REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 5-A-26

Subject: Inclusion of Discounted Prescription Medication in Patient Cost-Sharing

Presented by: Betty Chu, MD, MBA, Chair

Referred to: Reference Committee A

Resolution 710, "Requiring Insurances to Apply Discounted Cost Medication to the Patient's Deductible," was introduced by the New York delegation at the 2025 Interim Meeting and was referred. It asks the following:

> RESOLVED, that our American Medical Association (AMA) advocate for legislation or other appropriate means to ensure that all payment made by patients for prescription medications outside of their insurance coverage (such as pharmaceutical discount programs) count towards that patient's annual deductible and out of pocket maximum.

In response, this report reviews patient cost-sharing, patient assistance programs, and their impact on patients and physicians. Further, it provides an overview of related AMA policies and offers a recommendation for new House of Delegates (HOD) policy.

BACKGROUND

Cost-sharing is broadly defined as the portion of health care costs that a patient pays out-of-pocket (OOP). These costs are typically inclusive of deductibles, coinsurance, and copayment ("copay").[1] Deductibles are the amount that a beneficiary must pay before the insurance plan covers the costs of care. While specific amounts vary plan to plan, once a deductible is met the patient is then only responsible for a copay or coinsurance.[2] Plans that have lower deductibles typically have higher monthly premiums and plans with higher deductibles typically have lower monthly premiums. Some plans have separate deductibles for prescription drugs and often family plans include separate individual and family deductibles.[2] In addition to deductibles, many plans have an OOP maximum, which is the most a beneficiary would have to pay for covered services annually.[3] With passage of the Affordable Care Act (ACA), the vast majority of payers are required to cover preventive services fully, even prior to a deductible being met.[4] After a beneficiary's deductible is met, OOP costs are typically defined as either coinsurance or a copay.[2] Coinsurance is defined as the percentage of a covered service paid by the patient while a copay is a fixed amount paid by the patient.[5,6]

Importantly, there are several costs for which patients are responsible that are not included in deductible nor OOP maximum calculations. Specifically, payments made in relation to monthly premiums, out-of-network provider fees, non-covered treatments, over the counter medications, costs that exceed payer set allowable amounts, and some prescription discount programs are often not included in a plan's calculation of patient cost-sharing.[2,3] Out-of-network care can often incur increased OOP spending, with variation from plan to plan as to what services, or how much of a service is covered out-of-network. In an effort to control costs, most plans also have an OOP maximum or limit. Typically, care that is not billed initially to the insurance company is also excluded, such as medications or physician services paid with cash.

There is significant variability, especially among private payers, in the actual set amounts for each type of cost-sharing. Among ACA Marketplace plans, the average deductible for a single individual is just under $3,000. However, there is significant variation with some plans offering deductibles as low as $80 for low-income beneficiaries who qualify, to nearly $7,500 for bronze plans.[6] Although there is variation between states, the average deductible for a single person who has coverage through an Employer Sponsored Insurance (ESI) plan is just over $2,000.[7] Both Marketplace and ESI plans typically have a copay between $20-$40 for primary care visits and $40-$100 for specialty care visits once a deductible is met. When these plans include coinsurance, this rate typically averages around 20 percent.[8] For marketplace and ACA-compliant ESI plans, OOP maximums cannot exceed $10,600 per person or $21,200 per family. While more uncommon in private health insurance plans, Medicare sets deductibles and OOP maximums separately for prescription drug and non-drug related costs. Medicare Part D, which covers prescription drugs, has an annual OOP maximum of $2,100 and a prescription drug deductible of $615 as established by the Inflation Reduction Act.[9] Medicare Part D coinsurance and copay rates vary based on drug costs (e.g., generic drugs typically have lower patient OOP costs than brand name drugs).[10,11] While Medicaid OOP costs vary by state, federal regulation currently caps total OOP spending at no more than five percent of a family's annual income and includes exemptions for certain groups, like young children and pregnant individuals, and situations, like emergency care and family planning.[12] For prescription medications, among Medicaid beneficiaries making less than 150 percent of the Federal Poverty Limit, copays cannot exceed eight dollars.[12] For a more detailed breakdown of these costs and how they are typically collected, please reference CMS Report 2-I-23.

