# Presidents Day Recess: Legislative Priorities

American Cancer Society Cancer Action Network℠
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**Make the fight against cancer a national priority!**

By making the following lifesaving efforts a priority, we can ensure that progress continues in the fight against cancer. That is why we need Members of Congress to:

## Invest in Cancer Research and Prevention

Complete the Fiscal Year 2025 (FY25) spending bills before the current Continuing Resolution expires on March 14th and include the highest possible funding increases for cancer research at the National Institutes of Health, including the National Cancer Institute, and cancer prevention programs at the Centers for Disease Control and Prevention.

## Protect Care Through Medicaid

Reject changes to Medicaid's funding structure and oppose cuts that would result in loss of access to affordable care.

## Extend the ACA Enhanced Tax Credits

Support extending the ACA enhanced tax credits as soon as possible and before they expire at the end of 2025. Millions of Americans rely on these tax credits to afford quality health insurance.

## Innovation in Early Detection

Support final passage of the Medicare Multi-Cancer Early Detection Screening Coverage Act (MCED), H.R. 842 and S. 339, as soon as possible this year.

# Increase National Institutes of Health and National Cancer Institute Funding in FY2025

*Cancer Research Delivers Breakthroughs & Hope*

American Cancer Society Cancer Action Network℠

Increased and sustained investment at NIH and NCI in the fight against cancer year over year has been key to reducing the nation's cancer mortality rate by 30% since 1991, and will bring us closer to ending cancer as we know it, for everyone.

## We can't afford to lose momentum.

**2 Million+**
New cancer cases projected in 2024 for the 1st time ever

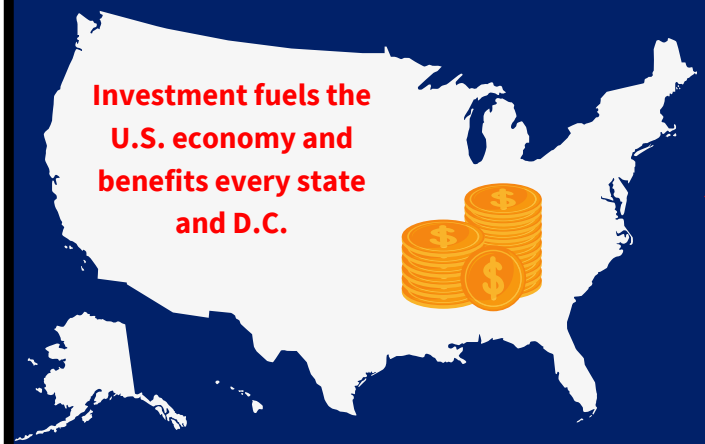
**611,720**
estimated deaths due to cancer in 2024

Colorectal cancer diagnoses among people younger than 55

**4**
screenable cancers - breast, prostate, colorectal, and cervical - on the rise

**18 Million+**
cancer survivors in the U.S.

## NIH and NCI Funding Drive U.S. Economic Growth




In fiscal year 2023, NIH generated

**$92.89 Billion**
in new economic activity nationwide

supported

**412,041**
jobs

and

**65,454**
research grants

**Return on Investment**

**$1** *in NIH funded research*

=

**$2.46** *in economic activity*

## Demand for NCI Research

The growth of NCI R01 research grant applications over the last 10 years is almost

**3x**
**that of the rest of NIH combined**

**5** out of **6**
researcher-initiated proposals go **unfunded** every year

**NCI HAS**

**13%**
**LESS buying power** than 20 years ago

## Impact of Underinvestment

- Decline in applications funded
- Fewer opportunities for the next generation of researchers
- Reduced role of U.S. as the global leader in biomedical research
- Slower pace of breakthroughs in cancer prevention, screening, and treatment

## FY 2025 NCI Scientific Opportunities

- Improving Patients' Lives Through Symptom Science Research
- Revolutionizing Cancer Clinical Trials
- Clarifying the Impact of the Environment on Cancer Risk
- Harnessing the Power of Cancer Data
- Unreaveling the Complexity of Cancer Metastasis

## Recent NCI Milestones

**First FDA-approved Treatment**
*advanced cases of alveolar soft part sarcoma*

**Development of Drug Delivery Technology**
*protecting drugs from the outside environment and guiding them directly to the target cancer cells*

**Overcoming Treatment Resistance**
*identification of a drug that could be beneficial for ovarian cancer patients whose cancer has grown after treatment*

**Predicting Treatment Response**
*identification of gene signatures associated with mesothelioma prognosis to help determine response to therapy*

## ACS CAN urges Congress to provide:

To ensure that the research being supported today yields the cancer treatments of tomorrow, Congress must sustain and expand the support it is currently providing.

