Whereas, in 2016, total prescription drug spending reached $328 billion, more than double what was spent in 2002 and physicians are concerned that patients cannot afford necessary medications that will improve their health; and

Whereas, one in four patients report that they or another family member did not fill a prescription in the last year because of cost. One in four patients with cancer are choosing not to fill a prescription or are taking less due to cost; and

Whereas, prices for commonly used brand name drugs increased 164% and Medicare Part D spending doubled over the last decade; and

Whereas, under the current Medicare program, drug manufacturers set the price for Medicare Part D and Part B prescription drugs while all other providers (physicians, hospitals, home health, nursing homes) are subject to a government fee schedule; and

Whereas, according to an analysis published in *JAMA Internal Medicine*, if Medicare Part D paid prices for prescription medications similar to what the Department of Veterans Affairs pays, there could be an estimated annual savings of 38-50% because the VA has the ability to directly negotiate with pharmaceutical manufacturers; and

Whereas, under Medicare Part B, a pharmaceutical manufacturer can charge physicians as much as it wants for physician-administered drugs--unconstrained by any fee schedule or price limits. Moreover, physicians do not have access to the discounted drug prices that pharmacies and health plans enjoy, which make these drugs more costly; and

Whereas, many policy-makers are considering proposals to make it more difficult for physicians to provide important Medicare Part B medications in their offices; and

Whereas, Medicaid is authorized to negotiate best prices for drugs and thus, allowing Medicare to negotiate drug prices with drug-makers would make a meaningful difference in controlling costs in both the Medicare program and the private sector; and

Whereas, according to the Centers for Disease Control and Prevention (CDC), about 500,000 Americans age 60 and older get shingles (caused by the varicella zoster virus) every year. Individuals aged 60 and older are vulnerable to certain diseases that could be prevented by vaccines; and

Whereas, both the Medicare Part D and Part B programs have made it difficult for physicians to administer and patients to gain access to important vaccines; and
Whereas, Elderly patients should have the choice of receiving important vaccines and other medications in their physicians office, thereby allowing physicians to efficiently provide comprehensive care, particularly to those high-risk, chronically-ill patients; therefore be it

RESOLVED, That our American Medical Association advocate for Medicare to cover all physician-recommended adult vaccines in both the Medicare Part D and the Medicare Part B programs (Directive to Take Action); and be it further

RESOLVED, That our AMA make it a priority to advocate for a mandate on pharmaceutical manufacturers to negotiate drug prices with the Centers for Medicare and Medicaid Services for Medicare Part D and Part B covered drugs (Directive to Take Action); and be it further

RESOLVED, That our AMA explore all options with the state and national specialty societies to ensure that physicians have access to reasonable drug prices for the acquisition of Medicare Part B physician-administered drugs and that Medicare reimburse physicians for their actual drug acquisition costs, plus appropriate fees for storage, handling, and administration of the medications, to ensure access to high-quality, cost-effective care in a physician’s office. (Directive to Take Action)

Fiscal Note: Not yet determined

Received: 04/29/19

RELEVANT AMA POLICY

Appropriate Reimbursements and Carve-outs for Vaccines D-440.981
Our AMA will: (1) continue to work with the Centers for Medicare and Medicaid Services (CMS) and provide comment on the Medicare Program payment policy for vaccine services; (2) continue to pursue adequate reimbursement for vaccines and their administration from all public and private payers; (3) encourage health plans to recognize that physicians incur costs associated with the procurement, storage and administration of vaccines that may be beyond the average wholesale price of any one particular vaccine; and (4) seek legislation mandating that health insurance companies in applicable states either adequately pay for vaccines recommended by the Advisory Committee on Immunization Practices, or clearly state in large bold font in their notices to patients and businesses that they do not follow the federal advisory body on vaccine recommendations, the Advisory Committee on Immunization Practices.

Citation: (BOT Rep. 20, A-03; Reaffirmation A-07; Res. 128, A-09; Reaffirmation I-10; Reaffirmed: Res. 807, I-11

Financing of Adult Vaccines: Recommendations for Action H-440.860
1. Our AMA supports the concepts to improve adult immunization as advanced in the Infectious Diseases Society of America’s 2007 document "Actions to Strengthen Adult and Adolescent Immunization Coverage in the United States," and support the recommendations as advanced by the National Vaccine Advisory Committee’s 2008 white paper on pediatric vaccine financing.
2. Our AMA will advocate for the following actions to address the inadequate financing of adult vaccination in the United States:

Provider-related
a. Develop a data-driven rationale for improved vaccine administration fees.
b. Identify and explore new methods of providing financial relief for adult immunization providers through, for example, vaccine company replacement systems/deferred payment/funding for physician inventories, buyback for unused inventory, and patient assistance programs.
c. Encourage and facilitate adult immunization at all appropriate points of patient contact; e.g., hospitals, visitors to long-term care facilities, etc.
d. Encourage counseling of adults on the importance of immunization by creating a mechanism through which immunization counseling alone can be reimbursed, even when a vaccine is not given.

Federal-related
a. Increase federal resources for adult immunization to: (i) Improve Section 317 funding so that the
program can meet its purpose of improving adult immunizations; (ii) Provide universal coverage for adult vaccines and minimally, uninsured adults should be covered; (iii) Fund an adequate universal reimbursement rate for all federal and state immunization programs.

b. Optimize use of existing federal resources by, for example: (i) Vaccinating eligible adolescents before they turn 19 years of age to capitalize on VFC funding; (ii) Capitalizing on public health preparedness funding.

c. Ease federally imposed immunization burdens by, for example: (i) Providing coverage for Medicare-eligible individuals for all vaccines, including new vaccines, under Medicare Part B; (ii) Creating web-based billing mechanisms for physicians to assess coverage of the patient in real time and handle the claim, eliminating out-of-pocket expenses for the patient; (iii) Simplifying the reimbursement process to eliminate payment-related barriers to immunization.

d. The Centers for Medicare & Medicaid Services should raise vaccine administration fees annually, synchronous with the increasing cost of providing vaccinations.

