

REPORT 1 OF THE REPORT OF THE COUNCIL ON MEDICAL SERVICE (I-07)
Cost-Sharing Arrangements for Prescription Drugs
(Reference Committee K)

EXECUTIVE SUMMARY

At the 2006 Interim Meeting, the House of Delegates adopted, as amended, Resolution 816, which asked that the AMA “study the relative advantages and disadvantages of two models of patient cost-sharing in prescription benefits, namely fixed dollar co-payments and percentage-based coinsurance, and recommend a plan of action that will advocate for better containment of price inflation and greater freedom for patients to obtain the best prescriptions for their disorders.”

Consistent with the focus of Resolution 816 (I-06), this report examines factors influencing prescription drug prices and trends in prescription drug spending and insurance coverage of pharmaceuticals; presents information regarding the use of co-payments and coinsurance; discusses value-based benefit design as an alternative to traditional benefit design; and describes ways in which increased price transparency can encourage efficient and appropriate use of prescription drugs.

Many factors contribute to prescription drug spending, and it is unlikely that any one approach will have a significant impact in solving the frustrations of physicians and patients over drug access and cost. It is not clear that a system based on either coinsurance or co-payments, per se, would yield greater efficiencies. The relative effects of a co-payment or coinsurance arrangement will depend on the cost of the medication in question, the medical condition being treated, and on the specific level of cost-sharing assigned. In addition, although shifting to coinsurance from co-payments may offer some benefits in terms of increasing patient sensitivity to prescription drug prices, greater patient cost-sharing could lead to patients being unable to afford necessary care, especially as new, high-cost specialty pharmaceuticals become increasingly important to the treatment of an expanding array of diseases and conditions.

Consistent with the need to prioritize “value” in health care spending, the Council believes that one strategy to help address pharmaceutical costs would be to support the development of “value-based” benefit designs, a strategy that emphasizes promoting the most efficient and effective use of prescription drugs, rather than manipulating out-of-pocket costs without regard for therapeutic value. In addition, emerging trends in the use of electronic prescribing have the potential to reveal to physicians and patients the true out-of-pocket and other costs of medications at the time the prescription is written. Improvements in this type of technology could be a valuable tool in helping physicians and patients work together to determine the most efficient and effective treatment for the patient’s medical condition.

The report recommends the development of new policy stating that cost-sharing arrangements for prescription drugs should be designed to encourage the judicious use of health care resources, rather than simply shifting costs to patients, and that cost-sharing requirements should be based on several factors known to affect patient compliance and health outcomes. The report also recommends support for the development and use of tools and technology that enable physicians and patients to determine the actual price and out-of-pocket costs of individual prescription drugs prior to making prescribing decisions, so that physicians and patients can work together to determine the most efficient and effective treatment for the patient’s medical condition.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

Subject: Cost-Sharing Arrangements for Prescription Drugs

Presented by: Georgia A. Tuttle, MD, Chair

Referred to: Reference Committee K
(M. Leroy Sprang, MD, Chair)

1 At the 2006 Interim Meeting, the House of Delegates adopted, as amended, Resolution 816, which
 2 asked that the AMA “study the relative advantages and disadvantages of two models of patient
 3 cost-sharing in prescription benefits, namely fixed dollar co-payments and percentage-based
 4 coinsurance, and recommend a plan of action that will advocate for better containment of price
 5 inflation and greater freedom for patients to obtain the best prescriptions for their disorders.” The
 6 Board of Trustees assigned this item to the Council on Medical Service, for a report back at the
 7 2007 Interim Meeting.

8
 9 As noted in Council on Medical Service Report 3 (I-00), “Pharmaceutical Spending in the United
 10 States,” “there is a combination of factors contributing to the rapid rise in pharmaceutical spending
 11 in the US,...[and] there will need to be a combination of solutions” to address the problem. As in
 12 most economic markets, the factors affecting pharmaceutical spending can be divided into two
 13 broad categories that have different, but often interrelated, opportunities for intervention. “Supply-
 14 side” interventions seek to influence factors related to individual per-unit drug pricing and the
 15 availability of prescription drugs. Examples include imposing price controls, redesigning the Food
 16 and Drug Administration approval process for new drugs, or modifying patent restrictions on
 17 newly-developed therapies. “Demand-side” interventions focus on changing patterns of
 18 consumption, including the number of prescriptions dispensed, and the choices made among
 19 available drug therapies. Examples of demand-side interventions include utilization management
 20 strategies typically implemented by insurers such as tiered or restricted formularies, and
 21 preauthorization requirements.