**NIH**
**$51.3 Billion**

**NCI**
**$7.934 Billion**

[1] American Cancer Society. Cancer Facts and Figures 2024. Atlanta: American Cancer Society; 2024.
[2] United For Medical Research. 2024 Update NIH's Role in Sustaining the U.S. Economy. Retrieved on April 11, 2024, from: https://www.unitedformedicalresearch.org/wp-content/uploads/2023/03/UMR_NIHs-Role-in-Sustaining-the-U.S.-Economy-2023-Update.pdf
[3] National Cancer Institute: Annual Plan & Budget Proposal for Fiscal Year 2025. Retrieved on April 11, 2024, from: https://www.cancer.gov/research/annual-plan/2024-annual-plan-budget-proposal-aag.pdf
[4] CCR Milestones: Annual Highlights 2024. Retrieved on April 11, 2024, from: https://ccr.cancer.gov/news/milestones-2024/flippingbook

May 2024

# Congress Should Provide Higher Funding for CDC Cancer Programs and the National Breast and Cervical Cancer Early Detection Program

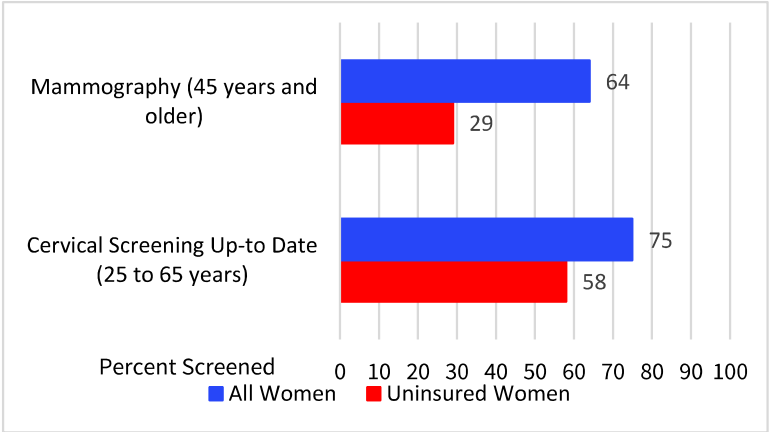
## Breast and Cervical Cancer in the U.S.

- In 2024, an estimated 310,720 women[i] in the U.S. will be diagnosed with invasive breast cancer, and 42,250 will die from the disease.[ii] Additionally, an estimated 13,820 people will be diagnosed with invasive cervical cancer, and 4,360 will die from the disease.[ii]
- Despite the fact that U.S. breast and cervical cancer death rates have been declining for several decades, **not all people have benefited equally from the advances** in prevention, early detection, and treatments that have helped achieve these lower rates.
- For example, research shows that those who are **uninsured and underinsured have lower breast and cervical cancer screening rates,** resulting in a greater risk of being diagnosed at a later, more advanced stage of disease.[iii]
- Breast and cervical cancer impact transgender and gender nonconforming individuals yet diagnosis and mortality estimates for 2024 are unknown due to existing gaps in data collection that need to be strengthened to include transgender and gender nonconforming individuals.

## The National Breast & Cervical Cancer Early Detection Program (NBCCEDP)

The Centers for Disease Control and Prevention's (CDC) Division of Cancer Prevention and Control (DCPC) oversees the **National Breast and Cervical Cancer Early Detection Program (NBCCEDP)**. For over 30 years the NBCCEDP has decreased disparities in breast and cervical cancer deaths. Through cooperative agreements with all 50 states, the District of Columbia, 13 tribal organizations, 2 U.S. territories, and 5 U.S.-Affiliated Pacific Islands, the program provides breast and cervical cancer screenings, diagnostic tests, and treatment referral services to communities that are limited-income, underserved, under-insured, and uninsured in the U.S.

**Prevalence of Up-To-Date Breast & Cervical Cancer Screening Rates (%) - 2021**




*Mammogram within the past year (ages 45-54 years) or past 2 years (ages ≥ 55 years); Pap Test and/or HPV DNA test as recommended, depending on age. Source: National Health Interview Survey, 2021.

**The NBCCEDP is the only nationally organized cancer screening program for breast and cervical cancer in the U.S. for disadvantaged and diverse populations who historically have not had adequate access to or have likely experienced other barriers to cancer screening.**

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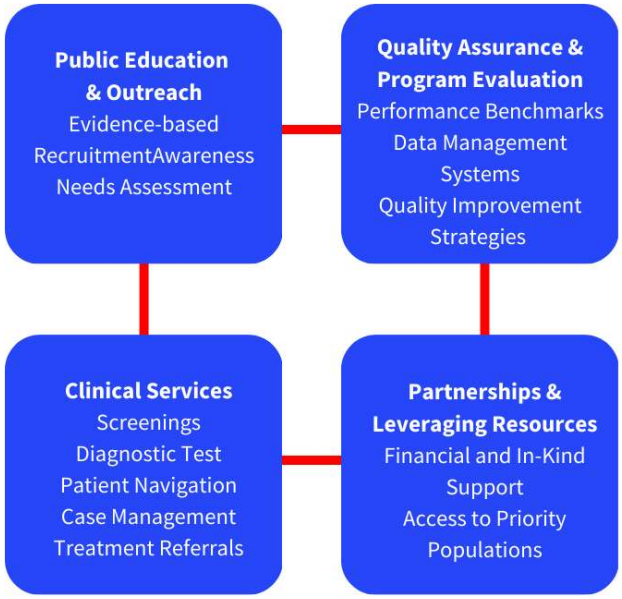
## Program Highlights

