EXECUTIVE SUMMARY

At the November 2020 Meeting, the House of Delegates referred Resolution 213, “Pharmacies to Inform Physicians when Lower Cost Medication Options are on Formulary,” which was sponsored by the American College of Allergy, Asthma and Immunology. Resolution 213 asked the American Medical Association (AMA) to support legislation or regulatory action to require that in the event a patient cannot afford the medication prescribed, either because it is not on the formulary or it is priced higher than other medications on the formulary, the pharmacist must communicate to the prescriber a medication option in the same class prescribed with the lowest out-of-pocket cost to the patient. The Board of Trustees assigned this item to the Council on Medical Service for a report back to the House of Delegates.

Resolution 213-NOV-20 highlights the untenable position patients and their physicians encounter as they attempt to choose among appropriate prescription drug options with incomplete information. When recommending a pharmaceutical to a patient, physicians consider not only clinical appropriateness, but also patient preferences and patient ability to afford the prescribed medication. Nevertheless, at the point of joint decision-making, patients and their physicians often lack access to critical prescription drug price information. Instead, patients and their physicians may choose a clinically appropriate prescription drug, but without access to accurate, patient-specific insurance plan and/or Pharmacy Benefit Manager (PBM) formulary and utilization management information, they may not know until the patient attempts to purchase the drug at a pharmacy that the selected pharmaceutical was unaffordable for the patient.

This report studies the communication challenges that arise among patients, physicians, pharmacies, and health plans when patients are unable to afford prescribed medication and health information technology solutions that can help. In addition, this report highlights ongoing AMA advocacy to improve prescription drug price transparency and presents policy recommendations.
Subject: Access to Health Plan Information regarding Lower-Cost Prescription Options (Resolution 213-NOV-20)

Presented by: Asa C. Lockhart, MD, MBA, Chair

Referred to: Reference Committee G

At the November 2020 Meeting, the House of Delegates referred Resolution 213, “Pharmacies to Inform Physicians when Lower Cost Medication Options are on Formulary,” which was sponsored by the American College of Allergy, Asthma and Immunology. Resolution 213 asked the American Medical Association (AMA) to support legislation or regulatory action to require that in the event a patient cannot afford the medication prescribed, either because it is not on the formulary or it is priced higher than other medications on the formulary, the pharmacist must communicate to the prescriber a medication option in the same class prescribed with the lowest out-of-pocket cost to the patient. Reference committee testimony at the meeting was mixed regarding Resolution 213. While testimony supported the intent of Resolution 213, testimony also expressed concern that Resolution 213 could lead to unintended consequences of creating unnecessary administrative burdens on physicians, confusion for patients, and potential pharmacy scope of practice expansion.

The Board of Trustees assigned this item to the Council on Medical Service for a report back to the House of Delegates. This report studies the communication challenges that arise among patients, physicians, pharmacies, and health plans when patients are unable to afford prescribed medication and health information technology (HIT) solutions that can help. In addition, this report highlights ongoing AMA advocacy to improve prescription drug price transparency and presents policy recommendations.

