

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 817
(I-22)

Introduced by: Medical Student Section

Subject: Promoting Oral Anticancer Drug Parity

Referred to: Reference Committee J

1 Whereas, Chemotherapy drugs have been traditionally administered intravenously, although the
2 FDA has increasingly approved oral anticancer drugs to reflect not only medical advancement
3 but a growing patient preference^{1,2}; and
4

5 Whereas, Oral drug disparity is found in the disparity between insurance policy medical benefits
6 versus pharmacy benefits, with the former requiring little to no copay for IV chemotherapy and
7 the latter frequently requiring heavy out-of-pocket costs for oral anti-cancer medications^{3,4}; and
8

9 Whereas, For many oral chemotherapeutics, their classification as prescription drug benefits as
10 opposed to medical benefits allows private insurers to impose more expensive monthly copays,
11 sometimes as high as \$2500 compared to \$50 for the IV-administered form of the same drug¹;
12 and
13

14 Whereas, Many oral chemotherapeutics present the only viable option in cancer treatment and
15 have no IV-counterpart⁵; and
16

17 Whereas, Upwards of 40% of all new chemotherapeutics are available solely as oral
18 treatments⁶; and
19

20 Whereas, A portion of patients who cannot afford these oral chemotherapeutics forego taking
21 them, resulting in higher rates of hospitalizations, complications, and increased costs to both the
22 patient and health care system^{2,3,7,8}; and
23

24 Whereas, Despite the inaccessibility of oral chemotherapeutics, studies demonstrate patient-
25 reported preferences for oral administration over intravenous due to convenience, perceived
26 improvement of quality of life, and comfort⁹; and
27

28 Whereas, Higher monthly payments can be associated with a statistically significant higher risk
29 of medication non-adherence²; and
30

31 Whereas, Nonadherence to therapy is the strongest risk factor for cancer recurrence, after
32 which total cost of cancer-related treatment for the patient increases significantly^{2,10}; and
33

34 Whereas, "Oral parity" refers to ensuring equitable costs to patients for orally-administered
35 anticancer drugs as compared to IV-administered anticancer drugs¹¹; and
36

37 Whereas, While some form of oral parity legislation exists in 43 states, many states' policies are
38 unevenly applied such that large, private-sector, multi-state health plans are often excluded^{2,5};
39 and

1 Whereas, The Cancer Drug Parity Act (originally introduced in the House of Representatives
2 and Senate in 2019, and later re-introduced in 2021) promotes equal coverage of intravenous
3 and oral medications and prohibits insurance companies from making an inequitable distinction
4 between oral and intravenous forms of chemotherapy drugs but has still not been passed in the
5 US Congress⁵; and
6

7 Whereas, Coverage requirements for private health insurance companies are regulated by the
8 federal government through the Public Health Service Act (PHSA), the Employee Retirement
9 Income Security Act of 1974 (ERISA), and the Internal Revenue Code (IRC)¹²; and
10

11 Whereas, There has been little evidence of increased premiums amongst the 43 states that
12 have enacted oral parity legislation, relative to states without such legislation^{9,13}; and
13

14 Whereas, Oral parity is supported by numerous organizations including the American Society of
15 Clinical Oncology (ASCO), the Leukemia and Lymphoma Society, and Susan G. Komen Breast
16 Cancer Foundation^{11,14,15}; and
17

18 Whereas, Existing AMA policy H-55.986 supports financial reimbursement of chemotherapy and
19 antibiotic drugs at home via infusion or injection, but does not extend coverage to oral therapies;
20 therefore be it
21

22 RESOLVED, That our American Medical Association amend policy H-55.986, "Home
23 Chemotherapy and Antibiotic Infusions," by addition and deletion to read as follows:
24