22
 23 Consistent with the focus of Resolution 816 (I-06), this report is limited to considering ways in
 24 which influencing patient demand for pharmaceuticals through the use of cost-sharing
 25 arrangements may limit growth in price inflation and spending on pharmaceuticals. Accordingly,
 26 this report examines factors influencing prescription drug prices, and trends in prescription drug
 27 spending and insurance coverage of pharmaceuticals; presents information regarding the use of co-
 28 payments and coinsurance; discusses value-based benefit design as an alternative to traditional
 29 benefit design; and describes the ways in which increased price transparency can encourage
 30 efficient and appropriate use of prescription drugs.

31
 32 PRESCRIPTION DRUG PRICING

33
 34 Background information provided by the author of Resolution 816 clarified that the intent of the
 35 resolution was to “suggest that patient cost-sharing arrangements will have differing effects on the
 36 inflation of retail prescription pricing....” According to the author, fixed dollar co-payments lead

1 to higher prescription drug prices because patients have insufficient information and incentive to
2 respond to and influence prescription drug prices. Conversely, coinsurance rates expose
3 individuals to out-of-pocket costs based on actual prescription drug prices, thus increasing patient
4 awareness of drug costs, and providing an incentive for consumers to become more active
5 participants in the prescription drug pricing process.

6
7 According to a January 2007 report by the Congressional Budget Office (CBO), “as prescription
8 drugs move from manufacturers to consumers, a complex set of market transactions involving
9 prices, discounts and rebates occurs along the supply chain.” After the original prices are set by
10 drug manufacturers, prices are negotiated by entities such as wholesalers, pharmacies, and insurers,
11 before reaching the price that consumers ultimately pay. At each of those stages, price negotiations
12 occur based on availability of generic or brand-name therapeutic alternatives for a given drug, and
13 on the volume of drugs being purchased (i.e., larger purchasers can negotiate larger discounts).
14 The CBO report notes that, “a purchaser’s bargaining power depends on both the volume
15 purchased and the purchaser’s ability to choose which drug to purchase from a set of competing
16 drugs.” Health insurers and pharmacy benefit managers are able to exert significant influence over
17 prices based on their willingness to designate a drug as “preferred” within their formulary structure.
18 Ultimately, the prices that consumers pay are dependent upon the results of a multi-layer price-
19 negotiation process.

20
21 The complexity of the prescription drug pricing process suggests that it is unlikely that modifying
22 cost-sharing arrangements will have a significant impact on drug pricing, per se. However,
23 evidence suggests that cost-sharing arrangements can directly influence the efficiency with which
24 health care resources are utilized. A significant factor in prescription drug spending trends is drug
25 utilization, which reflects the number and type of prescriptions written and dispensed. Thus, the
26 effect of cost-sharing on drug price inflation may be seen as a secondary effect of more efficient
27 drug use, to the extent that cost-sharing arrangements encourage the judicious use of prescription
28 drugs.

29 30 TRENDS IN PRESCRIPTION DRUG SPENDING

31
32 After nearly a decade of double-digit rate increases, the growth in drug spending has slowed
33 recently, and was only 5.8% in 2005. According to the Kaiser Family Foundation, prescription
34 drug spending accounted for 10% of US national health spending in 2005. Although spending on
35 physician and hospital services accounted for larger shares overall (21% and 31%, respectively),
36 the steady growth in prescription drug expenditures makes it one of the most closely monitored
37 segments of the health care market.

38
39 As noted, there are several components of drug spending, including the unit price of each drug, and
40 the number of and type of prescriptions dispensed. According to the 2006 Express Scripts Drug
41 Trends Report, the cost of non-specialty drugs increased 5.9% in 2006. Of that amount, 58.9% was
42 attributable to an increase in drug prices, 38.5% was attributable to increased utilization, and 2.6%
43 was attributable to the introduction of new drugs. According to Express Scripts, the introduction of
44 several major generics significantly limited cost growth in 2006.