BACKGROUND

Patients are directly impacted by high prescription drug prices when they are still in the deductible period of their insurance plans, when the drugs prescribed are not covered by their insurance, when a nonpreferred formulary status for a particular drug leads to a higher patient cost-share, when Medicare Part D beneficiaries are in the “donut hole,” or when patients are uninsured. As the number of patients enrolled in high-deductible health plans and Medicare Part D continues to rise, more patients may struggle with prescription affordability challenges. Resolution 213-NOV-20 highlights the untenable position patients and their physicians encounter as they attempt to choose among appropriate prescription drug options with incomplete information. When recommending a pharmaceutical to a patient, physicians consider not only clinical appropriateness, but also patient preferences and patient ability to afford the prescribed medication. Nevertheless, at the point of joint decision-making, patients and their physicians often lack access to critical prescription drug price information. Instead, patients and their physicians may choose a clinically appropriate prescription drug, but without access to accurate, patient-specific insurance plan and/or Pharmacy Benefit Manager (PBM) formulary and utilization management information, they may not know until patients attempt to purchase their drugs at the pharmacy that the selected pharmaceuticals are unaffordable for the patient.
Pharmacists play an important role in identifying instances of prescription drug prices impairing access to care. Critically, a pharmacist may be the first, and potentially only health care professional, who knows that a patient has declined a prescribed medication due to cost. The prescribing physician should be informed when a patient declines to fill a prescription as soon as possible, but as noted in testimony on Resolution 213-NOV-20, requiring pharmacists to communicate to the prescriber a lower-cost medication option can be problematic. Ideally, patient out-of-pocket costs associated with prescription options would be easily available through the electronic systems used by physicians and pharmacists, but that information is not currently universally available. In the absence of a technology tool, the only way to know which medications are on the formulary is for the physician, pharmacist, or patient to research the formulary and/or call the insurance plan or PBM. Clearly, such a process is burdensome for everyone. Since the ultimate decision regarding which medication is most appropriate for a patient is made directly between physicians and patients, requiring pharmacists to research patients’ formularies and discuss their research with the physician unnecessarily adds burden to both physicians and pharmacists. Moreover, unnecessarily inserting pharmacists into the prescribing process may increase confusion among patients and scope of practice concerns as patients seek prescription guidance from their pharmacists. Rather than imposing burdensome new legal requirements on pharmacists, the goal of improved prescription drug price transparency at the point of prescribing could be accomplished via improved HIT.

PRICE TRANSPARENCY AT POINT OF PRESCRIBING AND REAL-TIME PRESCRIPTION BENEFIT TECHNOLOGY

To empower informed joint decision-making, patients and physicians must have a way to obtain real-time, patient-specific prescription drug coverage information at the point of prescribing in physicians’ electronic health records (EHR)s. Having access to accurate, current information about a patient’s prescription benefit will enable physicians and patients to evaluate drug costs and consider possible alternative therapies when selecting a medication regimen. Drug price transparency at the point of care has the potential to reduce drug costs for patients (and public and private payers). Additionally, provision of such data within the e-prescribing workflow will ensure physician awareness of utilization management requirements, such as prior authorization requirements, step therapy protocols, and quantity limitations at the point of prescribing. Transparency of patient out-of-pocket costs and coverage restrictions in EHRs can therefore help mitigate medication nonadherence and treatment abandonment. Finally, by leveraging a technology solution embedded into existing EHRs, neither patients, physicians, pharmacists, nor payers would be burdened with the time-consuming process of manually cross-checking current formularies and potential medication alternatives. This technology solution currently exists in proprietary form, and a standardized version is on the horizon.

Real-Time Prescription Benefit (RTPB) technology, also known as Real-Time Benefit Tool (RTBT) technology in federal regulatory language, is a prescription drug decision-making tool that embeds real-time, patient-specific benefit information in the e-prescribing workflow. RTPB tools allow prescribers to access accurate, patient-specific coverage and benefit information, including the expected out-of-pocket cost, for a chosen medication and pharmacy. RTPB tools also present prescribers with utilization management restrictions and plan-preferred alternative medication options, which may be more cost-effective for the patient. RTPB tools represent a significant improvement over the drug formulary information otherwise incorporated into EHRs and e-prescribing. Existing drug formulary information is often inaccurate, outdated, and generally unreliable due to delayed updates and lack of patient specificity. The significant limitations in drug formulary information embedded into EHRs have caused some physicians to distrust (and consequently ignore) the formulary data currently available in EHRs.
Several proprietary RTPB tools are already being used by some physicians and health systems, but the proprietary nature of these tools limits their impact. Currently, physicians’ ability to access RTPB information for a specific patient depends on whether there is a business relationship between the physician practice’s RTPB tool software provider and the patient’s drug plan. For example, Surescripts is collaborating with several EHR companies and leveraging information from the PBMs CVS Health and Express Scripts to provide RTPB tools for the patients and physicians in their network. Similarly, OptumRx and UnitedHealthcare are collaborating to provide a similar tool, specifically for their enrollees. Accordingly, some physicians may have access to RTPB tools for some patients, but physicians cannot yet access comprehensive benefit information across all prescription drug plans, and tools do not yet integrate with all EHRs/e-prescribing systems. To achieve that level of universal access and transparency, a non-proprietary RTPB standard is required.

