



THE CANCER DRUG PARITY ACT OF 2017 (H.R. 1409)

BACKGROUND: Traditionally, intravenous (IV) and injected treatments were the primary methods of chemotherapy delivery. Today, patient-administered chemotherapy has become more prevalent and is the standard of care for many types of cancer. But insurance coverage has not kept pace with medical innovation and the growing trend towards orally administered chemotherapy. While traditional anticancer treatments are covered under a health plan's medical benefit, often requiring patients to pay a minimal co-pay or no cost at all for the medication, oral anticancer medications are usually covered under the health plan's pharmacy benefit, often resulting in burdensome out-of-pocket costs through coinsurance (requiring patients to pay a percentage of the overall cost of the prescription drug). These co-pays can be hundreds or thousands of dollars per month and, as a result, almost 10% of patients choose not to fill their initial prescriptions for oral anticancer medications.

- Oral chemotherapy accounts for approximately 35% of the oncology development pipeline.
- Many oral anticancer medications do not have IV or injected alternatives and are the only option for some cancer patients. As these medications become more prevalent in cancer treatment, they must be as affordable as their IV counterparts.
- This benefit disparity negatively impacts patient adherence and forces physicians to make decisions based on outdated health plan benefit designs rather than what is best for the patient.
- 43 states and the District of Columbia have passed oral parity laws, but these laws only affect state-regulated insurance plans. Federal legislation is needed to reach plans regulated by the Employee Retirement Income Security Act (ERISA), which are most private sector health plans, and usually large, multi-state health plans.
- **The Cancer Drug Parity Act of 2017** requires any health plan that provides coverage for chemotherapy treatment to provide coverage for self-administered anticancer medication at a cost *no less favorable* than the cost of IV, port-administered, or injected anticancer medications. This law is not a mandate as it only applies to health plans that already cover chemotherapy. This bill ensures equality of access and insurance coverage for ALL anticancer regimens.

**Request: In the House, please cosponsor H.R. 1409 to ensure every cancer patient has access to the anticancer treatments recommended by their physicians.
In the Senate, please join your House colleagues in introducing this legislation.**

For more information on the bill or to sign on as a cosponsor, please contact Rob Butora in Representative Leonard Lance's office at Robert.Butora@mail.house.gov or Erin Meegan in Representative Brian Higgins' office at Erin.Meegan@mail.house.gov.



THE CANCER CARE PLANNING AND COMMUNICATIONS (CCPC) ACT (H.R. 5160)

BACKGROUND: The complexities of cancer care coordination and limited cancer program resources often results in cancer patients not receiving a care plan for treatment and survivorship. Patient navigation and survivorship care planning have emerged as important cancer program strategies to help advance early integration of supportive care services as part of quality cancer treatment. Integrated supportive care services promote patient-centered care, enhance shared decision-making, and improve the patient and family experience – key markers for delivering high quality and value in cancer care. Cancer care is particularly complex because it is multidisciplinary, requires the coordination of active treatment and management of symptoms and side effects, and encompasses elements of acute and chronic care. The needs of the cancer patient, too, are more than simply medical – patients and their families need psychosocial, financial, and navigation support throughout treatment.

- Cancer programs consistently cite reimbursement limitations, staffing shortages, and resource allocation concerns as major impediments to delivering integrated supportive care services, such as patient navigation and survivorship care planning.
- Most cancer patients still do not receive a written plan that explains their diagnosis, prognosis, treatments, and expected symptoms, leaving them to navigate the complexities of a cancer diagnosis without clear direction or knowing what to expect from their care.
- Research has confirmed that coordinated cancer care outlined in a written care plan—care that integrates active treatment and symptom management—improves patient outcomes, increases patient satisfaction, and reduces utilization of health care resources.
- **The Cancer Care Planning and Communications Act** would establish a new Medicare service for cancer care planning. The bill will encourage the development of a personalized cancer care plan for Medicare beneficiaries, aligning with the Centers for Medicare & Medicaid Services' (CMS) recent efforts to foster care planning in Medicare.
- The CCPC Act would encourage shared and informed decision-making between patients and their cancer care teams and empower patients with tools to manage their care from active treatment through long-term survivorship.