- Since the program's inception in 1991, **NBCCEDP has provided over 16.1 million screening exams to more than 6.2 million eligible people**, detecting 77,968 invasive breast cancers and 24,656 premalignant breast lesions, as well as 5,220 invasive cervical cancers, and 242,261 premalignant cervical lesions, of which 38% were high grade.[iv]

- In program year 2022 alone, NBCCEDP provided breast cancer screening and diagnostic services to 263,134 eligible people and **diagnosed 2,168 invasive breast cancers**.[iv] The program also provided cervical cancer screening and diagnostic services to 121,197 eligible people and **diagnosed 99 invasive cervical cancers and 5,732 precancerous lesions, of which 35% were high grade**.[iv]

### A Successful Delivery Model – NBCCEDP




## Program Eligibility

People with incomes at or below 250 percent of the federal poverty level (FPL) are eligible for the program at ages 21-64 for individuals with a cervix for cervical cancer screening and women ages 40-64 for breast cancer screening.[v] **The NBCCEDP is highly effective at detecting and treating breast and cervical cancer in a population that may otherwise not be screened.** The results of not screening in a timely and appropriate fashion can be higher costs and unnecessary suffering and death due to cancers found in later stages.

The Affordable Care Act has helped improve insurance coverage, raise awareness, and reduce the costs of breast and cervical cancer screenings. **However, millions remain underinsured or uninsured and often face structural and economic barriers to lifesaving screenings.** Partnerships, an essential component of the NBCCEDP, help address many of the structural and economic barriers low-income people face when it comes to getting screened.

## Need for Adequate Funding for this Lifesaving Program

Due, in part, to funding challenges, the NBCCEDP cannot service all eligible individuals. According to most recent program data, among those eligible for the program, less than 1 in 10 received cervical cancer screenings (2015-2017) and less than 2 in 10 received breast cancer screenings (2016-2017).[iv] Ensuring adequate funding for the NBCCEDP will preserve a critical safety net for those who continue to lack access to lifesaving screening, diagnostic, and treatment services and is an important step toward reducing disparities and advancing health equity in breast and cervical cancer.

**Thousands count on the National Breast and Cervical Cancer Early Detection Program for lifesaving cancer screenings and diagnostic services.**


## ACS CAN Position

ACS CAN urges Congress to provide **$472.4 million for CDC cancer programs, including $230 million**[vi] for the National Breast and Cervical Cancer Early Detection Program for FY25 to ensure access to lifesaving screenings and cancer services.

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[i] Throughout this document *women* refers to individuals assigned female at birth. However, the NBCCEDP program also provides screening and treatment services to eligible transgender individuals.

[ii] American Cancer Society. *Cancer Facts & Figures 2024*. Atlanta: American Cancer Society; 2024.

[iii] American Cancer Society. Cancer Prevention & Early Detection Facts & Figures 2021-2022. Atlanta: American Cancer Society; 2021.

[iv] Centers for Disease Control and Prevention. National Breast and Cervical Cancer Early Detection Program: About the program. Updated March 28, 2023. Accessed February 19, 2024 at https://www.cdc.gov/cancer/nbccedp/about.htm.

[v] Tangka, F., Kenny, K., Miller, J., & Howard, D. H. (2020). The eligibility and reach of the national breast and cervical cancer early detection program after implementation of the affordable care act. Cancer causes & control: CCC, 31(5), 473–489. https://doi.org/10.1007/s10552-020-01286-0

[vi] Amount does not include the WISEWOMAN heart disease program.

[vii] DeGroff A, Miller J, Sharma K, Sun J, Helsel W, Kammerer W, Rockwell T, Sheu A, Melillo S, Uhd J, Kenney K, Wong F, Saraiya M, Richardson LC. COVID-19 impact on screening test volume through the National Breast and Cervical Cancer early detection program, January-June 2020, in the United States. Prev Med. 2021 Oct;151:106559. doi: 10.1016/j.ypmed.2021.106559. Epub 2021 Jun 30. PMID: 34217410; PMCID: PMC9026719.

# Medicaid is Essential in the Fight Against Cancer

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**Medicaid provides access to life-saving care for people in America fighting cancer, especially low-income individuals primarily from rural and underserved communities.**

Cancer is the second-highest cause of death in America, and more than 2 million people will be diagnosed with cancer this year. Medicaid covers cancer screenings, diagnostic tests, treatments, surgeries, prescription medications and follow-up care that give cancer patients the best chance after a life-changing diagnosis.