45
46 Express Scripts also reports trend data for specialty drugs. The increased availability of high-cost
47 biotech drugs (e.g., Epogen, Enbrel) is projected to be one of the most significant drivers of
48 prescription drug spending in the next several years. Although “traditional” drug costs increased
49 only 5.9% in 2006, specialty drug costs increased 20.9%. As with traditional drugs, several factors

1 contributed to the increase in specialty drug spending. Increases in per prescription costs and
2 utilization were almost equally responsible for the increase in specialty drug costs (42.9% and
3 40.2% of the cost increase, respectively), but, unlike non-specialty drugs, the introduction of new
4 medications also played a significant role (16.9% of the cost increase). Although specialty
5 pharmaceuticals currently represent a relatively small portion of the total pharmaceutical market,
6 many industry experts predict that specialty pharmaceuticals will dominate the prescription drug
7 market over the next several years, resulting in larger spending growth increases.

8 9 INSURANCE COVERAGE AND PHARMACEUTICAL SPENDING

10
11 The 1999 prescription drug spending growth rate of 18% marked the peak of several years of
12 accelerated growth, which some analysts attribute, in part, to increases in insurance coverage for
13 pharmaceuticals. Noting that “trends in drug spending over time closely paralleled the growth in
14 drug coverage,” economists Patricia Danzon and Mark Pauly (2002) examined the relationship
15 between insurance coverage and drug costs. They concluded that increased utilization associated
16 with the “moral hazard effect” (whereby individuals over-consume services because they are
17 insulated from their true costs) of prescription drug coverage accounted for between one-fourth and
18 one-half of the increase in drug spending through the 1990s.

19
20 Danzon and Pauly also note, however, that although increased insurance coverage may have led to
21 increases in utilization, it is likely that it also contributed to limiting inflation of drug prices.
22 Increases in the price of existing drugs accounted for only 20% of prescription drug-spending
23 growth during the 1990s, and according to Danzon and Pauly, drug prices grew more slowly in the
24 1990s (when insurance coverage of prescription drugs was on the increase) than during the 1980s.
25 They suggest that the emergence of pharmacy benefit managers as intermediaries between drug
26 manufacturers and beneficiaries resulted in stronger negotiations for lower drug prices. The use of
27 formularies is one of the major tools by which pharmacy benefit managers are able to leverage
28 rebates and other pricing advantages offered by manufacturers, since a drug’s placement on a
29 closed formulary, or its placement within a “preferred” tier is likely to increase that drug’s market
30 share.

31
32 While insurers are able to exert some influence on drug manufacturers to offer lower drug prices to
33 covered beneficiaries, they also have begun to implement aggressive utilization management
34 strategies in order to control consumer demand. According to the Centers for Medicare and
35 Medicaid Services, “the...slowdown [in prescription drug spending] between 2000 and 2005 was
36 driven by the proliferation of tiered-co-payment benefit plans, which slowed growth in brand-name
37 drug use, and a decrease in the number of new drug introductions.”

38 39 CO-PAYMENTS AND COINSURANCE

40
41 The use of fixed-dollar co-payments for pharmaceuticals is extremely common, and is generally
42 combined with the use of a tiered formulary, in which lower co-payments are assessed for generic
43 and “preferred” drugs. Under a co-payment structure, an individual’s out-of-pocket responsibility
44 is the same for any drug within a given tier, regardless of the cost of the individual drug.

45
46 According to the 2007 Employer Health Benefits Survey from the Kaiser Family Foundation and
47 the Health Research and Educational Trust (KFF/HRET), between 82% and 87% of workers
48 covered under plans with three or four tiers of cost-sharing have co-payments for traditional (i.e.,
49 non-specialty) medications.

1 In contrast to co-payments, out-of-pocket costs under a coinsurance structure vary depending on
2 the actual price of the individual drug purchased. Coinsurance requires individuals to pay a fixed
3 percentage of a drug's total cost, so that the amount paid is highly dependent on the cost of the
4 drug itself. Between 6% and 9% of workers covered under tiered plans are subject to coinsurance
5 rates.

