

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 221
(A-24)

Introduced by: California

Subject: Reforming Medicare Part B Drug Reimbursement to Promote Patient Affordability and Physician Practice Sustainability

Referred to: Reference Committee B

1 Whereas, the skyrocketing cost of drugs is a key driver of U.S. healthcare costs; In 2021,
2 Medicare spent \$215B and \$33B on Part D and Part B drugs respectively, with Part B clinically-
3 administered drugs costs rising at an average rate of 9.2% annually from 2008-2021;^{1,2} and
4

5 Whereas, Medicare Part B reimburses for Part B drugs under the “Buy and Bill” method, in
6 which healthcare systems or physicians purchase, stock, maintain inventory for and administer
7 drugs, and are reimbursed at an amount equal to the Average Sales Price (ASP) of the drug
8 plus 6% of the ASP;^{3,4} and
9

10 Whereas, multiple factors contribute to the high cost of Part B drugs, including longer patent
11 exclusivity periods, lack of market competition and generic alternatives, and historical prohibition
12 of Medicare in negotiating drug prices; and
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14 Whereas, the “Buy and Bill” reimbursement structure which ties reimbursement directly to drug
15 prices disincentivizes healthcare systems or physicians to choose the lowest-cost drugs;⁵ and
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17 Whereas, Part B drugs have high levels of patient cost-sharing, as patients are charged a
18 coinsurance of 20% of the cost of the drug rather than a fixed copay;⁶ and
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20 Whereas, more than half of patients with a chronic illness are in medical debt, and 25% of
21 cancer patients experience eviction, home foreclosure or bankruptcy;⁷ and
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23 Whereas, The Inflation Reduction Act authorized Medicare to begin drug price negotiations for
24 Part B drugs in 2026, with these prices taking effect in 2028;⁸ and
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26 Whereas, while lower drug prices will undoubtedly improve affordability for patients, as noted in
27 an AMA Letter to CMS in 2018⁹, tying reimbursement to the ASP over time as prices drop “may
28 no longer be sufficient to cover the administrative costs to the practice”, threatening practice
29 viability and therefore patient access to care; and
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31 Whereas, ASP-based Medicare reimbursement for physicians has a six-month lag period,
32 contributing to the financial vulnerability of small/medium-sized physician practices, practices in
33 rural and/or underserved areas, and practices serving a significant proportion of Medicare
34 patients;¹⁰ and
35

36 Whereas, While the administration of Part B drugs is most prevalent in the fields of oncology,
37 rheumatology, ophthalmology, dermatology and gastroenterology, this issue affects all
38 physicians serving Medicare patients, as the anticipated billions saved annually through drug
39 price negotiations could be reappropriated towards improving physician reimbursement across-
40 the-board; therefore be it

- 1 RESOLVED, that our American Medical Association support the creation of a new
2 reimbursement model for Part B drugs that 1) Disentangles reimbursement from the drug price,
3 or any weighted market average of the drug price, by reimbursing physicians for the actual cost
4 of the drug, and 2) Ensures adequate compensation for the cost of acquisition, inventory,
5 storage, and administration of clinically-administered drugs that is based on physician costs, not
6 a percent of the drug price (New HOD Policy); and be it further
7
8 RESOLVED, that our AMA maintain the principles that any revised Part B reimbursement
9 models should promote practice viability, especially for small physician practices, practices in
10 rural and/or underserved areas, and practices with a significant proportion of Medicare patients,
11 to promote continued treatment access for patients. (New HOD Policy)

Fiscal Note: Minimal - less than \$1,000

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RELEVANT AMA POLICY

H-330.888 Exempt Physician-Administered Drugs from Medicare Sequestration

Our AMA supports passage of federal legislation 1) exempting payments for biologics and other drugs provided under Medicare Part B from sequestration cuts, and 2) reimbursing providers for reductions in payments for biologics and other drugs furnished under Medicare Part B on or after April 1, 2013. [Reaffirmed: Res. 212, I-21; Reaffirmation A-15; Res. 235, A-13]

D-330.960 Cuts in Medicare Outpatient Infusion Services

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.