To test the hypothesized benefits of a standard RTPB tool, a research team at Johns Hopkins Medicine recently studied the impact of an RTPB tool integrated into the EHR at their institution. The study found that the RTPB tool reduced physician prior authorization burden, achieved patient cost savings, and facilitated improved medication adherence. Specifically, the cost and day-supply information provided by the RTPB tool frequently led physicians and patients to choose a 3-month supply of medication instead of a 1-month supply, as many PBMs discount the copay on 3-month supplies, making the 3-month supply more cost effective. This has important health outcomes implications, as medication adherence increases with longer day-supply of prescriptions. The most common changes in drug selection involved switching to alternatives with minimal clinical, but notable financial, significance. In addition, the information provided by the RTPB tool was able to guide prescribers in choosing medication alternatives without prior authorization requirements, and to convert from an agent covered with restrictions to one covered without restrictions, or to convert from an agent not covered to one covered with restrictions. These features reduced administrative burden on prescribers and increased the likelihood of patients being able to obtain their medication without delay. The study found patient cost savings of up to $2,370 when a prescription was switched from a retail to mail order pharmacy. The average patient out-of-pocket cost savings due to changes in prescription was approximately $21. Essential to building physician trust in the tool, the study found that the price estimates provided by the RTPB tool were accurate in 98 percent of the orders. The research team emphasized that webinars and in-person meetings were held to promote increased adoption and appropriate use of the RTPB tool, and since going live with the tool, they observed a significant increase in awareness from prescribers about the tool.

CMS intensified the need for standardized RTPB technology with its May 2019 final rule requiring that each Medicare Part D plan adopt one or more RTBTs that are capable of integrating with at least one EHR or e-prescribing system by January 1, 2021. While this mandate could potentially help accelerate physician practices’ access to RTPB tools, the CMS rule is significantly limited. The CMS rule allows Medicare Part D plans to support a single RTBT that is required to integrate with only one physician EHR/e-prescribing system. As such, physicians and their EHR vendors could presumably need to support a different RTBT for every Medicare Part D plan in order to have access to prescription benefit information for every Medicare patient treated by the practice. This would be an overwhelming, expensive, and burdensome proposition for vendors and physicians and would likely discourage adoption of this technology. Alternatively, since CMS is only requiring one RTBT capable of integrating with at least one e-prescribing system or EHR, some physicians may find that they have RTPB information for some, but not all, of their patients. Such incomplete access to RTPB information may lead to greater confusion and frustration, both among physicians and patients. An RTPB standard is needed to progress beyond the current proprietary and incomplete RTPB technology landscape and allow all physicians access through any EHR to any patient’s specific benefit information.
The National Council for Prescription Drug Programs (NCPDP) has been developing an electronic standard for RTPB technology since 2014. The NCPDP’s Real Time Prescription Benefit Standard Task Group (RTPB Task Group) is responsible for developing the RTPB standard, and the AMA has participated in the RTPB Task Group since its inception. At its August 2021 Virtual Interim Work Group meeting, the RTPB Task Group agreed to recommend that CMS recognize, via the federal rulemaking process, the RTPB standard that has been developed by NCPDP. It is anticipated that the RTPB standard will have an implementation time-period of 2 years following the publication of a final rule.

As articulated in Resolution 213-NOV-20, currently it can be impossible for insured patients and their physicians to know at the point of prescribing what a prescribed drug will cost the patient. A standardized RTPB tool embedded into physicians’ EHRs will close the current information gap among insurance plans, PBMs, pharmacies, patients and their physicians. The universality of a standardized RTPB tool is expected to significantly improve interoperability, expand transparency, increase prescription drug adherence, and promote informed communication and trust between patients and their physicians.

