, are you?

Ms. RANDALL. I am not objecting.

Mr. GROTHMAN. Okay. First of all, I will make a point outside of this. We may or may not have other people show up for the Subcommittee, I will make a point that we should do something about Subcommittee attendance later on. Okay.

Mr. GOSAR. Well, I will tell you, I enjoyed this. I get an unlimited number of questions today.

Mr. GROTHMAN. I know.

Mr. GOSAR. I will tell you that right now.

Mr. GROTHMAN. All the more importance for the people who do show up.

Mr. OKON, this is for you, 43 states and the District of Columbia have already passed oral parity laws. I believe I voted for such a law when I was in the state legislature in Wisconsin. But those state laws do not reach self-funded employer plans, so those states do not—so those state laws do not reach self-funded employer plans, which cover roughly two-thirds of Americans. So, you know, if you are sitting back home and you hear this, you thought, wait, I thought my state took care of it, not if you are part of a self-funded employer plan.

The Cancer Drug Parity Act, which I reintroduced this Congress, closes the employer-plan gap by amending ERISA so a plan covering IV anticancer drugs must offer cost-sharing for medically necessary oral anticancer drugs on terms no less favorable than the IV alternative.

In practical terms, what changes would a patient at the pharmacy counter see if this bill becomes law?

Mr. OKON. Well, I think the beauty of it is, Mr. Chairman, is that now on a Federal level, you basically have parity for those self-funded plans. So, it fills in the gap that you have with those 43 states, that is just under state law.

So, I think it is an absolute step in the right direction. I think what we need to build on it, as I said, and Dr. Kircher said as well, too, is we need to build on it in terms of having no prior authorization, and no fail-first step therapy as well, too.

But everything we do, we have to understand, everything that Congress does here is a step in the right direction in terms of PBMs and insurers, and certainly oral cancer parity.

Mr. GROTHMAN. Dr. Kircher, I am going to ask you this: obviously the current system is broken. We have people dying unnecessarily because they cannot get the drugs they have. The question is, who exactly, because overall this should be, I would think, cheaper overall, right, because you are not going through this first step, sort of, nonsense in which somebody is paying the cost there, who is making the money off the current system at the expense of the patient? PBMs, drug companies, who is making the money?

Dr. KIRCHER. I think the answer to that question is, yes, all of those, at the expense of the patient. And so, I think, at every step in that chain that you just mentioned that there are inefficiencies, and likely abuse. You know, ultimately, I know that what I am seeing at the patient level, and at the physician level is where things are suffering, and that is where it matters the most.

You know, people are definitely not paying me more to handle these prior authorizations. And answer the phone call from the patient, and the numerous messages in the portal I receive of when is my authorization going to go through, and me not having an answer for them.

Mr. GROTHMAN. Okay. Now, there are obviously a lot of costs that goes into the current system, so common sense would say that overall, if this bill passes, it will be cheaper overall, right, if you could immediately go to the oral drug right off the bat.

Dr. KIRCHER. I would not assume that necessarily oral drugs are cheaper or less cheap than IV drugs. Sometimes IV drugs are more expensive. It just puts them on—this legislation is excellent because it puts them on par with each other, so at least there is some transparency in how we are covered.

Mr. GROTHMAN. I guess what I am trying to get to, this legislation is not a law today. And it is not law, somebody would have introduced something in past sessions, except for somebody is making money. So, the question for you really is, who is making the money? You can say. Who is making money on the current system that would stand in the way of this bill becoming a law.

Dr. KIRCHER. I think PBMs. Yes. And all the middlemen in between.

Mr. GROTHMAN. Okay. Dr. Okon, I can see you wanting to say something.

Mr. OKON. Excuse me, but when my wife listens to this and she hears you call me doctor, and she is the nurse, she will say there is only one medical professional in the Okon family and it is not him, as much as he thinks he knows about oncology. So, I appreciate your reference to the doctor.

But let me say that who is making the money are the insurers and the PBMs in this. I mean, I am not going to deny that basically launch prices are too high on the pharmaceutical company side, but you have to understand that they have an ordinate con-

trol. The top insurers are the top PBMs, so they have total control of the marketplace.

Mr. GROTHMAN. So, vertical integration is part of the problem, too.

Mr. OKON. Absolutely. And if I can say, consolidation—if you asked me one word to tell you what is wrong with our healthcare system, it is consolidation. And if you go online and you look at the color prescription for healthcare reform 2.0, you will see it is consolidation is our problem.

Mr. GROTHMAN. I do not want to wander here, but the general perception that I know people around here, is the current system, which was changed so much under President Obama, was largely written to benefit the insurance companies. And we have received private briefings on not only that, but the huge cost of fraud under the current system that is just through the roof. But in any event, we will go to Ms. Randall for her second round.

Ms. RANDALL. Thank you, Mr. Chair. I want to second the challenges of vertical integration and consolidation in the healthcare system. It is an issue that I worked a lot on in the Washington State legislature when I was there.