## The impact of Medicaid on cancer patients in America

### 1 in 10 people

One-in-ten individuals with a **history of cancer** rely on Medicaid for their health coverage. [1]

### 2,500 earlier cancer diagnoses
### 1,600 cancer deaths prevented

States that expanded Medicaid saw more than 2,500 earlier cancer diagnoses and prevented more than 1,600 deaths from cancer in the first five years of expansion. [3]

### 7 times higher

Late-stage cancer costs are up to 7 times higher than the costs to treat earlier-stage cancer. [2]

### 1 in 3 children

Approximately one-in-three children diagnosed with cancer were found to be enrolled in Medicaid at the time of their diagnosis. [3]

## Access to Medicaid...

- ✓ Increases cancer survival rates
- ✓ Increases the number of people who get cancer screenings and preventive services
- ✓ Helps more cancer patients and survivors get insurance coverage
- ✓ Leads to more early cancer diagnoses
- ✓ Helps people with cancer access timely treatment [4]

## Protecting cancer patients means protecting Medicaid

Medicaid is essential in supporting access to health insurance for individuals who would otherwise have no coverage options, ultimately improving health outcomes and reducing the burden of cancer on loved ones and health care systems.

1 2023 National Health Interview Survey data. Analysis performed by American Cancer Society Health Research Services, December 2024.

2 Reddy, S. R., Broder, M. S., Chang, E., Paydar, C., Chung, K. C., & Kansal, A. R. (2022). Cost of cancer management by stage at diagnosis among Medicare beneficiaries. *Current Medical Research and Opinion, 38*(8), 1285–1294. doi.org

3 Analysis provided to ACS CAN by Avalere Health. Coverage of patients with cancer in Medicaid under the AHCA. Analysis performed June 2017.

4 Building on the Evidence Base: Studies on the Effects of Medicaid Expansion, February 2020 to March 2021. Published May 6, 2021. www.kff.org

*"I don't like to think about what would've happened without Medicaid. It saved my life, and Liam got to grow up with his mom."*

**— Milly**
**Oklahoma City, OK**

# What Medicaid Means to Cancer Patients

In 2005, Milly became pregnant with her son, Liam. She was uninsured at the time but qualified for Medicaid and had a healthy and uneventful pregnancy and delivery.

But at her six-week postpartum checkup, Milly asked her doctor about a lump on her breast. "I was referred to a surgeon," she said. "I got overwhelmed and I got scared. Scared that I might have cancer and scared of what it would all cost. But my surgeon said, 'Don't worry. You've got Medicaid.'"

Milly was eligible to stay on Medicaid through Oklahoma's Breast and Cervical Cancer Program, and her health insurance covered everything she needed throughout her treatment. Since her treatment almost 20 years ago, she has gone to law school, has health insurance through her job as an attorney, and is the mother to two healthy children.



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# Medicaid Cuts Put People with Cancer at Risk

In 2023 10% of adults with a history of cancer in the U.S. relied on Medicaid for their health care.[1] Access to affordable health insurance is crucial for individuals to receive necessary care, especially for those with chronic conditions like cancer.

Research consistently shows that expanding access to Medicaid increases insurance coverage rates among cancer patients and survivors, increases early-stage cancer diagnoses, improves access to timely cancer treatment and survival rates, and increases receipt of cancer screenings and preventive services.[2] For example, a recent study showed that Medicaid expansion was associated with an increase in survival from cancer at 2 years post diagnosis, and the increase was most prominent among non-Hispanic Blacks in rural areas, highlighting how expanding Medicaid can reduce health disparities.[3]

**The American Cancer Society Cancer Action Network opposes cuts to the Medicaid program, as these cuts will make it harder for many people to receive preventive services and cancer screenings, cancer treatments and health care in survivorship.**

## Funding cuts would jeopardize essential access for people with cancer

Medicaid is funded jointly by the federal and state governments. The federal share of funding is determined by the Federal Medical Assistance Percentage (FMAP). Today, the federal government pays between 50 and 77 percent of the cost of providing most health services to most Medicaid enrollees,[4] and a higher percentage for the Medicaid expansion population.

If FMAP rates are cut, states would have to find a way to pay more from their already tight budgets or make cuts to Medicaid. One analysis of such cuts in 10 states and the District of Columbia showed that these 10 states would have to pay an additional $43 billion to maintain their current programs. **Faced with funding shortfalls, it's likely that states would reduce "optional" Medicaid benefits, like home- and community-based services or prescription drugs**.[5]

## Funding caps could limit eligibility or coverage for people with cancer

The Medicaid program was designed to provide a safety net for the low-income and disabled, and to enable states to cover all individuals who meet program requirements – growing or shrinking depending on the needs of the people in the state. A block grant or cap on Medicaid spending would change this funding structure to provide a set (and smaller) amount of federal funds to state Medicaid programs. The Congressional Budget Office (CBO) has estimated that capping federal Medicaid funds would result in spending cuts of $576 to $934 billion, depending on the details of the policy.[6]

**To stay within capped funding, states would likely take steps such as capping overall enrollment, cutting coverage for people in certain eligibility groups (such as some children, some people with disabilities, and many adults – including those with cancer), increasing cost sharing, and/or reducing health benefits.**

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## ✂ Work requirements would create more bureaucracy and administrative hassle