6
7 Increasing numbers of employers and health plans are considering switching to coinsurance
8 because, unlike co-payments, patient out-of-pocket costs increase as drug costs increase. In this
9 way, there is a greater degree of "transparency" in actual drug costs, and patients are more aware of
10 the cost associated with individual drug choices. Interestingly, many insurers are introducing
11 separate tiers for specialty drugs, and using coinsurance, rather than co-payments, as the cost-
12 sharing vehicle for the separate tier. According to the KFF/HRET survey, 38% of workers have
13 insurance that uses coinsurance for fourth-tier (i.e., specialty) drugs.

14
15 The RAND Health Insurance Experiment (HIE), conducted nearly 30 years ago, continues to be
16 one of the most widely-cited sources of information about the effect of cost-sharing on health care
17 utilization. The HIE showed that individuals subject to higher levels of cost-sharing exhibit a
18 reduced demand for health care. As Dana Goldman and colleagues reported in a 2007 article
19 published in *JAMA*, observational studies suggest that a 10% increase in cost-sharing reduces
20 prescription drug spending by 2%-6%. However, the effects vary according to the medical
21 condition being treated, and the choice of drugs available. There is also evidence that suggests that
22 increased cost-sharing may result in forgoing necessary care, which can ultimately lead to higher
23 health care costs.

24
25 High out-of-pocket costs, whether for acute treatment or management of a chronic condition, are an
26 impediment to care for many patients. The possibility that high levels of cost-sharing may cause
27 individuals to forgo necessary care is becoming especially relevant with the growth of specialty
28 drug use. Traditional utilization management strategies are being challenged by the expansion of
29 the specialty drug market, since many of these drugs lack therapeutic alternatives, and often
30 represent a vital treatment option for patients suffering from chronic or life-threatening illnesses.
31 Insurance companies are struggling to develop new benefit structures that will help contain the
32 extremely high costs of specialty drug costs, because traditional "cost control" mechanisms are
33 inappropriate in many cases. As Goldman concluded in a 2006 *Health Affairs* article, most
34 specialty pharmaceuticals have few if any therapeutic alternatives, thus cost-sharing only serves to
35 shift costs to patients, rather than drive behavior toward more efficient and cost-effective choices.

36
37 There is limited information in the literature about the relative advantages and disadvantages of
38 using co-payments or coinsurance to help control drug spending. In many cases, the relative
39 effects of a co-payment or coinsurance arrangement will depend on the cost of the medication in
40 question, the availability of therapeutic alternatives, the intensity of treatment indicated (e.g.,
41 treatment of an acute or chronic condition), and the level of cost-sharing assigned. In the case of
42 chronic conditions, or those that require treatment with high-cost specialty drugs, the use of
43 coinsurance often results in significantly higher levels of patient cost-sharing than the use of co-
44 payments. As noted, there is a risk that patients will delay or forgo necessary care when out-of-
45 pocket costs become too great. Authors from the National Bureau of Economic Research have
46 suggested that coinsurance may result in lower levels of patient compliance because of the
47 uncertainty associated with a "floating" rather than fixed cost-sharing structure.

1 However, coinsurance may be useful as a tool to encourage the use of generic or other less
2 expensive therapeutic alternatives. As might be expected, a 2005 analysis by the National Opinion
3 Research Center suggested that individuals with coinsurance may be more likely than individuals
4 with fixed co-payments to switch to lower-cost drug alternatives, because doing so lowers out-of-
5 pocket costs. However, the willingness to switch to a less expensive medication depends on the
6 level of coinsurance (i.e., those with higher coinsurance are more likely to switch), and on the
7 availability of effective therapeutic alternatives.

8
9 The most significant feature of any cost-sharing design is the level at which the cost-sharing is set.
10 As Jonathan Gruber pointed out in a 2006 report prepared for the Kaiser Family Foundation, results
11 from the RAND experiment and related studies suggest that although appropriate levels of cost-
12 sharing (i.e., high enough to affect demand) can reduce utilization without adversely affecting
13 health, inappropriate levels (i.e., too high to be affordable) can restrict access to necessary care.
14 Thus, the relative advantages or disadvantages of using co-payment or coinsurance benefit designs
15 vary greatly depending on the levels of cost-sharing that are assigned under either mechanism.