State-related

a. State Medicaid programs should increase state resources for funding vaccines by, for example: (i) Raising and funding the maximum Medicaid reimbursement rate for vaccine administration fees; (ii) Establishing and requiring payment of a minimum reimbursement rate for administration fees; (iii) Increasing state contributions to vaccination costs; and (iv) Exploring the possibility of mandating immunization coverage by third party payers.

b. Strengthen support for adult vaccination and appropriate budgets accordingly.

Insurance-related

1. Provide assistance to providers in creating efficiencies in vaccine management by: (i) Providing model vaccine coverage contracts for purchasers of health insurance; (ii) Creating simplified rules for eligibility verification, billing, and reimbursement; (iii) Providing vouchers to patients to clarify eligibility and coverage for patients and providers; and (iv) Eliminating provider/public confusion over insurance payment of vaccines by universally covering all Advisory Committee on Immunization Practices (ACIP)-recommended vaccines.

b. Increase resources for funding vaccines by providing first-dollar coverage for immunizations.

c. Improve accountability by adopting performance measurements.

d. Work with businesses that purchase private insurance to include all ACIP-recommended immunizations as part of the health plan.

e. Provide incentives to encourage providers to begin immunizing by, for example: (i) Including start up costs (freezer, back up alarms/power supply, reminder-recall systems, etc.) in the formula for reimbursing the provision of immunizations; (ii) Simplifying payment to and encouraging immunization by nontraditional providers; (iii) Facilitating coverage of vaccines administered in complementary locations (e.g., relatives visiting a resident of a long-term care facility).

Manufacturer-related

Market stability for adult vaccines is essential. Thus: (i) Solutions to the adult vaccine financing problem should not deter research and development of new vaccines; (ii) Solutions should consider the maintenance of vibrant public and private sector adult vaccine markets; (iii) Liability protection for manufacturers should be assured by including Vaccine Injury Compensation Program coverage for all ACIP-recommended adult vaccines; (iv) Educational outreach to both providers and the public is needed to improve acceptance of adult immunization.

3. Our AMA will conduct a survey of small- and middle-sized medical practices, hospitals, and other medical facilities to identify the impact on the adult vaccine supply (including influenza vaccine) that results from the large contracts between vaccine manufacturers/distributors and large non-government purchasers, such as national retail health clinics, other medical practices, and group purchasing programs, with particular attention to patient outcomes for clinical preventive services and chronic disease management.

Citation: (CSAPH Rep. 4, I-08; Reaffirmation I-10; Reaffirmation: I-12; Reaffirmation I-14

Prescription Drug Prices and Medicare D-330.954

1. Our AMA will support federal legislation which gives the Secretary of the Department of Health and Human Services the authority to negotiate contracts with manufacturers of covered Part D drugs.

2. Our AMA will work toward eliminating Medicare prohibition on drug price negotiation.

3. Our AMA will prioritize its support for the Centers for Medicare & Medicaid Services to negotiate pharmaceutical pricing for all applicable medications covered by CMS.
Cuts in Medicare Outpatient Infusion Services D-330.960
1. Our AMA will actively support efforts to seek legislation to ensure that Medicare payments for drugs fully cover the physician’s acquisition, inventory and carrying cost and that Medicare payments for drug administration and related services are adequate to ensure continued patient access to outpatient infusion services.
2. Our AMA will continue strong advocacy efforts working with relevant national medical specialty societies to ensure adequate physician payment for Part B drugs and patient access to biologic and pharmacologic agents.

Opposition to the CMS Medicare Part B Drug Payment Model D-330.904
1. Our AMA will request that the Centers for Medicare & Medicaid Services (CMS) withdraw the proposed Part B Drug Payment Model.
2. Our AMA will support and actively work to advance Congressional action to block the proposed Part B Drug Payment Model if CMS proceeds with the proposal.
3. Our AMA will advocate against policies that are likely to undermine access to the best course of treatment for individual patients and oppose demonstration programs that could lead to lower quality of care and do not contain mechanisms for safeguarding patients.
4. Our AMA will advocate for ensuring that CMS solicits and takes into consideration feedback from patients, physicians, advocates, or other stakeholders in a way that allows for meaningful input on any Medicare coverage or reimbursement policy that impacts patient access to medical therapies, including policies on coverage and reimbursement.

Restoring High Quality Care to the Medicare Part D Prescription Drug Program D-330.933
Our AMA will:

a. work to eliminate prior authorizations under the Medicare Part D Prescription Drug Program which undermine a physician’s best medical judgment;
b. work with the Centers for Medicare and Medicaid Services (CMS) to enforce the Medicare Part D Prescription Drug Program statutory requirement that all Part D plans include at least two drugs proven to be equally effective in each therapeutic category or pharmacologic class, if available, to be used by the physician in deciding the best treatment options for their patients;
c. work with CMS to place reasonable copays in the Medicare Part D Prescription Drug Program;
d. work with other interested parties to simplify the CMS prior authorization process such that a diagnosis or reason written on the prescription should be accepted as documentation for non formulary request; and
e. work with CMS to develop a one-page form for physicians and patients to utilize in appealing a prescription coverage denial.

Citation: (Res. 106, A-07; Reaffirmation A-08; Reaffirmation A-14