AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 234
(A-24)

Introduced by: Association for Clinical Oncology, American Academy of Dermatology Association, American College of Mohs Surgery, American Contact Dermatitis Society, American College of Rheumatology

Subject: State Prescription Drug Affordability Boards - Study

Referred to: Reference Committee B

Whereas, in an effort to control high prescription drug costs, states are increasingly considering prescription drug affordability boards (PDABs); and

Whereas, PDABs in Colorado, Maryland and Minnesota have the authority to set upper payment limits (UPLs) for certain high-cost medications; and

Whereas, a UPL is the maximum reimbursement rate above which purchasers throughout the state may not pay for prescription drug products; and

Whereas, Medicare pays most separately payable Part-B covered drugs and biologics at a rate of the drug's average sales price plus 6%; and

Whereas, the 6% add-on payment for Medicare Part B drugs is intended to cover expenses associated with administering drugs in-office, including storage and handling; and

Whereas, similar to the concept of an upper payment limit, the Inflation Reduction Act (IRA) establishes a "maximum fair price" for a negotiated drug; and

Whereas, under the IRA, Medicare's payment to providers for Part B drugs with negotiated prices will be at 106% of the maximum fair price; and

Whereas, reimbursement for physician administered drugs can be up to 125% of a drug's average sales price in the private insurance market; and

Whereas, state PDAB legislation that includes UPL authority often lacks language that would allow physicians to seek reimbursement for storage and handling of a physician-administered drug subject to a UPL; therefore be it

RESOLVED, that our American Medical Association conduct a study to determine how upper payment limits (UPLs) established by state prescription drug affordability boards (PDABs) will impact reimbursement for physician-administered drugs and what impact state UPLs will have on patient access to care (Directive to Take Action); and be it further

RESOLVED, that our AMA report the results of the study on UPLs to the House of Delegates at A-25. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 4/24/2024

REFERENCES

1. Comparison of State Prescription Drug Affordability Review Initiatives. National Academy for State Health Policy. January 2024. https://nashp.org/comparison-of-state-prescription-drug-affordability-review-initiatives/
2. Enacted Prescription Drug Affordability Boards 2019-2023. Aimed Alliance. January 2024. https://aimedalliance.org/wp-content/uploads/2024/01/AA-PDAB-Enacted-Chart-Jan-2024.pdf
3. Q&A on NASHP's Model Act to Reduce the Cost of Prescription Drugs. August 2022. https://nashp.org/qa-on-nashps-model-act-to-reduce-the-cost-of-prescription-drugs/
4. Cubanski et al. Explaining the Prescription Drug Provisions in the Inflation Reduction Act. KFF. January 2023. https://www.kff.org/medicare/issue-brief/explaining-the-prescription-drug-provisions-in-the-inflation-reduction-act/

RELEVANT AMA POLICY

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.

Medicare Part B Competitive Acquisition Program (CAP) H-110.983
Our AMA will advocate that any revised Medicare Part B Competitive Acquisition Program meet the following standards to improve the value of the program by lowering the cost of drugs without undermining quality of care:
(1) it must be genuinely voluntary and not penalize practices that choose not to participate;
(2) it should provide supplemental payments to reimburse for costs associated with special handling and storage for Part B drugs;
(3) it must not reduce reimbursement for services related to provision/administration of Part B drugs, and reimbursement should be indexed to an appropriate healthcare inflation rate;
(4) it should permit flexibility such as allowing for variation in orders that may occur on the day of treatment, and allow for the use of CAP-acquired drugs at multiple office locations;
(5) it should allow practices to choose from multiple vendors to ensure competition, and should also ensure that vendors meet appropriate safety and quality standards;
(6) it should include robust and comprehensive patient protections which include preventing delays in treatment, helping patients find assistance or alternative payment arrangements if they cannot meet the cost-sharing responsibility, and vendors should bear the risk of non-payment of patient copayments in a way that does not penalize the physician;
(7) it should not allow vendors to restrict patient access using utilization management policies such as step therapy; and
(8) it should not force disruption of current systems which have evolved to ensure patient access to necessary medications.