16 17 VALUE-BASED BENEFIT DESIGN

18
19 Cost-sharing mechanisms should be designed to encourage the judicious use of health care
20 resources, rather than simply shifting costs to patients. As noted, the presence of insurance
21 coverage can result in over-consumption of services, but the absence of insurance or the presence
22 of high cost-sharing requirements can compromise access to needed services. There is increasing
23 discussion among policymakers about the value of introducing more targeted and “value-based”
24 forms of cost-sharing that consider the effect of patient compliance on health outcomes. Value-
25 based decision-making can be thought of as an extension of evidence-based medicine, in which a
26 host of private and public decisions are improved through greater availability of information and
27 through incentives. This framework could be applied in numerous situations, including when
28 physicians and patients are choosing among alternative drug therapies; insurers are designing
29 health plan cost-sharing features; or when legislators are determining public health budgets or
30 considering mandating insurance coverage of particular benefits.

31
32 Value-based targeted benefit design uses varying levels of out-of-pocket cost-sharing to reward
33 compliance by patients with chronic conditions, thereby averting costly adverse outcomes. An
34 example of this type of insurance design is being piloted at the University of Michigan with their
35 MHealthy: Focus on Diabetes Program, which targets university employees and their dependents
36 who have been diagnosed with diabetes. Under the program, diabetic patients receive co-payment
37 reductions for specific medical interventions that have been shown to be clinically effective in the
38 treatment or management of diabetes. Reduced co-payments are applied to drugs to help control
39 blood sugar, blood pressure and cholesterol, and to annual eye exams for diabetic patients.
40 According to the university’s human resources Web site, the goal of the MHealthy: Focus on
41 Diabetes Program is to “encourage the proper and sustained use of specific drugs...and help
42 prevent or reduce the long-term complications of diabetes.” The program has been well received,
43 and the university hopes that it can serve as a model for more cost-effective delivery of health care.

44
45 At the 2007 Annual Meeting, the House adopted the recommendations contained in Council on
46 Medical Service Report 8 (A-07), which supported the use of targeted benefit design, noting that
47 consideration should be given to tailoring cost-sharing requirements to patient income and other
48 factors known to impact compliance (Policy H-155.960, AMA Policy Database).

1 PRICE TRANSPARENCY OF PRESCRIPTION DRUGS

2
3 In addition to implementing cost-sharing strategies that help encourage the efficient and judicious
4 use of resources, the development and use of tools that allow physicians and patients to estimate
5 total out-of-pocket costs for a given prescription could help ensure that patients and physicians
6 work together to identify appropriate treatment options. Although AMA policy supports increasing
7 physician awareness about the cost of drugs prescribed for their patients (H-110.996), and
8 encouraging physicians to consider cost along with therapeutic benefits when selecting medications
9 for their patients (H-110.997), physicians are often unaware of relative drug prices, and, further,
10 likely have no way of estimating total out-of-pocket costs under a patient’s health insurance plan.
11 Specific information about out-of-pocket costs, especially under a traditional coinsurance structure,
12 is often only available when a patient actually fills a prescription. By that time, the patient no
13 longer has convenient access to his or her physician, and may be forced to make an independent
14 and uninformed decision about whether to forgo or substitute a medication based on cost
15 considerations.

16
17 The use of electronic prescribing software is becoming increasingly popular as a way to decrease
18 medication errors, and to allow physicians access to real-time information that they can discuss
19 with their patients about things like drug interactions and potential side effects. There are some
20 cases in which these technologies are beginning to include cost information, to help increase
21 physician awareness of drug costs, and enable them to consider the relative cost of alternative
22 therapies when prescribing medications for their patients. The expansion of this type of technology
23 could be extremely useful in helping physicians and patients have an informed dialogue about the
24 value (as defined by cost and clinical outcomes) of a particular medication.

25
26 RELEVANT COUNCIL ON MEDICAL SERVICE REPORTS

27
28 Over the years, the Council has presented numerous reports that specifically address the rise in
29 prescription drug costs. Council Report 3 (I-00) responded to a directive from the House of
30 Delegates to undertake a comprehensive study of “the problem of increasing pharmaceutical costs,”
31 and concluded that there are several factors driving the increase in drug costs, and that a
32 combination of methods will be needed to address the problem (Policy D-110.997, AMA Policy
33 Database).