But Dr. Kircher, you were talking about your patients, you know, you see them on their hardest days having to make really tough choices about what they can afford, what kind of treatment they can afford to access. And I could not help but think, I had a friend who was diagnosed with a very serious and aggressive GI cancer before her 30th birthday and, you know, best way to get through it was to think about money as like monopoly money. She is like, well, either I am going to survive and I will figure it out, or I will not and what does my credit card bill mean to anyone, which is a really challenging place to be for someone fighting for their life.

As your patients are making these decisions about what they can afford, what other considerations, you know, are they sharing with you? Is it taking care of their children, their housing? What goes into making this decision about what is possible for them.

Dr. KIRCHER. It is really interesting, when you talk to patients, they oftentimes will not bring up the finances. You know, you are sitting in front of them telling them, you know, the worst news of their life, and they do not want to share with their doctor that they do not—that they are worried that they cannot afford the medications. They will put it on their credit card, they will sell the house, they will do whatever they can for that glimmer of hope, and they do not want me to make decisions based on whether or not cost is an issue.

But, you know, I oftentimes remind my patients, and have to remind my team and myself that these patients have lives outside of these four walls. Work did not stop, although they may not be able to go to it, their children still—you know, anyone who has a five-year-old knows that, I do not know if they care if mom does not feel well. Mom has got to do what she has got to do. And so, childcare continues, work continues, and the bills just keep piling up.

So, when we talk about even a total, you know, an out-of-pocket cost of \$50, \$100, it is not the \$50, it is not the \$100, it is that amount of money sitting on a pile of direct and indirect costs. And,

you know, I wish that credit card bill would just go away, but really what it is doing is leaving a financial legacy to their kids and their spouse and their loved ones on top of them potentially passing from their cancer.

Ms. RANDALL. Thank you so much. You know, Mr. Wright, you earlier enumerated a number of things that Congress could be doing to address some of the problems with rising healthcare costs. Can you share, again, some of your best recommendations so that we can ensure rising drug prices do not translate into patients delaying, abandoning, or going without treatment?

Mr. WRIGHT. Thank you, Congresswoman. I first start with coverage. None of this conversation means anything to people who are uninsured or underinsured. People who are uninsured live sicker, die younger, or are one emergency away from financial ruin. Reversing the cuts that have been made, and trying to further expand coverage is a direction we need to go to properly honor cancer patients and make sure that they are covered.

Second, once they are in coverage, that coverage needs to be comprehensive. And that means not have untold cost-sharing barriers, whether it is because if it is oral or IV, or just because it is a cancer treatment and it is thousands of dollars. And so having some review and oversight over benefit design, whether it is standardized plans, whether it is co-pay caps, or other things.

But then, basically that is basically just a cost shift within the insurer to then shift onto other types of cost sharing, or to premiums if you do not deal with the base cost of why the drugs are so darn expensive to begin with. And that means dealing with the issues of why drugs are so expensive, whether it is with regard to patent abuse, whether it is with regard to other issues of problematic practices, or just even just having the government negotiate for the best possible deal, like both President Biden and Trump did under the Inflation Reduction Act. That would be an appropriate way to expand that Medicaid negotiating power to more drugs, to more people across the board.

Ms. RANDALL. Thank you. I hope some of those recommendations are things we can work on bipartisanship. I just have one more UC request for you, I ask unanimous consent to enter into the record an article from *Families USA* highlighting how the Trump Administration is prioritizing insurance companies over American families.

Mr. GROTHMAN. Without objection. Okay. We will call on Congressman Gosar one more time.

Mr. GOSAR. Sounds good. Mr. Wright, would you agree with the statement I am going to make here, "good process builds good policy builds good politics"?

Mr. WRIGHT. Generally, yes.

Mr. GOSAR. So, we are talking about process. Now, I guess what we looked at, we have seen Republicans try to do this comprehensive healthcare, we have seen Democrats try to do it, and it is a failure all the time because I think we lack the aspect of working with our Federal system, the incubators called states. I think we really need to do this to find out how it works, how it is working for them.

And what one may work in Arizona, does not work in Washington State. May work in California, but it does not work in New York. We have got to tailor it to that measure, and we do not know those answers until we do that. Would you agree?

Mr. WRIGHT. I have been a state advocate for 30 years before taking this job, I absolutely agree.

Mr. GOSAR. Mr. Okon, do you agree with that?

Mr. OKON. Yes.

Mr. GOSAR. How about you, Doc?

Dr. KIRCHER. Generally, yes.

Mr. GOSAR. Well, so I am looking at this, and I empathize with you so badly, because you are forced subconsciously, especially when you belong to a network, you are subconsciously geared toward that, what you know is being paid for and not being paid for, right? Does that make sense to you? So, you get this vertical integration.

Dr. KIRCHER. Yes.

Mr. GOSAR. They own the docs, they own the pharmacies, they own the hospitals, and you are forced to do that. So, it subconsciously puts you in a predicament, well, I know what they are going to be paid for so that I can get this compensated, but it may not be the treatment of choice.

Dr. KIRCHER. Correct. Yes. You know, we are oftentimes playing that calculus in our head as far as I need treatment fast, and what am I going to be able to get authorized quickly. Oftentimes, we do not have that luxury of options, but yes.