Most adults enrolled in Medicaid already work: in 2021, 42% of adult Medicaid enrollees aged 19–64 were employed full-time, working an average of 34 hours per week. Another 23% were not working due to caregiving responsibilities, illness or disability, or school attendance.[7] Despite this fact, several state and federal policymakers have proposed conditioning Medicaid enrollment on working or volunteering a certain number of hours per week. **Whenever they have been implemented, these requirements simply add a huge burden of tracking, recording and paperwork to Medicaid offices and enrollees – and result in people inappropriately losing their Medicaid coverage.** For example, Georgia's current work requirements have resulted in only 4,500 individuals enrolling in Medicaid as of July 2023 – far short of the 25,000 participants the state expected, and the 359,000 low-income adults in Georgia who need this coverage.[8]

## ✂ Making it harder to enroll or stay enrolled would cut people from Medicaid - including people with cancer

Research shows that improper payments in Medicaid typically result not from fraud or abuse but instead from paperwork problems; many times they don't involve enrollment of ineligible people.[9] Yet, some policymakers have proposed measures – like adding new paperwork, limiting the use of *ex parte* renewals, and banning the use of pre-populated forms – that make it harder for people to enroll or stay enrolled in Medicaid. **These policies would increase errors and burden for everyone and make it more likely for individuals to be unable to access benefits for which they are eligible. These would include coverage of life-saving cancer screenings and treatment.**

**ACS CAN opposes cuts to Medicaid and urges Congress to protect this crucial program for lower-income people with cancer, cancer survivors, and people in need of preventive services and cancer screenings.**

*December 17, 2024*

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[1] 2023 National Health Interview Survey data. Analysis performed by American Cancer Society Health Research Services, December 2024.
[2] Building on the Evidence Base: Studies on the Effects of Medicaid Expansion, February 2020 to March 2021. Published May 6, 2021. https://www.kff.org/report-section/building-on-the-evidence-base-studies-on-the-effects-of-medicaid-expansion-february-2020-to-march-2021-report/
[3] Han, Xuesong, et al. Association Between Medicaid Expansion Under the Affordable Care Act and Survival Among Newly Diagnosed Cancer Patients. Journal of the National Cancer Institute. 2022 Aug 8;114(8):1176-1185. doi: 10.1093/jnci/djac077.
[4] KFF, "Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier," fiscal year 2025, https://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/?currentTimeframe=0&sortModel=%7B%22colId%22:%22FMAP%20Percentage%22,%22sort%22:%22desc%22%7D.
[5] CBO, "Reduce Federal Medicaid Matching Rates," option from "Options for Reducing the Deficit, 2023-2032 – Volume I: Larger Reductions," December 7, 2022, https://www.cbo.gov/budget-options/58624. CBO's estimated net federal savings include offsetting increases in federal spending and any related revenue effects.
[6] CBO, "Establish Caps on Federal Spending for Medicaid," option from "Options for Reducing the Deficit, 2023-2032 – Volume I: Larger Reductions," December 7, 2022, https://www.cbo.gov/budget-options/58622.
[7] Lee A, Ruhter J, Peters C, De Lew N, Sommers BD. Medicaid Enrollees Who are Employed: Implications for Unwinding the Medicaid Continuous Enrollment Provision (Issue Brief No. HP-2023-11). Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. April 2023.
[8] Rayasam, Renuka and Whitehead, Sam. KFF Health News. The First Year of Georgia's Medicaid Work Requirement is Mired in Red Tape. September 13, 2024. https://kffhealthnews.org/news/article/georgia-medicaid-work-requirement-red-tape/
[9] Jessica Schubel, "Medicaid Improper Payment Rates Don't Signal Fraud or Abuse," CBPP, November 19, 2020, https://www.cbpp.org/blog/medicaid-improper-payment-rates-dont-signal-fraud-or-abuse.

# Congress Must Extend the Enhanced ACA Tax Credits

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Having affordable and comprehensive health insurance coverage is a key determinant for surviving cancer. Research from the American Cancer Society shows that uninsured Americans are less likely to get screened for cancer and thus are more likely to have their cancer diagnosed at an advanced stage when survival is less likely and the cost of care more expensive. Public policies that make insurance more affordable help to ensure that more people will have the coverage they need.

## ACA Tax Credits

The *Affordable Care Act* (ACA) established tax credits to help lower the cost of health insurance purchased in the Marketplaces. Under the ACA, individuals earning between 100% to 400% of the federal poverty level (FPL) ($15,650 - $62,600 for an individual in 2025) are eligible for these tax credits on a sliding scale – the lower the income level, the higher the amount of tax credits. The total amount a person would pay for premiums is capped as a percentage of their income. The ACA tax credits are permanent and do not expire. As part of the *American Rescue Plan Act* (ARA) enacted in March 2021, Congress made two *temporary*, but major changes to the tax credits: it increased the amount of the tax credit for those between 133%-400% FPL ($20,815-$62,600 for an individual in 2025); and extended the eligibility for the tax credits to those earning beyond 400% FPL ($62,600 for an individual in 2025). These enhanced tax credits were in effect in 2021 and 2022. As part of the *Inflation Reduction Act* (IRA), Congress extended these enhanced tax credits again, this time through 2025.