34
35 Council Report 2 (A-02) responded to a House directive to study the effects of various state actions
36 to control pharmaceutical costs. The informational report examined the use of strategies such as
37 pharmaceutical discount and rebate programs, and group purchasing cooperatives, and cited efforts
38 in Maine to use the threat of price controls to help keep drug prices low.

39
40 Council Report 3 (I-04) responded to two resolutions that asked the AMA to consider ways to
41 reduce prescription drug prices, including the use of price controls. The Council reiterated the
42 AMA’s fundamental opposition to price controls and provided recommendations that would
43 continue to promote market-based solutions to the problem of increasing drug costs (Policy D-
44 110.993).

45
46 Recently, the Council has prepared two reports for the House (Council Report 2, I-05 and Report 4,
47 I-06) that examined the uniquely high costs of specialty pharmaceuticals. The reports examined
48 the trend toward increased availability and utilization of high-cost specialty pharmaceuticals, and
49 described the insurance company response to this trend. In an effort to mitigate the effects of the

1 rapid expansion of the specialty drug market, insurers are attempting to control costs using a
2 variety of methods, such as innovative formulary structures, adjusting co-payment and co-
3 insurance rates, and working with pharmacy benefit managers. The Council emphasized the
4 importance of ensuring complete transparency of health care coverage policies related to specialty
5 pharmaceuticals, including co-payment or coinsurance levels and how these levels are determined
6 (Policy H-185.953).

7
8 Most recently, the Council prepared Report 2 (A-07), in response to referred Resolution 103 (A-
9 06), which asked that the AMA call for the development and regulation of a maximum allowable
10 cost of each prescription medication sold in the US. The report examined data related to the
11 apparent success of Medicare Part D in controlling drug costs by leveraging market forces. As
12 noted in Council Report 2 (A-07), the use of private plans to administer the Part D program has
13 resulted in lower-than-projected costs both for seniors and the federal government. The House of
14 Delegates supported the report's recommendation to oppose the use of price controls in any
15 segment of the health care industry, and continue to promote market-based strategies to achieve
16 access to an affordability of health care goods and services (Policy H-155.962).

17 18 ADDITIONAL AMA POLICY

19
20 The AMA is committed to ensuring patient access to necessary drugs (Policy H-110.997), and has
21 developed a comprehensive set of policies directed toward controlling prescription drug costs.
22 Several policies (H-110.995, H-110.998, H-110.996, D-110.993, and D-110.99) stress the
23 importance of urging the pharmaceutical industry itself to “identify, develop, and implement
24 market-based solutions to addressing those factors contributing to the rapid growth in
25 pharmaceutical spending.” Policies also call for the careful study of the true costs and benefits of
26 prescription drug availability (D-110.991 and D-110.995). Other policies emphasize the value of
27 generic drugs in offering a lower-cost, therapeutically equivalent alternative to brand name drugs
28 (H-110.997, and H-125.984), and helping patients understand the true (i.e., before insurance) cost
29 of prescription medications (H-110.991).

30 31 DISCUSSION

32
33 Resolution 816 (I-06) asks the AMA to examine ways in which pharmaceutical spending can be
34 reduced by influencing utilization patterns. Specifically, the whereas clauses of Resolution 816,
35 and communication from the author of the resolution, suggest that inflation in prescription drug
36 prices is due in part to the fact that patients are insulated from the true costs of prescription drugs
37 by their health insurance coverage. The concern expressed in Resolution 816 is that this effect is
38 compounded by the fact that patients' tendency to over-consume has resulted in increasing levels
39 of third-party intervention, in the form of pharmacy benefit managers, preauthorization
40 requirements, and restrictive formularies. These strategies may result in changes in utilization
41 patterns, but also impose unnecessary administrative hassles and costs.

