

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

- 1 Whereas, in an effort to control high prescription drug costs, states are increasingly considering
2 prescription drug affordability boards (PDABs); and
3
4 Whereas, PDABs in Colorado, Maryland and Minnesota have the authority to set upper
5 payment limits (UPLs) for certain high-cost medications; and
6
7 Whereas, a UPL is the maximum reimbursement rate above which purchasers throughout the
8 state may not pay for prescription drug products; and
9
10 Whereas, Medicare pays most separately payable Part-B covered drugs and biologics at a rate
11 of the drug's average sales price plus 6%; and
12
13 Whereas, the 6% add-on payment for Medicare Part B drugs is intended to cover expenses
14 associated with administering drugs in-office, including storage and handling; and
15
16 Whereas, similar to the concept of an upper payment limit, the Inflation Reduction Act (IRA)
17 establishes a "maximum fair price" for a negotiated drug; and
18
19 Whereas, under the IRA, Medicare's payment to providers for Part B drugs with negotiated
20 prices will be at 106% of the maximum fair price; and
21
22 Whereas, reimbursement for physician administered drugs can be up to 125% of a drug's
23 average sales price in the private insurance market; and
24
25 Whereas, state PDAB legislation that includes UPL authority often lacks language that would
26 allow physicians to seek reimbursement for storage and handling of a physician-administered
27 drug subject to a UPL; therefore be it
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29 RESOLVED, that our American Medical Association conduct a study to determine how upper
30 payment limits (UPLs) established by state prescription drug affordability boards (PDABs) will
31 impact reimbursement for physician-administered drugs and what impact state UPLs will have
32 on patient access to care (Directive to Take Action); and be it further
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34 RESOLVED, that our AMA report the results of the study on UPLs to the House of Delegates at
35 A-25. (Directive to Take Action)
36

Fiscal Note: To Be Determined

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.