ILLINOIS STATE MEDICAL SOCIETY

Resolution 11.2023-16
(A-24)

Introduced by: Katherine Tynus, MD, ISMS Member

Subject: Prescription Drug Affordability Board Legislation

Referred to: Governmental Affairs Council

Whereas, the escalating cost of prescription drugs creates an undue financial burden on consumers and state governments and decreases access and adherence to medication treatment; and

Whereas, drug manufacturers may change the list prices of their drugs at any time after launch, and over the period from January 2022 to January 2023, more than 4,200 drug products had price increases, of which 46 percent were larger than the rate of inflation(1); and

Whereas, a survey from the Kaiser Family Foundation in 2023, found that about three in ten adults report not taking their medicines as prescribed at some point in the past year because of the cost(2); and

Whereas, federal legislation (Inflation Reduction Act) controls prices for some medications covered by Medicare but not those covered by other insurance plans nor for patients without pharmacy benefits; and

Whereas, amongst the various states several approaches to controlling pharmaceutical costs that are being explored include Prescription Drug Accountability Boards (PDABs), price gouging bills, PBM regulations and Medicaid payment limits. While these laws address important aspects of drug pricing, recently enacted PDAB legislation that includes the ability to set upper payment limits offers the greatest opportunity yet for direct action by states working to bend the cost curve(3); and

Whereas, Prescription Drug Affordability Boards (PDABs) are state-level independent bodies with the authority to evaluate high-cost drugs and set Upper Payment Limits (UPLs) on what consumers will pay in order to reduce prescription drug costs to consumers. PDABs address all payors within a state and across all steps of the pharmaceutical supply chain; and

Whereas, in 2019, Maryland became the first state to establish a PDAB. Currently, eight other states (Colorado, Maine, New Hampshire, Ohio, Oregon, Washington, Michigan and Minnesota) have followed Maryland and enacted laws establishing PDABs. According to the National Academy for State Health Policy, a number of other states (Arizona, Connecticut, Massachusetts, New Jersey, New Mexico, Pennsylvania, Rhode Island, and Virginia) have introduced legislation that is currently pending. Illinois legislators plan to introduce PDAB legislation in the spring 2024 legislative session; therefore, be it

RESOLVED, that the Illinois State Medical Society adopt policy in support of legislation that adds to federal efforts to control medication costs, and specifically the creation of an Illinois Prescription Drug Affordability Board; and be it further

RESOLVED, that the ISMS delegation to the AMA bring a resolution to the AMA House of Delegates to adopt a policy supporting the creation of state-level Prescription Drug Affordability Boards.

References:

1. Bosworth, A, Sheingold, S, Finegold, K, Sayed, B.A., De Lew, N, Sommers, B.D. (Issue Brief No. HP-2023-25). Washington, DC: Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. October 2023.
2. https://www.kff.org/health-costs/poll-finding/public-opinion-on-prescription-drugs-and-their-prices/
3. State Strategies to Lower Drug Costs NASHP 2021

Fiscal Note:

None

Existing ISMS policy related to this issue:

ISMS supports the following health care system reform principles: 1. Health care delivery and financing reform should build on and leverage the benefits of our pluralistic system, including public and private financing mechanisms, to increase access and equity; maintain cost-consciousness; and reduce administrative burdens on physicians and medical practices. ISMS will only consider other health system financing reform proposals, including a single payer system, if such a proposed system is consistent with these principles. 2. Any health reform proposal should take into account the social determinants of health and their impact on access to and delivery of care, and should