PATIENT ASSISTANCE PROGRAMS

In the United States, prescription medications are often tied to significant OOP costs for patients. Research has shown that nearly a quarter of adults with insurance reported a necessary prescription was either not covered or required a "very high" copay.[13] For individuals with chronic conditions, like diabetes, cancer, arthritis, or HIV, this can be especially problematic as generic drugs are often not available for these diagnoses. While the biologic and specialty drug market has increased access to name-branded drugs, patients often incur exceptionally high costs to obtain them.[14] Although this is an issue cited across all insurance types, Medicare beneficiaries reported the issue more frequently than those with other types of insurance coverage.[13,14] This often results in cost-related nonadherence, meaning patients delay or skip, refilling a prescription and/or take smaller doses. Patients who are unable to adhere to their treatment plans are more likely to experience poor health outcomes, harmful side effects, and/or unsuccessful treatment outcomes.[15] Current estimates show that about 15 percent of patients demonstrate cost-related nonadherence behaviors.[15] As a result of challenges with OOP costs, patient assistance programs (PAPs) have become relatively common. These programs can be offered through the government, drug manufacturers, non-profit organizations, and/or as discount or coupon cards.

For individuals who are beneficiaries of government funded insurance plans, there are PAPs offered by state and federal governments when medications are prohibitively expensive. For example, Medicare beneficiaries who meet certain annual income and resource limits qualify for the "Extra Help" or Low-Income Subsidy which limits OOP payments beyond the larger Medicare limits.[16] To qualify for this program, individuals must be dual-eligible and enrolled in a Medicaid drug coverage plan, make less than $2,015 per month, and have total assets below $18,090. Individuals who are also enrolled in Medicaid, Supplemental Security Income, or a Medicare Savings Program automatically qualify. For these beneficiaries, all generic drugs have an associated copay of just over $5 and all name-brand drugs have a copay of just under $13. If beneficiaries also qualify for Medicaid, these copays can be as low as $1.60 for generics and $4.90 for name-brand drugs.[17] In addition to federal programs, nearly every state has a program designed to cover the cost of prescriptions not covered by Medicare Part D plans. In addition, most states have State Pharmaceutical Assistance Programs (SPAPs). These programs are designed to reduce the cost of medication related spending for targeted populations, often those who have an income

under a set level, are under/uninsured, have a specific diagnosis, and/or those over 65 years of age.[18] For example many, but not all, states have a specific program designed to ensure that individuals with HIV/AIDS are able to access the necessary medications. Additional SPAPs are designed to center around seniors who are unable to access medications, while others are more general and apply to broader populations. For example, Alabama has one SPAP designed to assist in accessing HIV/AIDs medications (Alabama AIDS Drugs Assistance Program) and another designed to support seniors (SenioRx) who cannot afford their medications.[18]

Beyond SPAPs, 13 states offer some kind of discount program that is often available to a wider population. Some states, such as Arizona, offer discount cards to any state resident via CoppeRx/Arizona Rx, while other states have more specified requirements. For example, California's Discount Program is exclusive to Medicare recipients and Vermont's program, Health Vermonters, is exclusive to those who meet an income threshold and do not have prescription coverage.[18] Oregon and Washington State combined their drug assistance programs into ArrayRx, formerly the Northwest Prescription Drug Consortium, which not only provides a discount card program to residents in those states, but also pure-pass through pharmacy benefit manager (PBM) services and a group purchasing organization.[19] The initial joint efforts of Washington and Oregon allowed for the program to increase its investments and impacts, which has been furthered with the more recent inclusion of Arizona, Connecticut, Nevada. Estimates from this program's discount card show that patients who utilize these cards save between 18 and 80 percent when filling their prescription at a retail pharmacy.[18,19] In February 2026, the federal government launched TrumpRx, which is described as offering the "cheapest prices in the world" for the negotiated drugs. As of the launch of the website, 43 medications were included with intentions to grow this number.[20] While this website has been publicized as a major cost saver for patients who need the included medications, initial reviews are mixed.[20,21] First, the site does not allow patients to utilize their health insurance, meaning that for individuals with prescription drug coverage, the level of savings may be limited. Second, approximately half of the drugs included on the site have generic alternatives that are less expensive than the name brand drugs.[21,20,21,22]