ENHANCED PHYSICIAN EDUCATION REGARDING APPLICATION OF RTPB TECHNOLOGY

The Council commends the resolution sponsors for highlighting the critical problem of cost-related non-adherence and prescription abandonment and the urgent need for tools that will enhance communication among physicians and pharmacists on behalf of patients. Resolution 213-NOV-20 also illustrates that RTPB technology is not currently a top-of-mind solution for the majority of physicians. The AMA’s 2020 Physician Practice Benchmark Survey (2020 Benchmark Survey), which is a nationally representative survey of US physicians who provide patient care, and which included an explanation of RTPB technology, found that only 35.7 percent of physicians had heard of RTPB technology prior to taking the survey. Moreover, among that portion of the physician population who had heard of RTPB technology, only about 55 percent of those physicians had access to RTPB technology. This may be due to the proprietary nature of the currently available RTPB tools. However, the physicians who have access to RTPB technology overwhelmingly choose to take advantage of the tool. In fact, the 2020 Benchmark Survey found that physicians who have access to RTPB tools are over four times as likely to use the RTPB technology available to them than not. Accordingly, not only is there an urgent need for a standard RTPB tool that will provide all physicians access to all patients’ specific benefit information at the point of prescribing, but there is also an urgent need to help the approximately 64 percent of physicians who are unfamiliar with RTPB technology understand the tool’s significant value so that they will be prepared to optimally utilize RTPB technology, once it is available to them.

ADDITIONAL TOOLS TO FILL PRESCRIPTION DRUG COST INFORMATION GAPS

The Council recognizes that RTPB technology is not a panacea that can solve the much broader problem of prescription drug cost transparency in all contexts. As the “Benefit” element of the RTPB name implies, RTPB tools will only increase point of prescribing price transparency for insured patients. Yet, out-of-pocket prescription drug cost transparency is essential for all patients. Some patients are uninsured or underinsured, and formulary status may not be relevant to these patients. Some local pharmacies may charge lower retail prices for certain prescription drugs than others, and there may be prescription discount programs available for some medications (e.g., directly through manufacturers or through drug discount aggregator websites, such as GoodRx). Clearly, there is an urgent need for ongoing HIT innovation to enhance prescription drug price transparency in all contexts, and the AMA continues to advocate for improvements.
While the health care industry awaits implementation of a standard RTPB tool to provide price
transparency for insured patients and awaits additional future tools to provide optimal prescription
out-of-pocket cost information at the point of prescribing for all patients, physicians may want to
further explore how tools within their current EHR systems could be used to mitigate concerns
about prescription abandonment. Among the features that are legally required to be included in all
EHR software are tools that facilitate communication between pharmacies and prescribers, and
these tools could be used to help identify and respond to patients who encounter cost barriers when
attempting to fill their prescriptions. For example, the “RxFill transaction” can be used to
communicate between a pharmacy and a prescriber, informing a prescriber whether a specific
prescription was dispensed (or partially dispensed) to a patient. Accordingly, if a physician is
notified that a patient has never picked up an essential medication, the physician can follow-up
with the patient to determine why the prescription was abandoned and if an alternative medication
is appropriate. Physicians can choose to receive RxFill notifications for certain patients who are
prescribed certain medications (e.g., insulin for patients with diabetes), but not for others (e.g.,
prescriptions for seasonal allergy medication). EHRs may allow physicians to further customize
how and when they are notified. Similarly, physicians can communicate electronically with
pharmacies to discuss prescription options. If a patient declines a drug, pharmacies can use the
“RxChangeRequest Transaction” to send prescribers options regarding potential alternatives to
originally prescribed medications. For example, pharmacists may suggest a generic alternative to
a brand-name drug, or they may suggest another drug that is available at a cheaper price. Upon
receiving an RxChangeRequest, a prescriber can respond with an “RxChangeResponse transaction”
to either approve or decline the RxChangeRequest, and the prescriber is able to provide additional
comments in the response. Importantly, both EHR vendor implementation and pharmacy
information systems technology implementation of these e-prescribing tools varies. Physicians who
believe that the use of RxFill and/or RxChangeRequest and RxChangeResponse could support their
practice are encouraged to seek additional information from their EHR vendor and local
pharmacies.