The following chart shows how much an individual who qualified for tax credits pays in premiums under the original ACA tax credits compared to how much they pay with the enhanced tax credits provided under the ARA and IRA. For example, an individual whose income is 149% FPL would pay a premium of about 4% of their income under the ACA tax credits but would not pay any premiums under the enhanced tax credits.

| **How Much a Person Eligible for Tax Credits Pays for Marketplace Coverage (as a percentage of income)** | | |
|---|---|---|
| | **Affordable Care Act Tax Credits** | **American Rescue Plan & Inflation Reduction Act (Enhanced ACA Tax Credits)** |
| *Income Eligibility (FPL)* | | |
| Under 100% | Not eligible for subsidies | Not eligible for subsidies |
| 100% -- 138% | 2.07% | 0% |
| 138% -- 150% | 3.10%-4.14% | 0% |
| 150% -- 200% | 4.14%-6.52% | 2.0% |
| 200% -- 250% | 6.52%-8.33% | 4.0% |
| 250% -- 300% | 8.33%--9.83% | 6.0% |
| 300% -- 400% | 9.83% | 8.5% |
| Over 400% | Not eligible for subsidies | 8.5% |
| *Expiration Date* | None. ACA tax credits are permanent | Enhanced ACA tax credits expire at the end of 2025 |

The actual amount of the tax credit will vary depending on a person's income and where they live. Under the ACA, the Marketplace will determine the amount an individual is required to pay for their premium based on two factors: (1) their income (see chart above); and (2) the second-lowest cost silver plan in each area. The premium for this plan serves as the basis for the tax credit provided to an individual. The difference between that plan premium and the individual's expected contribution is the amount of the tax credit.

### *Examples based on plan year 2024:*

- Tim lives in Columbus, OH. He works two part-time jobs, neither of which offer health insurance coverage, and he makes slightly less than $22,000 a year (roughly 150% FPL for a household of one).
    - With Enhanced Tax Credits: Because of the enhanced tax credits, Tim can sign up for a $0 premium Marketplace plan.
    - Without the Enhanced Tax Credits: He would have to pay a premium of $130 per month for his health insurance coverage.[i] Since money is tight for Tim, he may decide he isn't able to pay premiums, and go without insurance.
- Heidi lives in Potsdam, NY and recently started her own business making $61,000 a year (just over 400% FPL for a household of one).
    - With Enhanced Tax Credits: Because of the enhanced tax credits, Heidi is eligible for tax credits of $128 bringing the monthly premium for her silver plan to $432[ii] which helps offset the cost of the premiums for her Marketplace coverage.
    - Without the Enhanced Tax Credits: She would not qualify for any assistance and would pay $560 a month in premiums – therefore making insurance unaffordable for her.

## Benefits of Enhanced ACA Tax Credits

*Comprehensive coverage*: The enhanced tax credits allow more people to purchase comprehensive health insurance coverage that covers things like Essential Health Benefits (including doctor's visits, prescription drugs, hospitalizations, and preventive services, including cancer screenings), caps annual out-of-pocket costs, and prohibits plans from denying coverage or charging more based on pre-existing conditions, such as cancer history.

*Record enrollment*: As a result of the enhanced tax credits, more than 21 million Americans enrolled in Marketplace coverage in 2024, with 80% of people enrolled in a plan with a monthly premium of $10 or less. More than 5 million of those who enrolled in Marketplace plans in 2024 were new customers. (State-specific enrollment information is available here.)

## ACS CAN Position

ACS CAN urges Congress to extend the enhanced ACA tax credits before they expire at the end of 2025. If these enhancements are not extended, people enrolled in Marketplace plans will face higher premiums and millions could lose coverage altogether, undoing much of the progress made in recent years. If the enhanced ACA tax credits are allowed to expire, affordability could become a barrier to lifesaving cancer screening, early detection, treatment and follow up care.

*More information is available at*
*https://www.fightcancer.org/what-we-do/health-insurance-affordability*

*February 11, 2025*

[i] Author's analysis for 30 year old male using healthcare.gov for silver plans in zip code 43210.
[ii] Author's analysis using New York State of Health Marketplace plan finder of silver plans using zip code 13676.

# The Nancy Gardner Sewell Medicare Multi-Cancer Early Detection Screening Coverage Act (H.R. 842/S. 339)

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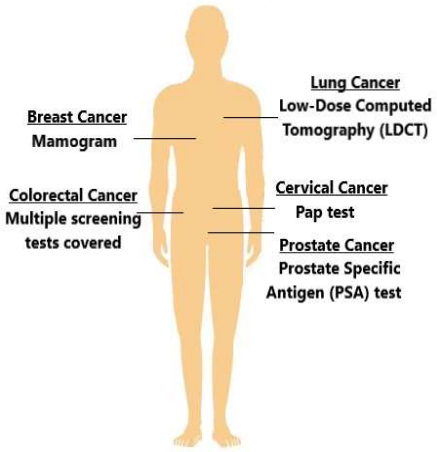
## Multi-Cancer Screening Tests Can Catch Cancer Early

Earlier screening for cancer is important because when detected at later stages, treatments are more limited, and outcomes are generally poorer. Medicare enrollees should have access to multi-cancer screening tests when the benefit is clinically shown. Multi-cancer early detection tests are innovative tests that have the potential to detect multiple cancers through the use of a single test. Several private and academic entities are currently developing multi-cancer early detection (MCED) blood-based tests. Published data indicate that some of these tests can screen for many different types of cancers at the same time, including some rare cancers.