While successful government assistance programs can be exceptionally helpful for those who qualify, many people do not meet the qualifications. Therefore, private organizations and companies have stepped in to offer assistance. Many drug manufacturers, especially those of very high-cost drugs, offer PAPs. In addition, drug manufacturers and companies have developed business models to provide direct-to-consumer dispensing, avoiding PBMs and retail pharmacies at a lower cost, but also require forgoing the use of insurance. Although some programs are only offered to patients who are uninsured or underinsured, other programs are open to all recipients of a drug.[23] These programs can be in the form of copay assistance, discounts to the price of the medication, and/or offsetting of associated costs like transportation or infusion services. However, in many cases patients must navigate an application process that is often demanding.[23,24] Even so, for some patients these programs provide the only means to access their prescription(s). In addition to the aforementioned manufacturer-based programs, many non-profit organizations exist designed to help patients access their medications, often in relation to a specific diagnosis or family of diagnoses.[24] For example, the Patient Access Network (PAN) Foundation works to provide grants to patients with a variety of diagnoses that are considered chronic, rare, and/or life-threatening.[25]

In addition to both government and non-governmental assistance programs, coupon or discount cards have grown in accessibility and popularity across the country. These cards are primarily based on three types of discounts: manufacturer, pharmacy-specific, and prescription coupon. Manufacturer discount cards are submitted by the patient to the pharmacy and the manufacturer then pays the difference between the patient payment and actual cost. For example, if a patient paid $50 when using the discount card on a medication that typically costs $100 OOP, the manufacturer would reimburse the pharmacy the remaining $50.[26] Pharmacy-specific discount cards are unique to a pharmacy and generally allow patients to pay a

lower price on a medication, typically a generic medication, but do not work in conjunction with insurance coverage. While these types of cards are particularly beneficial to uninsured patients, they also can be beneficial to those with insurance coverage, as it is not uncommon for the discounted rate to be less than the copay or coinsurance rate for a patient who is fully insured.[26] Prescription discount (or coupon) cards are similar but apply to multiple pharmacies. These cards are driven by private, for-profit companies that negotiate with PBMs to secure discounts on specific medications. When these cards, such as GoodRx, America's Pharmacy, or SingleCare, are used a portion of the transaction is split between the PBM and card company, and the remainder goes to the pharmacy in the form of payment.[26,27] With the widespread use of discount cards and coupons, many payers became concerned that their benefit designs would be altered and profits lessened. As a result, some plans made changes to how OOP costs are calculated, often not counting patient payments made via coupons or discount cards toward annual cost sharing in order to maintain benefit designs and profits.[27,28] Further, some plans utilize copay accumulators to maximize their profits. In these systems, when a patient relies on a coupon to afford medications, the value is not included toward the OOP costs. Therefore, when the coupon is exhausted and/or expires, the patient is subjected to paying the full deductible along with a copay/coinsurance. In this system, the payer ends up with the majority of the benefit from the coupon, as they are able to shift many of the costs back to the patient. Alternatively, payers may implement a copay maximizer program. These programs apply the coupon evenly across the year, meaning that the patient may be responsible for a smaller monthly copay in addition to the coupon. This can be problematic as plan beneficiaries that utilize copay maximizers often do not meet their annual deductible and may end up spending more on health care costs.[27,28] This is particularly problematic for patients with high-deductible health plans (HDHP) as they are much less likely to meet the deductible.[27]

As a result of increasing PAP availability, Alternative Funding Programs (AFPs) have grown significantly. AFPs are designed to assist beneficiaries in navigating the PAP application process and are relied upon when a plan sponsor, such as an employer, does not want to pay for an expensive drug. Specifically, ESI plans preemptively determine that a medication, typically a high-cost specialty prescription, is "non-essential" and as a result they are removed from the formulary making the patient "un/underinsured" for that medication and AFPs step in to assist patients in negotiating the PAP process. While these programs may seem to be beneficial to patients, AFPs can result in significant ethical concerns and impact patients negatively.[29] Specifically, there have been concerns raised that the use of AFPs may conflict with consumer protection laws/regulations via the ACA, the Employee Retirement Income Security Act, and/or the Health Insurance Portability and Accountability Act. For example, under the ACA, prescription drugs are considered an essential health benefit (EHB) and, as a result, they must be covered. By deeming a prescription "non-essential," there is some concern that the ACA EHB clause is violated. Further, there is significant concern that these programs are exploiting PAPs and causing ethical issues by incorrectly labeling patients as "underinsured" when their health plan pushes them into using an AFP.[29] This could lead to not only patients who are truly un/underinsured not being able to receive support but may unduly burden patients who are not deemed eligible for support even with assistance from the AFP. A full overview of AFPs can be found in this AMA issue brief.[29]