Physicians can also encourage their patients to utilize currently available consumer-facing
prescription drug price transparency tools. For example, when shopping for a Medicare plan,
Medicare patients can look-up the cost of their prescription medications under various Medicare
plan options. There are a variety of drug discount programs, including drug discount aggregator
websites, that allow patients to compare prescription drug prices and obtain coupons that can be
used at local pharmacies. Drug discount aggregator websites allow patients to view and compare
prices of brand name and generic versions of prescription drugs and provide coupons that patients
may choose to use when filling their prescriptions. These coupons can be especially helpful and
straightforward for patients who do not have insurance coverage for prescription drugs, but because
medications purchased using a coupon may not automatically be counted towards insured patients’
deductibles, they may not always provide overall cost-savings for insured patients. A federal
regulation finalized in 2020 provides insured patients with greater out-of-pocket cost transparency
beginning in 2023. The Transparency in Coverage final rule requires most individual and group
health plans to make available to participants, beneficiaries and enrollees personalized out-of-
pocket cost information for all covered health care items and services, including prescription drugs,
through an internet-based self-service tool and in paper form upon request. This will allow
patients to obtain real-time, accurate out-of-pocket cost estimates that they can share with their
physicians as they engage in joint decision-making and care planning. In addition to providing
greater real-time cost transparency for patients and their physicians, starting in 2022, the
Transparency in Coverage final rule will require disclosure of in-network negotiated rates and
historical net prices for all covered prescription drugs by plan or issuer at the pharmacy location
level. Researchers and third-party developers and innovators can use this data to create private
sector solutions to achieve greater price transparency.
AMA POLICY AND ADVOCACY

Long-standing AMA policy supports ongoing advocacy for the development of HIT tools, such as an RTPB standard, that enhance prescription drug price transparency. Policy H-450.938 states that physicians should have easy access to and review the best available data associated with costs at the point of decision-making, which necessitates cost data to be delivered in a reasonable and usable manner by third-party payers and purchasers. In addition, the policy calls for physicians to seek opportunities to improve their information technology infrastructures to include new and innovative technologies to facilitate increased access to needed and usable evidence and information at the point of decision-making. Related, Policy H-125.979 encourages PBMs, health insurers, and pharmacists to enable physicians to receive accurate, real-time formulary data at the point of prescribing, and promotes the value of online access to up-to-date and accurate prescription drug formulary plans from all insurance providers nationwide. Similarly, Policy H-110.990 supports 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 jointly decide on treatment. Recent Policy H-125.974 states that our AMA will advocate to the Office of the National Coordinator for Health Information Technology (ONC) and CMS to work with physician and hospital organizations, and HIT developers, in identifying RTPB implementations and published standards that provide real-time information across all prescription drug plans, patient portals and other viewing applications, and EHR vendors. This policy also states that the AMA will advocate to the ONC and CMS that any policies requiring HIT developers to integrate RTPB within their products do so with minimal disruption to EHR usability and cost to physicians and hospitals. Moreover, the policy establishes that the AMA will support alignment and real-time accuracy between the prescription drug data offered in physician-facing and consumer-facing RTPB tools.

Additionally, AMA policy and advocacy promote open communication between pharmacists and physicians when issues of prescription unaffordability arise and increased price transparency at the pharmacy. Policy H-285.965 urges pharmacists to contact the prescribing physician if a prescription written by the physician violates the managed care drug formulary under which the patient is covered, so that the physician has an opportunity to prescribe an alternative drug, which may be on the formulary. Moreover, Policy H-110.991 advocates for greater prescription drug price transparency at the pharmacy point of sale by: (1) advocating that both the retail price and the patient’s copay be listed on prescription receipts, (2) pursuing legislation that would require pharmacies to inform patients of the cash price as well as the formulary price of any medication prior to purchase, and (3) opposing provisions in contracts between pharmacies and PBMs that would prohibit pharmacies from disclosing when a patient’s copay is higher than the drug’s cash price (so called “gag clauses”). The AMA developed model legislation consistent with Policy H-110.991, similar bills have been enacted in several states, and federal legislation was enacted to prohibit gag clauses in Medicare, Medicare Advantage, group, and individual health insurance plans. Related, in response to Policy H-110.987, the AMA developed model state legislation entitled, “An Act to Increase Drug Cost Transparency and Protect Patients from Surprise Drug Cost Increases during the Plan Year” which addresses the issue of timely prescription decision support and would authorize a pilot study to integrate transparency data at the point of care, with information such as medicines’ formulary status, cost-sharing tier, patient out-of-pocket cost, and coverage restrictions being integrated into EHRs or e-prescribing systems.