[Reaffirmation: I-18; Reaffirmed: CMS Rep. 10, A-16; Reaffirmation A-15; Reaffirmed and Modified: CMS Rep. 3, I-08; Res. 926, I-03]

D-330-.904 Opposition to the CMS Medicare Part B Drug Payment Model

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.

[Res. 241, A-16]

H-110-983 Medicare Part B Competitive Acquisition Program (CAP)

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.

[Reaffirmed: CMS Rep. 4, A-22; Reaffirmed: CMS Rep. 4, I-19; Res. 216, I-18]

H-110.987 Pharmaceutical Costs

1. Our AMA encourages Federal Trade Commission (FTC) actions to limit anticompetitive behavior by pharmaceutical companies attempting to reduce competition from generic manufacturers through manipulation of patent protections and abuse of regulatory exclusivity incentives.

2. Our AMA encourages Congress, the FTC and the Department of Health and Human Services to monitor and evaluate the utilization and impact of controlled distribution channels for prescription pharmaceuticals on patient access and market competition.

3. Our AMA will monitor the impact of mergers and acquisitions in the pharmaceutical industry.

4. Our AMA will continue to monitor and support an appropriate balance between incentives based on appropriate safeguards for innovation on the one hand and efforts to reduce regulatory and statutory barriers to competition as part of the patent system.
 5. Our AMA encourages prescription drug price and cost transparency among pharmaceutical companies, pharmacy benefit managers and health insurance companies.
 6. Our AMA supports legislation to require generic drug manufacturers to pay an additional rebate to state Medicaid programs if the price of a generic drug rises faster than inflation.
 7. Our AMA supports legislation to shorten the exclusivity period for biologics.
 8. Our AMA will convene a task force of appropriate AMA Councils, state medical societies and national medical specialty societies to develop principles to guide advocacy and grassroots efforts aimed at addressing pharmaceutical costs and improving patient access and adherence to medically necessary prescription drug regimens.
 9. Our AMA will generate an advocacy campaign to engage physicians and patients in local and national advocacy initiatives that bring attention to the rising price of prescription drugs and help to put forward solutions to make prescription drugs more affordable for all patients.
 10. Our AMA supports: (a) drug price transparency legislation that requires pharmaceutical manufacturers to provide public notice before increasing the price of any drug (generic, brand, or specialty) by 10% or more each year or per course of treatment and provide justification for the price increase; (b) legislation that authorizes the Attorney General and/or the Federal Trade Commission to take legal action to address price gouging by pharmaceutical manufacturers and increase access to affordable drugs for patients; and (c) the expedited review of generic drug applications and prioritizing review of such applications when there is a drug shortage, no available comparable generic drug, or a price increase of 10% or more each year or per course of treatment.
 11. Our AMA advocates for policies that prohibit price gouging on prescription medications when there are no justifiable factors or data to support the price increase.
 12. Our AMA will provide assistance upon request to state medical associations in support of state legislative and regulatory efforts addressing drug price and cost transparency.
 13. Our AMA supports legislation to shorten the exclusivity period for FDA pharmaceutical products where manufacturers engage in anti-competitive behaviors or unwarranted price escalations.
 14. Our AMA supports legislation that limits Medicare annual drug price increases to the rate of inflation.
- [Reaffirmed: Res. 801, I-23; Reaffirmed in lieu of: Res. 810, I-22; Appended: Res. 113, I-21; Reaffirmed: Res. 105, A-19; Appended: BOT Rep. 14, A-19; Appended: CMS Rep. 07, A-18; Reaffirmed: BOT Rep. 14, A-18; Appended: Alt. Res. 806, I-17; Modified: Speakers Rep. 01, A-17; Reaffirmed in lieu of Res. 107, A-17; Appended: Res. 201 A-17; Reaffirmed in lieu of: Res. 817, I-16; CMS Rep. 2, I-15]