LEGISLATION AND REGULATION

To address the issues raised by copay accumulator programs, some states have implemented legislation and/or regulation to require health plans to include reductions in OOP expenses for prescription drugs in cost-sharing calculations.[30] States vary in their requirements but generally necessitate that insurance plans include a combination of third-party payments, financial assistance, discounts, and/or product vouchers in cost-sharing totals. However, many states have faced challenges in implementing these laws due to conflicts with HDHP requirements and health savings account (HSA) eligibility. Specifically, there is concern that the credit for financial assistance, prior to meeting a deductible, could cause a beneficiary to be ineligible to contribute to their HSA. In other words, to maintain HSA eligibility, beneficiaries must

meet a statutory deductible before discounts or coupons can be applied to cost-sharing calculations.[30,31] States have generally managed to work around this requirement by broadening legislation language or allowing for exceptions to ensure that those with HDHP/HSA plans are not ruled ineligible.[30]

As of the writing of this report, 25 states, the District of Columbia, and Puerto Rico have laws aimed at addressing copay accumulator adjustments by insurers and PBMs. While states vary in the specifics of their legislation, many focus on a basic requirement for all payments to be included in copay calculations. In most states, the requirements apply to all state regulated plans, meaning that some plans may be exempt. For example, Illinois, via the Managed Care Reform and Patient Rights Act, requires that any state regulated health plan must count third party payments, financial assistance, discounts, product vouchers, or any other reduction in OOP expenses on prescription drugs toward cost-sharing totals.[32] Kentucky law prohibits state regulated payers and PBMs from excluding payments via coupons, discounts, or vouchers when calculating cost-sharing. The law does allow for the use of copay accumulators when a generic alternative is available with an exception if the prescriber deems the brand-name drug is medically necessary or approved by insurance.[33,34] Texas requires that health plans and PBMs apply any third-party payment, financial assistance, discount, product voucher, or other reduction in OOP expenses be included in calculations for deductibles, copays, cost-sharing responsibility, or OOP maximum. Further, Texas law shares the Kentucky exemption when a name-brand drug is medically necessary or approved by insurance.[34]

At the federal level, the Centers for Medicare & Medicaid Services (CMS) released a 2021 rule that allowed health plans to use accumulator adjustments but deferred to states for regulation. However, this rule was challenged in 2023 and it was determined that copay accumulators are only permissible among CMS-regulated plans if allowed by state regulations and for name branded drugs that have a generic alternative.[35] An additional CMS final rule clarified that among ACA Marketplace plans, drugs that are considered EHBs have a limit on annual cost sharing protected by ACA consumer protections.[36] While not yet released, the Department of Labor and the Department of Health and Human Services have indicated plans to release rules outlining similar standards that will apply to broader health plans and self-insured group plans.[35]

AMA POLICY AND ADVOCACY

The AMA has existing policy on copay accumulators, as Policy D-110.986 outlines AMA intent to develop model state legislation and support federal and state efforts to ban co-pay accumulator policies. As a result of this policy, the AMA has joined the All Co-pays Count coalition and adopted their model legislation. This model legislation is available to all states and is endorsed by over 30 organizations and advocacy groups. The model legislation outlines the issue and ensures that OOP spending is included in cost-sharing calculations. Related Policy H-125.977 advocates that OOP expenses be calculated toward Medicare Part D coverage gap calculations and that assistance programs be available to all individuals regardless of insurance type or coverage. Policy D-110.982 goes further and supports advocacy on the "ethical dilemma" that is presented when patients are able to obtain medication or equipment at a price lower than their insurance offers due to discount cards or cash prices. In addition, Policy D-110.983 outlines educational efforts on AFPs and the negative impacts they have and advocacy to limit AFPs via regulation or legislation. Of note, when legislation supporting the inclusion of these discounted OOP payments in cost-sharing calculations was introduced, the AMA expressed its support (House Testimony, Senate Testimony, House Letter).

