Policy Recommendations

The American Cancer Society Cancer Action Network (ACS CAN) is committed to ensuring that all people with cancer have access to the appropriate care across the cancer continuum from prevention and screening to diagnosis and treatment and into survivorship. Ensuring access to equitable, medically necessary and affordable care is a multi-faceted approach that requires multi-faceted solutions.

To that end, ACS CAN supports the following policies to improve the specific parts of the Medicare program:

Improvements to Part A:

- **Impose a cap on beneficiary cost sharing for Part A services:** Currently, there is no cap on Part A cost sharing, potentially leaving Medicare beneficiaries (particularly those who lack supplemental coverage) with significant out-of-pocket costs. **Congress should enact legislation to cap beneficiaries' Part A out-of-pocket costs.**
- **Ensure long-term solvency of Part A:** Because of the way the Part A program is financed, the long-term solvency of the program is at risk. While the Part A trust fund has never become insolvent to the point where it is no longer able to pay benefits, **Congress should act to ensure long-term solvency of the program.**

Improvements to Part B:

- **Impose a cap on beneficiary cost sharing for Part B services:** Like Part A, there is currently no cap on Part B cost sharing, potentially leaving Medicare beneficiaries who lack supplemental coverage with significant out-of-pocket costs. **Congress should enact legislation to cap beneficiaries' Part B out-of-pocket costs.**
- **Improve Medicare coverage of preventive screening services:**
  - Ensure Medicare coverage of multi-cancer early detection tests: Researchers are developing innovative tests that are capable of detecting many different types of cancer using a simple blood test. This includes many cancers for which there has been no recommended screening. This is particularly important because currently only one in seven cancers are diagnosed through traditional screening measures.[115] **Congress should enact the Medicare Multi-Cancer Early Detection Act, to ensure that Medicare can cover these innovative new tests once they are approved by the Food and Drug Administration and clinical benefit is shown.**
  - Eliminate cost sharing for preventive services: While most cancer screenings are covered without cost sharing,116 Medicare often imposes cost sharing for follow-up testing. For example, while Medicare covers mammography screening as a preventive service benefit, beneficiaries would be assessed 20% cost sharing for imaging and/or a biopsy following a screening mammogram. The American Cancer Society defines cancer screening to include all recommended screening and follow-up testing for an asymptomatic individual, regardless of risk.[117] **Congress should waive all cost sharing for follow-up testing.**
- **Ensure access to biomarker testing:** Biomarker testing is often used to determine the most appropriate treatment for an individual with cancer, such as targeted therapies that are only indicated for cancers with a given biomarker. Biomarker-informed care can lead to improved survivorship and better quality of life for patients. **The Centers for Medicare & Medicaid Services (CMS) should ensure broad coverage of comprehensive biomarker testing consistent with clinical practice guidelines and other evidence.**

Improvements to Part C:

- **Ensure adequacy of provider networks:** While Medicare Advantage plans are required to cover all Part A and B services, they are permitted to utilize plan provider networks to control plan costs. While Medicare Advantage plans are required to adhere to certain network adequacy standards, there is a concern that depending on the adequacy of a plan's network (particularly networks in rural areas) beneficiaries may have to travel long distances to access preventive services or to see a specialist, and the plan may not have a specific subspecialist (including providers and facilities) available in network. **CMS should revisit its network adequacy requirements to ensure that beneficiaries have access to medically necessary providers within the plan's network.**

Improvements to Part D:

- **Maintain the six protected classes:** Part D requires plans to cover all or substantially all categories and classes of drugs within the six categories of clinical concern (also known as the six protected classes). The six classes are immunosuppressants, antidepressants, antipsychotics, anticonvulsants, antiretrovirals and antineoplastics. This policy is needed because drugs within these categories are not necessarily therapeutically equivalent within the same class. For example, the class of antineoplastics contains a subcategory of tyrosine kinase inhibitors, which have been developed to treat cancer, but each drug within this category may target a different mutation that is relevant to a small subcategory of patients with a given disease. **CMS should maintain the current six protected classes policy to ensure that vulnerable beneficiaries have access to medically appropriate therapies.**
- **Improve the ability for beneficiaries to spread cost-sharing requirements over the course of the plan year:** As part of the Inflation Reduction Act, Congress imposed a cap on beneficiaries' Part D cost sharing and instituted a new policy (the Medicare Prescription Payment Plan) that allows beneficiaries the option to pay their Part D cost sharing over the course of the plan year. While the Medicare Prescription Payment Plan will help beneficiaries better afford the cost sharing for their prescription drugs, there is a concern that CMS' initial plan of implementation would not allow beneficiaries to enroll at the point of sale. Allowing beneficiaries to enroll at the point of sale will facilitate enrollment in the program, because otherwise they will face significant administrative hurdles that will hinder enrollment. **CMS should revise the Medicare Prescription Payment Plan requirements to allow beneficiaries to enroll at the point of sale.**

In addition to the Part-specific recommendations, ACS CAN advocates for the following overarching improvements to the Medicare program:

- **Improve affordability:** Medicare beneficiaries can face significant out-of-pocket costs for their cancer care. While these out-of-pocket costs can be mitigated with supplemental coverage, availability of such coverage and premiums associated with that coverage will vary considerably and still impose financial strain on beneficiaries. **Congress should enact caps on beneficiaries' out-of-pocket costs.**
- **Limit the use of utilization management tools:** Medicare Advantage and Part D plans are permitted to impose utilization management tools (such as prior authorization, step therapy, quantity limits, etc.) on covered services, including prescription drugs. In some cases, the use of utilization management tools can be an important safety precaution (for example, imposing a prior authorization requirement to ensure there is a cancer diagnosis before approving coverage of a chemotherapy drug). However, in recent years, there has been a significant increase in the use of utilization management tools, which can be burdensome on providers and delay care for patients. There is also a trend among some issuers to use artificial intelligence and other automated processes to deny medical claims.[118] **CMS should review Medicare Advantage plans' and Part D plans' use of utilization management tools and restrict their use to those tools that are clinically appropriate.**

- **Improve the appeals process:** When Medicare Advantage plans and Part D plans impose utilization management tools or use narrow plan networks, beneficiaries who have unique needs often have to file an appeal in order to get coverage for their product or service. Unfortunately, the Medicare appeals processes are confusing and can be cumbersome and time-consuming.[119] **CMS should improve the Medicare appeals process (as recommended in The Medicare Appeals Process: Reforms Needed to Ensure Beneficiary Access).**

- **Improve access to patient navigation services:** Patient navigation is an evidence-based intervention that eliminates health disparities across the cancer care continuum. Patient navigation services have been shown to help increase cancer screening rates among historically marginalized racial and ethnic populations by providing access to disease prevention education, conducting community outreach and facilitating public education campaigns.[120, 121, 122, 123] One study showed that women with access to patient navigation services were significantly more likely to be up to date on their mammography screening compared to women who did not receive these services, with the largest impact among African American Medicare beneficiaries living in urban areas who were previously not up to date on their breast cancer screenings.[124] However, patient navigation is still absent or limited in many cancer programs and hospital settings due to a lack of long-term funding to pay for these services. **CMS should expand upon the provisions in the FY2024 physician fee schedule, which provides Medicare reimbursement for principal illness navigation services for high-risk illnesses like cancer, to also include patient navigation services beginning with screening services.**

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18 2024 Medicare Parts A and B fact sheet.

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21 2024 Medicare Parts A and B factsheet.

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23 2023 Medicare Trustees Report.

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