support comprehensive, evidence-based strategies to advance health equity. 3. All patients should have access to an affordable health benefit plan that includes coverage for comprehensive preventative care, catastrophic care, appropriate screening, primary and specialty care, hospitalizations, immunizations, and affordable prescription drug coverage. 4. Health care reform should prioritize the development and improvement of payment models and coverage plans that reward care that improves patient outcomes, properly recognizes the value that physicians provide to patient care, and provides coverage and payment for care based on the best available medical evidence. 5. All health care expenditures, including health savings accounts and high-deductible coverage plans, should receive equal treatment for purposes of tax deduction and tax credits. 6. Professional liability reform – including caps on noneconomic damages – should continue to be pursued and defended as a way to reduce direct and indirect costs (defensive medicine) and to address the adverse effect the current medical liability system has on the physician-patient relationship and access to health care. 7. Information technology in health care delivery should focus on interoperability, reduction of administrative burden, enhanced efficiency of care, and improvement in patient outcomes. Health information technology should enhance and improve clinical decision-making, rather than encumbering or restricting treatment decisions. 8. Health care delivery and financing reform should prioritize the importance and impact of consumer education and health literacy on improved patient outcomes. 9. Health care reform proposals should include provisions for physicians to set and negotiate fees in order to adequately compensate physicians and other health care providers for the promotion of personal and public health. 10. Evidence-based protocols should support, not replace, the patient-physician relationship. Clinical practice and treatment guidelines should serve to support, not control, clinical decision-making. 11. ISMS objects to third parties, including insurance carriers, commercial agencies, and government payers, interfering with the practice of medicine and the patient-physician relationship. (HOD 2007; BOT 2015-JAN; Revised 2008; Reaffirmed 2011; Reaffirmed 2012; Reaffirmed 2015-JAN; Reaffirmed 2016; Reaffirmed 2017; Reaffirmed 2018; Reaffirmed 2019; Revised 2023; Last BOT Review 2023)

ISMS encourages changes in U.S. law to permit Medicare to negotiate prices for prescription drugs with pharmaceutical manufacturers. (HOD 2016; Reaffirmed 2018; Reaffirmed 2019)

ISMS opposes the policy of insurance companies denying payment for safe and efficacious drugs prescribed by physicians. (HOD 2009; Last BOT Review 2014)

It is the policy of ISMS to continue to work with appropriate state agencies, the pharmaceutical industry, and our congressional delegation to improve access to a broad range of affordable prescription drug products and promote awareness of the availability

of low cost drug programs for needy seniors. (HOD 2002; Reaffirmed 2018; Reaffirmed 2019; Last BOT Review 2014)

ISMS strongly supports subsidization of prescription drugs for Medicare patients based on means testing. (HOD 2003; Last BOT Review 2014)

ISMS encourages its members to be aware of the cost of hospital services, supplies and drugs and encourages physicians to receive and review the hospital bill of each patient they hospitalize as a voluntary step toward cost containment of health care. ISMS is unalterably opposed to governmental control of hospital costs and physicians' fees. ISMS encourages cost sharing by patients in all medical care reimbursement plans. (HOD 1977; Reaffirmed 2018; Last BOT Review 2011)

House of Delegates adopted Res. 64 (A-01) as amended, which directed that the ISMS send a resolution to our AMA asking our AMA to study and explain how a prescription drug plan for seniors can be funded responsibly at this time and in the future. (HOD 2001)

House of Delegates adopted Res. 44 (A-92) as amended which directed that the Society support legislation that amends the Illinois Insurance Code and the Health Maintenance Organization Act to provide that no group accident or health insurance policy or HMO that covers approved prescription drugs for certain types of cancer shall exclude coverage on the basis that the drug has not been approved for that specific indication by the Food and Drug Administration, and utilizes the three standard reference books or compendia and the peer-reviewed literature rather than just the FDA label in determining reimbursement. (HOD 1992)

House of Delegates adopted Resolution B204 (A-18), Reform of Pharmaceutical Pricing: Negotiated Payment Schedules, which states: RESOLVED, that the Illinois State Medical Society introduce a resolution to the American Medical Association urging the AMA to support federal legislation that modifies the Hatch-Waxman Act and the Biologics Price Competition and Innovation Act (Biosimilars Act) to institute the replacement of time-specific patent protections with negotiated payment schedules and indefinite exclusivity for FDA-approved drugs in the Medicare Part D Program. (HOD 2018)

The pharmaceutical industry should be encouraged to discontinue mass advertisement of prescription drugs and pass on the savings to the patients. (HOD 1999; Last BOT Review 2013)

Existing AMA policy related to this issue:

Cost of Prescription Drugs H-110.997

Our AMA:

(1) supports programs whose purpose is to contain the rising costs of prescription drugs, provided that the following criteria are satisfied: (a) physicians must have significant input into the development and maintenance of such programs; (b) such programs must encourage optimum prescribing practices and quality of care; (c) all patients must have access to all prescription drugs necessary to treat their illnesses; (d) physicians must have the freedom to prescribe the most appropriate drug(s) and method of delivery for the individual patient; and (e) such programs should promote an environment that will give pharmaceutical manufacturers the incentive for research and development of new and innovative prescription drugs…