In addition to policies oriented towards cost-sharing/copays and OOP spending, the AMA has extensive policy designed to improve the affordability of prescription drugs. Policies H-110.980 and H-110.987 demonstrate efforts to ensure that patients have access to affordable medications. These policies discuss AMA standards for drug affordability, process transparency, and patient access. Policy

H-110.986 discusses AMA support for adding value metrics into drug prices. In conjunction with the aforementioned policies that address all payer types, Policy D-330.954 specifically focuses on managing prescription drug prices in Medicare and outlines support for price negotiation. Along with aforementioned D-110.986, Policies D-120.988 and D-120.934 target PBMs and the need for increased regulation and transparency. Specifically, Policy D-120.934 outlines AMA steps to ensure that PBMs do not prevent physicians from appropriately treating patients and Policy D-120.988 details prevention of appropriate treatment by PBMs. Combined with its grassroots advocacy campaign TruthinRx, the AMA has sent a significant number of letters to legislators, regulators, and payers working to regulate PBMs and make prescription drugs affordable. Finally, the AMA voiced support for the PBM regulations passed in the Consolidated Appropriations Act of 2026.

DISCUSSION

Patient OOP spending is typically utilized to calculate cost-sharing amounts. For example, patients will usually need to spend a certain amount OOP to achieve their deductible amount. Once met, the payer will pay a larger share of the accrued health care costs. While this generally remains the same with prescription drug spending, the introduction of PAPs has complicated the process. PAPs can take a wide variety of forms and may be sponsored by governmental and non-governmental organizations. Due to the high, and rising costs of prescription drugs in the United States, patients continue to search for methods to make their medications more affordable. For those who qualify, government and private programs can help to reduce costs. For others, drug manufacturer discounts and support programs can assist in affordability. However, these programs often have specific eligibility qualifications that many do not meet, and as a result many have begun to utilize coupons/discount cards.

While PAPs are generally beneficial to patients, payers and PBMs may employ these programs for their own financial gains. Further, the utilization of these discount cards has complicated cost-sharing calculations, as much of this spending now happens outside of insurance. For example, some accumulator adjustment programs allow for health insurers and/or PBMs to duplicate payments, in a sense “double dipping,” by accepting compensation or reimbursement from both the PAP and the patient’s OOP spending. While not all insurance companies or PBMs participate in this practice, it seems to be becoming more widespread and is harmful to patients. To take further advantage of the situation, AFPs have begun to materialize. These programs are often viewed as predatory and harmful to not only the patients that they directly serve, but also to those patients who may not be able to access the PAPs. Additionally, these AFPs may circumvent federal and state legislation and regulation. To combat the payer and PBM tactics and ensure that patient cost-sharing calculations are based on actual OOP spending, some states have recently moved to implement legislation, the impact of which has yet to be seen. To support these efforts, the Council recommends the adoption of new policy that supports that all OOP spending submitted to the payer by the patient, or on behalf of the patient, be included in calculations for cost-sharing.

RECOMMENDATION

The Council on Medical Service recommends that the following recommendation be adopted in lieu of Resolution 710-A-25, and the remainder of the report be filed:

1. Our American Medical Association supports efforts to ensure that all payers and pharmacy benefit managers include any out-of-pocket prescription drug spending related to a covered benefit submitted by the patient, or on behalf of the patient, in cost-sharing, and/or out-of-pocket spending calculations. (New HOD Policy)