### Current Medicare Coverage of Cancer Screening Tests




**Multi-Cancer Screening Tests**
1 Test: Multiple Cancers

### The Nancy Gardner Sewell Medicare Multi-Cancer Early Detection Screening Coverage Act Would Enhance Medicare Screening

Because the risk of cancer increases with age, Medicare beneficiaries are especially vulnerable. The *Nancy Gardner Sewell Medicare Multi-Cancer Early Detection Screening Coverage Act (MCED)* (H.R. 842/S. 339) would potentially expand access to cancer screenings in Medicare. The legislation would grant Medicare the authority to cover multi-cancer early detection (MCED) tests, once the test has been approved by the FDA and clinical benefit is shown. CMS will determine its coverage parameters through an evidence-based process.

The bill makes clear that Medicare's coverage of MCED tests does not affect Medicare's coverage of other screening modalities. Coverage of these new tests will complement – and not replace – Medicare's existing coverage of cancer screening tests. The bill will provide CMS the authority to create coverage parameters but does not mandate that CMS cover specific tests. Without legislation, Medicare beneficiaries could experience unacceptable delays in access to multi-cancer early detection.

This bipartisan and bicameral legislation was the most supported health care bill in the 118th Congress with the broad support of 320 members of the House of Representatives and 65 members of the Senate.

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## A Phased-In Approach

In order to ensure the legislation provides the greatest benefit to the those who are most likely to benefit, and to ensure the legislation falls within certain budget parameters, the legislation includes the following policies:

- *Implementation date*: The legislation makes clear that CMS may not begin coverage of MCED tests until 2028. This change aligns with an anticipated timeline for FDA approval of MCEDs.
- *Phase-in eligibility*: The revised legislation phases in coverage of MCED tests. All evidence-based cancer screenings have an age criterion. Beginning as early as January 1, 2028, Medicare could provide coverage of MCED tests for individuals who are 68 years old and younger. For each subsequent year Medicare coverage would increase by one year. For example, in the year 2029 Medicare could cover MCED tests for individuals who are 68 years old and younger.

| Age Phase-in | | |
|---|---|---|
| **Year** | **Who IS covered** | **Who is NOT covered** |
| 2028 | 68 years old and younger | 69 years old and older |
| 2029 | 69 years old and younger | 70 years old and older |
| 2030 | 70 years old and younger | 71 years old and older |
| 2031 | 71 years old and younger | 72 years old and older |
| 2032 | 72 years old and younger | 73 years old and older |
| 2033 | 73 years old and younger | 74 years old and older |
| 2034 | 74 years old and younger | 75 years old and older |
| 2035 | 75 years old and younger | 76 years old and older |
| *Upper age limit keeps increasing by one year….* | | |

- *Payment rate*: The legislation would set the Medicare payment rate for MCED tests. For tests furnished before Jan. 1, 2031, the payment amount is equal to the payment for multi-target stool screening DNA test (Cologuard test) in place on date of enactment of the legislation. Tests furnished after Jan. 1. 2031, the payment amount is equal to the lesser of the payment amount of the stool-based DNA test on the date of enactment or the current payment amount for that test.

## Multi-Cancer Early Detection Screening Could Help Reduce Cancer Disparities

Overall cancer mortality rates have been declining for more than two decades in the United States, but racial, socio-economic and geographic disparities persist. The availability of multi-cancer screening tests has the potential to address cancer mortality disparities by detecting more cancers earlier in more people. Cancer disparities occur mostly because of barriers to high quality cancer prevention, early detection, and treatment due to inequities in employment, wealth, education, housing, and standards of living. For example, approximately 20% of Medicare beneficiaries live in rural areas and residents of rural areas have lower rates of cancer screenings for services like lung cancer for which specialized equipment is needed. A simple blood test may be more accessible and acceptable to patients, thereby extending screening opportunities to traditionally underserved communities. Reducing cancer disparities can only be achieved if there is equitable access to the test in underserved communities, which Medicare coverage can help promote.

*February 2025*

# ACS CAN Supports the *Nancy Gardner Sewell Medicare Multi-Cancer Early Detection Act* (H.R. 842/S. 339)

American Cancer Society Cancer Action Network
fightcancer.org

## Multi-Cancer Screening Tests Can Catch Cancer Early

Earlier screening for cancer is important because when detected at later stages, treatments are more limited, and outcomes are generally poorer. Medicare enrollees should have access to multi-cancer screening tests when the benefit is clinically shown. Multi-cancer early detection tests are innovative tests that have the potential to detect multiple cancers through the use of a single test. Several private and academic entities are currently developing multi-cancer early detection blood-based tests. Published data indicate that some of these tests can screen for many different types of cancers at the same time, including some rare cancers.