25 H-55.986 - HOME CHEMOTHERAPY AND ANTIBIOTIC INFUSIONS

26 Our AMA: (1) endorses the use of home medications to include those orally-
27 administered, injections and/or infusions of FDA approved drugs and group C drugs
28 (including chemotherapy and/or antibiotic therapy) for appropriate patients under
29 physicians' recommendation and supervision; (2) only considers extension of the use of
30 home infusions for biologic agents, immune modulating therapy, and anti-cancer therapy
31 as allowed under the public health emergency when circumstances are present such
32 that the benefits to the patient outweigh the potential risks; (3) encourages CMS and/or
33 other insurers to provide adequate reimbursement and liability protections for such
34 treatment; (4) supports educating legislators and administrators about the risks and
35 benefits of such home infused antibiotics and supportive care treatments in terms of cost
36 saving, increased quality of life and decreased morbidity, and about the need to ensure
37 patient and provider safety when considering home infusions for such treatment as
38 biologic, immune modulating, and anti-cancer therapy; (5) advocates for appropriate
39 reimbursement policies for home infusions; and (6) opposes any requirement by insurers
40 for home administration of drugs, if in the treating physician's clinical judgment it is not
41 appropriate, or the precautions necessary to protect medical staff, patients and
42 caregivers from adverse events associated with drug infusion and disposal are not in
43 place; this includes withholding of payment or prior authorization requirements for other
44 settings; and (7) advocates for patient cost-sharing parity between office- and home-
45 administered anticancer drugs. (Modify Current HOD Policy)

Fiscal Note: Not yet determined

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RELEVANT AMA POLICY

Health Plan Coverage Policies for Anti-Nausea Regimens H-55.975

Our AMA advocates: (1) that ethical, cost effective, and compassionate cancer therapy requires the best possible anti-nausea treatment; (2) that no health plan should require a less expensive initial anti-nausea regimen that has been shown to be less than optimally effective compared to other available and approved regimens, thereby preventing patients from receiving the best possible anti-nausea therapy; (3) that all health plans should collaborate with the oncology physician community before changing coverage for anti-nausea therapy; and (4) that clinical coverage decisions for anti-nausea therapy should base considerations of cost effectiveness on the entire cost to the system, including patient co-pays and deductibles for oral anti-nausea agents, the use of oncologists' on-call time for fielding calls late at night when anti-nausea therapy fails, as well as the cost of office visits, emergency room visits, and hospitalizations.

Res. 826, I-10; Reaffirmed: CMS Rep. 01, A-20

Symptomatic and Supportive Care for Patients with Cancer H-55.999

Our AMA recognizes the need to ensure the highest standards of symptomatic, rehabilitative, and supportive care for patients with both cured and advanced cancer. The Association supports clinical research in evaluation of rehabilitative and palliative care procedures for the cancer patient, this to include such areas as pain control, relief of nausea and vomiting, management of complications of surgery, radiation and chemotherapy, appropriate hemotherapy, nutritional support, emotional support, rehabilitation, and the hospice concept. Our AMA actively encourages the implementation of continuing education of the practicing American physician regarding the most effective methodology for meeting the symptomatic, rehabilitative, supportive, and other human needs of the cancer patient.

CSA Rep. H, I-78; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: Sub. Res. 514, I-00; Modified: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20

Home Chemotherapy and Antibiotic Infusions H-55.986

Our AMA: (1) endorses the use of home injections and/or infusions of FDA approved drugs and group C drugs (including chemotherapy and/or antibiotic therapy) for appropriate patients under physicians' recommendation and supervision; (2) only considers extension of the use of home infusions for biologic agents, immune modulating therapy, and anti-cancer therapy as allowed under the public health emergency when circumstances are present such that the benefits to the patient outweigh the potential risks; (3) encourages CMS and/or other insurers to provide adequate reimbursement and liability protections for such treatment; (4) supports educating legislators and administrators about the risks and benefits of such home infused antibiotics and supportive care treatments in terms of cost saving, increased quality of life and decreased morbidity, and about the need to ensure patient and provider safety when considering home infusions for such treatment as biologic, immune modulating, and anti-cancer therapy; (5) advocates for appropriate reimbursement policies for home infusions; and (6) opposes any requirement by insurers for home administration of drugs, if in the treating physician's clinical judgment it is not appropriate, or the precautions necessary to protect medical staff, patients and caregivers from adverse events associated with drug infusion and disposal are not in place; this includes withholding of payment or prior authorization requirements for other settings..

Citation: Res. 186, I-89; Reaffirmed: Sunset Report and Reaffirmation A-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20; Modified: Res. 508, I-20;

Reducing Prescription Drug Prices D-110.993

Our AMA will (1) continue to meet with the Pharmaceutical Research and Manufacturers of America to engage in effective dialogue that urges the pharmaceutical industry to exercise reasonable restraint in the pricing of drugs; and (2) encourage state medical associations and others that are interested in pharmaceutical bulk purchasing alliances, pharmaceutical assistance and drug discount programs, and other related pharmaceutical pricing legislation, to contact the National Conference of State Legislatures, which maintains a comprehensive database on all such programs and legislation.

CMS Rep. 3, I-04; Modified: CMS Rep. 1, A-14; Reaffirmation A-14; Reaffirmed in lieu of Res. 229, I-14