The AMA continues to advocate extensively in support of an RTPB standard. Since 2014, the AMA has been actively engaged in the development of the NCPDP RTPB standard to ensure that any mandated standard will meet the needs of physician end-users and their patients. The AMA serves as a member of the NCPDP’s RTPB Task Group which is comprised of stakeholders from...
across the health care industry, including organized medicine, hospitals, payers, HIT vendors, and pharmaceutical/life sciences companies. NCPDP has quarterly workgroup meetings, and the RTPB Task Group meets weekly to discuss and continue developing the RTPB standard. Collectively, the RTPB Task Group is committed to the goal of developing and publishing an RTPB standard that will meet the needs of and benefit every sector of the health care industry and that will be readily adopted by CMS.

During recent testimony at the Congressional Hearing, “Lowering Prescription Drug Prices: Deconstructing the Drug Supply Chain,” the AMA emphasized the challenges patients and physicians encounter due their inability to access patient-specific formulary and cost-sharing information at the point of care. The AMA has also recently submitted written comments to CMS and presented to the ONC Health Information Technology Advisory Committee (HITAC) Intersection of Clinical and Administrative Data Task Force (ICAD) strongly supporting an RTPB standard. Additionally, the AMA recently submitted comments to CMS that highlighted the importance of physicians having access to real-time, patient-specific prescription drug coverage information at the point of prescribing in physicians’ EHRs, supported CMS’ efforts to expedite industry implementation of RTBT, and recommended that CMS require plans to support a single RTBT standard, when made available.

Finally, in 2016, the AMA launched a grassroots campaign and website, TruthinRx.org, the goal of which is to address the opaque process that pharmaceutical companies, PBMs, and health insurers engage in when pricing prescription drugs. TruthinRx.org provides a platform through which individuals can sign petitions to members of Congress and template letters that website visitors can customize and directly send to their US Senators and US Representatives, calling on them to support increased transparency in prescription drug prices. Coordinated with AMA model legislation, and state and national engagement, TruthinRx.org is updated to reflect advances in AMA policy and pharmaceutical industry activities.