Mr. GOSAR. Boy, we are in a real mess here because this is just a sticky wicket because if you look everywhere, it is a problem. When you look at the states as a Federalist, Mr. Wright, how would you go about doing that? Teach us something we may not know.

Mr. WRIGHT. I mean, I think I would look at states and what they are doing. Again, I mentioned my past experience as an advocate, a consumer and patient advocate in California where in Covered California, they actually have a public process where it is not—the insurance benefit design is not done in a corporate boardroom, it is done in a public process that includes providers, that includes patient advocates, includes the plans themselves, and they have a little bit of a straightjacket of trying to hit benefit designs that hit 70, 80, 90 percent of actuarial value. And so, there are real tradeoffs.

But then they can decide, hey, in order to have the most valuable benefit for folks, let us actually put primary and preventative care in a tier that has the least cost sharing possible, if no cost sharing at all, even if that means a slightly higher hospital benefit, it means dealing with some of the inequities between IV versus oral treatments so there is not this weird dislocation where the doctor is trying to not just give the best clinical advice, but also trying to help the patient with the financial advice, which is not the forte of a doctor. And I think that kind of public process is actually really important when setting standardized plans.

That is something—so, I do believe in the Federal system when, let states experiment, but when you have an idea that is working, then take it Federal across the land. And I think we are trying to

do that with the oral—with the Cancer Parity law, which is done in 43 states, but we need to fill the gap for the Federal plans, and other things like that.

Mr. GOSAR. Well, see, I get to this point where, you know, the Federal Government does not know all. And I think we put artificial restraints in when we do not think we are doing it at all. And so, I like the marketplace, but I want the compassionate aspect. So, I do not know if I—I do not know how to get that. Do you understand where I am coming from? You know, I want the system to work, but I want the patient to be the center focus. Because she is put in a quandary as a doctor, she is put in a quandary, I want her to be able to say, listen, this is the best mechanism, the best drug for you, here is how to get it.

Mr. WRIGHT. I actually, again, agree with you on one point, which is I do actually think some of these kinds of public things will actually allow the marketplace to work better. If you actually have clear standardized plans, consumers can actually then make apples-to-apples comparison, rather than be confused by different plans.

A person who is buying a coverage today has no idea if they are going to get—what kind of cancer they are going to get, or whether they should check to see if this plan does better with covering oral versus IV. That is not something that should be in somebody's mind when they are doing comparison.

Mr. GOSAR. So, first step for you would be parity with ERISA, right?

Mr. WRIGHT. I think you either do the good things at the Federal level, or you allow states to lift the floor.

Mr. GOSAR. Well, doesn't challenging ERISA allow you to go to the states more often?

Mr. WRIGHT. What?

Mr. GOSAR. Doesn't breaking down ERISA actually allow you to work with states more broadly?

Mr. WRIGHT. I think you can go in another direction. You can either allow states to do more putting the floor in place, or pass the rights and consumer protections at the Federal level.

Mr. GOSAR. Okay. Well, I thank you very much. I appreciate it.

Mr. GROTHMAN. Thank you very much. In closing, I want to thank our witnesses, again, for your testimony. Now we are going to go to closing remarks. Ms. Randall.

Ms. RANDALL. I just want to thank you all for bringing your best ideas today to this discussion. You know, healthcare is such a vital issue for all Americans across the country, folks in red states, and blue states, in rural communities, and urban communities, providers who are trying to keep their doors open and help their patients access the care that they so need, and families who are making tough decisions about what they can afford. And I think it is definitely our responsibility to ensure that everyone has all the tools that they need to not just survive, but thrive, and that means ensuring that healthcare is not a direct ticket to bankruptcy for families who are dealing with really severe challenges. Thank you so much. I yield back.

Mr. GROTHMAN. We have had several committee hearings dealing with healthcare on this Subcommittee, and on the Committee as a

whole, and it is always very depressing to hear the degree to which greed drives our healthcare system, and this is one of the most extreme examples of that.

So, I am glad we had this hearing today. I hope the people who have been up here remember what they hear in this hearing. I will never forget it. And because it is the last hearing prior to the election, I do not think my bill will pass this session, but hopefully the people up here can—well, I think all of you view it favorably, we will see what we can do to make sure it passes last time.

I heard similar testimony to this 14 years ago when I was in the Wisconsin legislature, and Wisconsin is one of the whatever, 42 states, or however many states have tried to do this, and like I said, you know, you hear about all these doctors and whatnot, and big insurance executives, and when you are sitting there as a patient, and you—if somebody is at home watching this hearing, it is depressing to hear how much—which one will make us more money drives the system, and sometimes in advertently. I would like to actually talk to Dr. Kircher later about something or other along these lines.

In any event, I want to thank our witnesses for their testimony today. I now yield—we have taken care of that. With [sic] and without objection, all Members have five legislative days within which to submit materials and additional written questions for the witnesses. If there is no further business, without objection, the Subcommittee stands adjourned.