**Request: In the House, please cosponsor H.R. 5160 to encourage the development of a personalized cancer care plan for Medicare beneficiaries.
In the Senate, please join your House colleagues in introducing this legislation.**



THE PALLIATIVE CARE AND HOSPICE EDUCATION AND TRAINING ACT (PCHETA) (H.R. 1676/S. 693)

BACKGROUND: Palliative care improves quality of life, enhances patient and family satisfaction with care, and controls costs for the rapidly expanding population of individuals with serious illness or multiple chronic conditions. In 2000, less than 25% of U.S. hospitals had a palliative care program, compared with 75% in 2015. Yet, not all these programs have in place the interdisciplinary team necessary to provide comprehensive, high-quality palliative care. At the same time, palliative care is increasingly being provided in community settings. This growth comes in response to the increasing numbers and needs of Americans living with serious or complex chronic illnesses and the realities of the care responsibilities faced by their families. Palliative care is a relatively new medical specialty, and more must be done to ensure patients and providers understand its benefits and that an adequate, appropriately trained workforce is available to provide the pain and symptom management, intensive communication and level of care coordination that addresses the episodic and long-term nature of serious and complex chronic illness.

PCHETA would:

- **Education Centers:** establish Palliative Care and Hospice Education Centers to improve the training of interdisciplinary health professionals in palliative care.
- **Physician Training:** authorize grants or contracts to schools of medicine, teaching hospitals and graduate medical education programs to train physicians (including residents, trainees, and fellows) who plan to teach palliative medicine.
- **Academic Career Awards:** establish a program to promote the career development of physicians who are board certified or board eligible in Hospice and Palliative Medicine and have a junior (non-tenured) faculty appointment at an accredited school of medicine.
- **Workforce Development:** establish fellowship programs within the new Palliative Care and Hospice Education Centers to provide short-term intensive courses focused on palliative care.
- **Career Incentive Awards:** provide grants or contracts for eligible health professionals who agree to teach or practice in the field of palliative care for at least 5 years.
- **Nurse Training:** create special preferences in existing nurse education law for hospice and palliative nursing, in education, practice and quality grants, workforce development, and nurse retention projects.
- **Palliative care education and awareness:** provide for the establishment of a national campaign to inform patients, families, and health professionals about the benefits of palliative care and the services that are available to support patients with serious or life-threatening illness.

- Enhanced research: direct the National Institutes of Health to use existing authorities and funds to expand palliative care research to advance clinical practice and improve care delivery for patients with serious or life-threatening illness.

Request: In the House, please cosponsor H.R. 1676.

In the Senate, S. 693 to strengthen research, workforce, and public awareness around palliative care.



ACCC PRINCIPLES FOR 340B SUSTAINABILITY AND REFORM

BACKGROUND: ACCC members provide cancer care in private practices and hospitals, both academic and community-based; both for-profit and not-for-profit. Given the diversity of our membership, and the growing discussion around the need for reforms to the 340B Drug Pricing Program, ACCC is uniquely positioned to engage with policymakers in a dialogue about how to ensure sustainability and reform of this important program.

ACCC believes that to preserve the original intent of the 340B program, to continue to ensure that savings help oncology providers reach more underserved patients and provide more comprehensive services, and to modernize and ensure long-term viability of the program, the following steps should be taken:

- Congress should revise the 340B statute to give HRSA the general rulemaking authority and adequate funding it needs to appropriately regulate and oversee the program.
- HRSA should require transparency and public reporting from covered entities on the savings accrued from the program and how these savings are spent on services that benefit underserved patients.
- Congress should revisit the metric used to determine eligibility of hospital covered entities for the 340B program to better reflect 1) the level of outpatient services provided by the hospital, which is relevant because the 340B program relates to covered outpatient drugs, and 2) the patient population that the hospital covered entity and its sites serve. For example, rather than the DSH adjustment, Congress should explore other proxies for eligibility, including patient insurance status in the outpatient setting.
- HRSA should seek stakeholder input to clarify the definition of “covered entity” to focus on programs treating patients in a reasonable catchment area.
- HRSA should seek stakeholder input to clarify the definition of eligible patient so that providers understand clearly which patients qualify for the program.
- HRSA should examine the impact contract pharmacies, pharmacy benefit managers, and other outside entities have on the 340B program.
- Congress should expand HRSA’s authority to sanction covered entities that knowingly and repeatedly violate the rules of the program.
- Congress should create a path for all oncology providers, including independent physician practices, to participate in the 340B program, particularly those that are already providing care for underserved patients.

Request: As Congress, the Health Resources & Services Administration (HRSA), and the Centers for Medicare & Medicaid Services (CMS) consider reforms to the 340B Drug Pricing Program, legislators should support policies that encourage and, at a minimum, do not discourage medical oncology providers from treating underserved populations. Any reforms to the 340B Program should address the above principles, not place an excessive burden on clinicians, be appropriately tested to safeguard against barriers to access, and focus on ensuring that existing resources are reaching those cancer programs willing to treat underserved populations.