DISCUSSION

Resolution 213-NOV-20 highlighted physicians’ need for patient-specific, real-time formulary and cost-sharing information, and an RTPB standard would fill that need. A standardized RTPB tool integrated into EHR systems will allow physicians to have real-time access, at the point of prescribing, to a current report of whether a specific medication is on a specific patient’s prescription formulary. A standardized RTPB tool will provide patient-specific out-of-pocket cost for a selected medication at that patient’s designated primary pharmacy, and it will alert physicians to applicable utilization management restrictions. A standardized RTPB tool will present physicians with options of alternative medications that are covered by a patient’s insurance plan, and this will empower physicians and patients to decide together, before the patient leaves the examination room, whether the medication is not only clinically, but also financially, well-suited for the patient. If the medication is unaffordable, the physician can pull up this same information for other medications equally clinically appropriate for the specific patient, and it will allow physicians to see the drug discount program prices for the queried pharmacy. Accordingly, the Council recommends that the AMA continue to zealously advocate for the development, publication, adoption, and mandated use of standardized RTPB tools with minimal burden on physicians. In addition, the Council recognizes that many practicing physicians have not been made aware of how a standard RTPB tool will enhance their practice, or how HIT tools already available within their EHR and/or e-prescribing systems can enhance communication between physicians and pharmacists. For this reason, the Council recommends that the AMA develop and disseminate educational materials that will empower physicians to leverage these HIT tools to enhance their practices.
The Council recognizes that the question of whether a particular prescription drug is on a patient’s insurance formulary is just one component of the much larger prescription drug affordability challenge. The AMA will continue to advocate for technology tools to efficiently address the broad range of prescription price transparency and affordability challenges unrelated to insurance benefits. For these reasons, the Council recommends amending Policy H-110.990 to specifically call for the development and use of tools and technology that enable physicians and patients to determine the actual price and patient-specific out-of-pocket costs of individual prescription drugs, taking into account insurance status or payer type, 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. Related, the Council recommends amending Policy H-125.974 which supports alignment and real-time accuracy between the prescription drug data offered in physician-facing and consumer-facing RTPB tools, and advocates that regulators work with physician and hospital organizations, and HIT developers, in identifying real-time pharmacy benefit implementations and published standards that provide real-time or near-time formulary information across all prescription drug plans, patient portals and other viewing applications, and EHR vendors. The Council recommends adding to this strong policy to also specify that the AMA will advocate that regulators include proven and established real-time pharmacy benefit criterion within EHR certification programs and that integration of RTPB tools within HIT be accomplished without disruption to EHR usability and minimal to no cost to physicians and hospitals. Finally, the Council recommends reaffirming Policy H-450.990 which calls for physician access to the best available cost data at the point of decision-making.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 213-NOV-20 and that the remainder of the report be filed:

1. That our American Medical Association (AMA) continue to support efforts to publish a Real-Time Prescription Benefit (RTPB) standard that meets the needs of all physicians and other prescribers, utilizing any electronic health record (EHR), and prescribing on behalf of any insured patient. (New HOD Policy)

2. That our AMA advocate that all payers (i.e., public and private prescription drug plans) be required to implement and keep up to date an RTPB standard tool that integrates with all EHR vendors, and that any changes that must be made to accomplish RTPB tool integration be accomplished with minimal disruption to EHR usability and cost to physicians and hospitals. (New HOD Policy)

3. That our AMA develop and disseminate educational materials that will empower physicians to be prepared to optimally utilize RTPB tools and other health information technology tools that can be used to enhance communications between physicians and pharmacists to reduce the incidence of prescription abandonment. (Directive to Take Action)

4. That our AMA amend Policy H-110.990 by addition and deletion, as follows:

   Our AMA:…
   2. believes that cost-sharing requirements should be based on considerations such as: unit cost of medication; availability of therapeutic alternatives; medical condition being treated; personal income; and other factors known to affect patient compliance and health outcomes; and
   3. supports the development and use of tools and technology that enable physicians and patients to determine the actual price and patient-specific out-of-pocket costs of individual
prescription drugs, taking into account insurance status or payer type, 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; and
4. supports public and private prescription drug plans in offering patient-friendly tools and
technology that allow patients to directly and securely access their individualized prescription
benefit and prescription drug cost information.

5. That our AMA amend Policy H-125.974 by addition and deletion as follows:

Our AMA…
(4) will advocate to the Office of the National Coordinator for Health Information Technology
(ONC) and the Centers for Medicare & Medicaid Services (CMS) to work with physician and
hospital organizations, and health information technology developers, in identifying real-time
pharmacy benefit implementations and published standards that provide real-time or near-time
formulary information across all prescription drug plans, patient portals and other viewing
applications, and electronic health record (EHR) vendors;
(5) will advocate to the ONC to include proven and established real-time pharmacy benefit
criteria within its certification program;
(§6) will advocate to the ONC and the CMS that any policies requiring health information
technology developers to integrate real-time pharmacy benefit systems (RTPB) within their
products do so without minimal disruption to EHR usability and minimal to no cost to
physicians and hospitals, providing financial support if necessary; and… (Modify Current
HOD Policy)