42
43 The findings in the Danzon and Pauly article are especially relevant to the interrelated elements of
44 prescription drug coverage and prescription drug expenditures alluded to in Resolution 816.
45 According to Danzon and Pauly, insurance coverage does have a moral hazard effect – isolating
46 patients from costs so that utilization increases. However, it also helps limit price inflation of some
47 drugs, since insurance companies can leverage greater market power than individuals when
48 negotiating with manufacturers. Insurance companies also implement utilization management
49 strategies to counteract the moral hazard effect. The use of co-payments or coinsurance is one of

1 these strategies, which is employed by virtually all insurers. Danzon and Pauly did not necessarily
2 find economic “inefficiencies” in the relationship between pharmaceutical coverage and
3 pharmaceutical spending, because patients clearly get some level of value from consuming greater
4 levels of pharmaceutical services.

5
6 As noted in Council on Medical Service Report 3 (I-00) regarding rising prescription drug costs,
7 many factors contribute to prescription drug spending, and it is unlikely that any one approach will
8 have a significant impact in solving the frustrations of physicians and patients over drug access and
9 cost. Although increasing utilization contributes to increases in prescription drug spending, it is
10 not clear that a system based on coinsurance versus co-payments would yield greater efficiencies.
11 The relative effects of a co-payment or coinsurance arrangement depend on the cost of the
12 medication in question, the medical condition being treated, and on the specific level of cost-
13 sharing assigned. In addition, although shifting to coinsurance from co-payments may offer some
14 benefits in terms of increasing patient sensitivity to prescription drug prices, greater patient cost-
15 sharing could lead to patients being unable to afford necessary care, especially as new, high-cost
16 specialty pharmaceuticals become increasingly important to the treatment of an expanding array of
17 diseases and conditions.

18
19 As with other segments of the health care market, controlling pharmaceutical costs and realigning
20 supply and demand will depend on finding ways to increase efficient use of resources. With regard
21 to controlling health care costs, Council on Medical Service Report 8 (A-07) noted:

22
23 It is critical to recognize that the ultimate public policy goal is not cost-reduction *per se*,
24 but achieving better value for health care spending. Value can be thought of as the best
25 balance between benefits and costs, and better value as improved clinical outcomes,
26 quality, and/or patient satisfaction per dollar spent. The goal is not necessarily to reduce
27 utilization but to “rightsize” use of services in accordance with their relative costs and
28 benefits. The likely, but not guaranteed, net result would be lower per capita spending,
29 with slower (or negative) cost growth over time.

30
31 Consistent with the need to prioritize “value” in health care spending, the Council believes that one
32 strategy to help address pharmaceutical costs would be to support the development of “value-
33 based” benefit designs, in which cost-sharing obligations would be determined based on an
34 analysis of anticipated clinical outcomes, and the relative therapeutic benefits of different drug
35 therapies. This strategy emphasizes promoting the most efficient and effective use of prescription
36 drugs, rather than manipulating out-of-pocket costs without regard for therapeutic value.

37
38 Finally, emerging trends in the use of electronic prescribing have the potential to reveal to
39 physicians and patients the true out-of-pocket and other costs of medications at the time the
40 prescription is written. Improvements in this type of technology could be a valuable tool in helping
41 physicians and patients work together to determine the most efficient and effective treatment for
42 the patient’s medical condition.

1 RECOMMENDATIONS

2

3 The Council on Medical Service recommends that the following be adopted and the remainder of
4 this report be filed:

5

6 1. That our American Medical Association believes that cost-sharing arrangements for
7 prescription drugs should be designed to encourage the judicious use of health care
8 resources, rather than simply shifting costs to patients. (New HOD Policy)

9

10 2. That our AMA believes that cost-sharing requirements should be based on considerations
11 such as: unit cost of medication; availability of therapeutic alternatives; medical condition
12 being treated; personal income; and other factors known to affect patient compliance and
13 health outcomes. (New HOD Policy)

14

15 3. That our AMA supports the development and use of tools and technology that enable
16 physicians and patients to determine the actual price and out-of-pocket costs of individual
17 prescription drugs prior to making prescribing decisions, so that physicians and patients
18 can work together to determine the most efficient and effective treatment for the patient's
19 medical condition. (New HOD Policy)

References for this report are available from the AMA Division of Socioeconomic Policy
Development.

Fiscal Note: No Significant Fiscal Impact