## Congressional Action

Because the risk of cancer increases with age, Medicare beneficiaries are especially vulnerable. The *Nancy Gardner Sewell Medicare Multi-Cancer Early Detection Screening Coverage Act (MCED)* would potentially expand access to cancer screenings in Medicare. The legislation was introduced in the House by Representatives Jodey Arrington (R-TX), Terri Sewell (D-AL), Richard Hudson (R-NC), Raul Ruiz (D-CA), Mariannette Miller-Meeks (R-IA) and Robin Kelly (D-IL) and in the Senate by Senators Mike Crapo (R-ID), Mike Bennet (D-CO), Tim Scott (R-SC) and Ron Wyden (D-OR). The following is a summary of the legislative language:

| | H.R. 842/S. 339 |
|---|---|
| *Title* | The *Nancy Gardner Sewell Medicare Multi-Cancer Early Detection Screening Coverage Act* |
| *What is covered?* | MCED test is test for the concurrent detection of multiple cancer types across multiple organ sites furnished on or after January 1, 2028. |
| | Tests are cleared or approved by FDA. |
| | Tests are a genomic sequencing blood or blood product test that includes the analysis of cell-free nucleic acids or comparable test determined by the Secretary. |
| | Secretary must determine the test is reasonable and necessary for the prevention/early detection of an illness or disability and appropriate for individuals entitled to benefits under Part A/enrolled in Part B. |
| *Process* | Makes clear the Secretary must use the existing NCD process in making coverage determination. |
| *Reimbursement amount* | For tests furnished before Jan. 1, 2031, the payment amount is equal to the payment for multi-target stool screening DNA test (Cologuard test) in place on date of enactment. |
| | Tests furnished after Jan. 1. 2031, the payment amount is equal to the lesser of the payment amount of the stool-based DNA test on the date of enactment or the current payment amount for that test. |
| *Age limitations* | Beginning Jan 1, 2028, coverage provided for individuals who are 68 years old and under. Each succeeding year, the upper age limit grows by one year. (See below for chart) |
| *Frequency of coverage* | Coverage provided once a year (once every 11 months) |

| | H.R. 842/S. 339 |
|---|---|
| *USPSTF clarification* | Clarifies that if the USPSTF recommends MCED tests with an A/B rating CMS can provide coverage under the MIPPA pathway to coverage. |
| *Other cancer screening tests* | Clarifies that nothing in this legislation will be construed to affect coverage for existing Medicare cancer screening tests. |

## A Phased-In Approach

- *Implementation date*: The legislation makes clear that CMS may not begin coverage of MCED tests until 2028. This change aligns with an anticipated timeline for FDA approval of MCEDs.
- *Payment rate*: The legislation would initially set the Medicare payment rate for MCED tests to the payment rate for multi-target stool DNA tests in place on the date of enactment of the legislation. After 2031, the legislation would set the payment amount to the lesser of the payment rate for the multi-target stool DNA tests in place on the date of enactment or the current payment rate for that test.
- *U.S. Preventive Services Task Force (USPSTF)*: The language makes clear that if the USPSTF recommends MCED tests with an "A" or "B" rating, then Medicare can choose to cover these tests under the existing pathway that was provided under the Medicare Improvements for Patients and Provider Act, which gives Medicare the authority to cover USPSTF-recommended services if the Secretary determines that such services are appropriate for the Medicare population in which case Medicare would no longer be required to adhere to the phase-in eligibility requirements (see below) or the reimbursement requirements.
- *Phase-in eligibility*: The legislation phases in coverage of MCED tests. All evidence-based cancer screenings have an age criterion. Beginning as early as January 1, 2028, Medicare could provide coverage of MCED tests for individuals who are 68 years old and younger. For each subsequent year Medicare coverage would increase by one year. For example, in the year 2029 Medicare could cover MCED tests for individuals who are 69 years old and younger.

| **Age Phase-in** | | |
|---|---|---|
| **Year** | **Who IS covered** | **Who is NOT covered** |
| 2028 | 68 years old and younger | 69 years old and older |
| 2029 | 69 years old and younger | 70 years old and older |
| 2030 | 70 years old and younger | 71 years old and older |
| 2031 | 71 years old and younger | 72 years old and older |
| 2032 | 72 years old and younger | 73 years old and older |
| 2033 | 73 years old and younger | 74 years old and older |
| 2034 | 74 years old and younger | 75 years old and older |
| 2035 | 75 years old and younger | 76 years old and older |
| *Upper age limit keeps increasing by one year….* | | |

***For more information is available at [https://www.fightcancer.org/what-we-do/emergent-science-multi-cancer-early-detection-tests](https://www.fightcancer.org/what-we-do/emergent-science-multi-cancer-early-detection-tests)***

*February 2025*