6. That our AMA reaffirm Policy H-450.938 which states that physicians should have easy access
to and review the best available data associated with costs at the point of decision-making,
which necessitates that cost data be delivered in a reasonable and useable manner by third-
party payers and purchasers. The policy also calls for physicians to seek opportunities to
improve their information technology infrastructures to include new and innovative
technologies to facilitate increased access to needed and useable evidence and information at
the point of decision-making. (Reaffirm HOD Policy)

Fiscal Note: Less than $2,500.
REFERENCES


13. Estimates were provided by Apoorva Rama, PhD and based on the AMA’s 2020 Physician Practice Benchmark Survey. For details about the Physician Practice Benchmark Survey see https://www.ama-assn.org/about/research/physician-practice-benchmark-survey


17. Find a Medicare plan. Available at: https://www.medicare.gov/plan-compare/#/?lang=en&year=2021
18 GoodRx. Do purchases with GoodRx count towards my deductible? Available at: https://support.goodrx.com/hc/en-us/articles/115004950383-Do-purchases-with-GoodRx-count-towards-my-deductible-


APPENDIX

Policy Recommended for Amendment or Reaffirmation

H-110.990 Cost Sharing Arrangements for Prescription Drugs
Our AMA:
1. believes 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;
2. believes that cost-sharing requirements should be based on considerations such as: unit cost of medication; availability of therapeutic alternatives; medical condition being treated; personal income; and other factors known to affect patient compliance and health outcomes; and

H-125.974 Continuity of Care for Patients Discharged from Hospital Settings
Our AMA:
(1) will advocate for protections of continuity of care for medical services and medications that are prescribed during patient hospitalizations, including when there are formulary or treatment coverage changes that have the potential to disrupt therapy following discharge;
(2) supports medication reconciliation processes that include confirmation that prescribed discharge medications will be covered by a patient’s health plan and resolution of potential coverage and/or prior authorization (PA) issues prior to hospital discharge;
(3) supports strategies that address coverage barriers and facilitate patient access to prescribed discharge medications, such as hospital bedside medication delivery services and the provision of transitional supplies of discharge medications to patients;
(4) will advocate to the Office of the National Coordinator for Health Information Technology (ONC) and the Centers for Medicare & Medicaid Services (CMS) to work with physician and hospital organizations, and health information technology developers, in identifying real-time pharmacy benefit implementations and published standards that provide real-time or near-time formulary information across all prescription drug plans, patient portals and other viewing applications, and electronic health record (EHR) vendors;
(5) will advocate to the ONC and the CMS that any policies requiring health information technology developers to integrate real-time pharmacy benefit systems (RTPB) within their products do so with minimal disruption to EHR usability and cost to physicians and hospitals; and
(6) supports alignment and real-time accuracy between the prescription drug data offered in physician-facing and consumer-facing RTPB tools. (CMS Rep. 2, A-21)

H-450.938 Value-Based Decision-Making in the Health Care System
PRINCIPLES TO GUIDE PHYSICIAN VALUE-BASED DECISION-MAKING
1. Physicians should encourage their patients to participate in making value-based health care decisions.
2. Physicians should have easy access to and consider the best available evidence at the point of decision-making, to ensure that the chosen intervention is maximally effective in reducing morbidity and mortality.

3. Physicians should have easy access to and review the best available data associated with costs at the point of decision-making. This necessitates cost data to be delivered in a reasonable and useable manner by third-party payers and purchasers. The cost of each alternate intervention, in addition to patient insurance coverage and cost-sharing requirements, should be evaluated.

4. Physicians can enhance value by balancing the potential benefits and costs in their decision-making related to maximizing health outcomes and quality of care for patients.

5. Physicians should seek opportunities to improve their information technology infrastructures to include new and innovative technologies, such as personal health records and other health information technology initiatives, to facilitate increased access to needed and useable evidence and information at the point of decision-making.

6. Physicians should seek opportunities to integrate prevention, including screening, testing and lifestyle counseling, into office visits by patients who may be at risk of developing a preventable chronic disease later in life. (CMS Rep. 7, A-08 Reaffirmed in lieu of Res. 5, A-12 Reaffirmation I-14 Reaffirmation: I-17 Reaffirmed: CMS Rep. 06, A-19)