Fiscal Note: Minimal

REFERENCES

1. Cost Sharing. 2025. CMS https://www.healthcare.gov/glossary/cost-sharing/
2. Deductible. 2025. CMS https://www.healthcare.gov/glossary/deductible/
3. Out-of-Pocket Maximum. 2025. CMS https://www.healthcare.gov/glossary/out-of-pocket-maximum-limit/
4. US Supreme Court Preserves ACA's No-Cost Preventive Care – At least for now. 2025. California Medical Association. https://www.cmadocs.org/newsroom/news/view/ArticleId/50932/U-S-Supreme-Court-preserves-ACA-s-no-cost-preventive-care-at-least-for-now
5. Co-payment. 2025. CMS https://www.healthcare.gov/glossary/co-payment/
6. Deductibles in ACA Marketplace Plans, 2014-2026. 2025. KFF. https://www.kff.org/affordable-care-act/deductibles-in-aca-marketplace-plans/
7. How ACA Marketplace costs compare to ESI. 2025. KFF. https://www.kff.org/affordable-care-act/deductibles-in-aca-marketplace-plans/
8. Average Annual Deductible per Enrolled Employee in Employer-Based Health Insurance for Single and Family Coverage. 2024. KFF. https://www.kff.org/private-insurance/state-indicator/average-annual-deductible-per-enrolled-employee-in-employer-based-health-insurance-for-single-and-family-coverage/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D
9. H.R.5376 - An act to provide for reconciliation pursuant to title II of S. Con. Res. 14. "The Inflation Reduction Act of 2022. https://www.congress.gov/bill/117th-congress/house-bill/5376/text
10. Medicare Cost-Sharing Rates. 2025. Center for Medicare Advocacy. https://medicareadvocacy.org/medicare-cost-sharing-rates-premiums-deductibles/
11. Cubanski J, Damico A. Key Facts About Medicare Part D Enrollment, Premiums, and Cost Sharing in 2025. 2025. KFF. https://www.kff.org/medicare/key-facts-about-medicare-part-d-enrollment-premiums-and-cost-sharing-in-2025/#:~:text=Whereas%20most%20MA%2DPD%20enrollees,drugs%20covered%20under%20Part%20D.
12. Cost Sharing Out of Pocket Costs. Medicaid.gov. 2025. https://www.medicaid.gov/medicaid/cost-sharing/cost-sharing-out-pocket-costs
13. Pollitz K, Pestaina K, Montero A, Lopes L, Valdes I, Kirzinger A, Brodie M. KFF Survey of Consumer Experiences with Health Insurance. 2023. KFF. https://www.kff.org/health-costs/copay-adjustment-programs-what-are-they-and-what-do-they-mean-for-consumers/
14. Long M, Salaga M, Pestaina K. Copay Adjustment Programs: What are They and What do They Mean for Consumers. 2024. KFF. https://www.kff.org/health-costs/copay-adjustment-programs-what-are-they-and-what-do-they-mean-for-consumers/
15. Amil-Rosario A, Slejko J, dosReis S. Changes in cost-related nonadherence among US adults with multiple chronic conditions from 2019 to 2023. 2025; Journal of Man Care & Spec Pharm. 31(7). https://www.jmcp.org/doi/10.18553/jmcp.2025.31.7.662
16. Prescription Drug Assistance Programs. CMS. 2025. https://www.cms.gov/medicare/coordination-benefits-recovery/prescription-drug-assistance-programs
17. Extra Help Basics. 2026. Medicare Rights Center: Medicare Interactive. https://www.medicareinteractive.org/understanding-medicare/cost-saving-programs/the-extra-help-low-income-subsidy-lis-program/extra-help-basics#:~:text=Key%20Takeaways,a%20Medicare%20Savings%20Program%20(MSP)
18. State Pharmaceutical Assistance Programs. 2022. National Conference of State Legislators. https://www.ncsl.org/health/state-pharmaceutical-assistance-programs#:~:text=Summary%20State%20Pharmaceutical%20Assistance%20Programs,support%20from%20the%20federal%20government
19. Who we are. 2026. ArrayRx. https://www.arrayrxsolutions.com/Our-story
20. Wilkerson J, Parker JE, Cirruzzo C, Chen E, Payne D. TrumpRx claims to offer the lowest prices. But many drugs have cheaper generics. 2026. STAT. https://www.statnews.com/2026/02/06/trumprx-discount-drug-website-undercut-by-cheaper-generics/
21. Choi J. How much will TrumpRx really cut down your drug costs?. 2026. The Hill. https://thehill.com/policy/healthcare/5727385-trumprx-drug-prices-how-much-savings/
22. Fact Sheet: 10 Reasons Why TrumpRx is an Utter Joke. 2026. Protect Our Care. https://www.protectourcare.org/fact-sheet-10-reasons-why-trumprx-is-an-utter-joke/
23. Chase L. What Are Patient Assistance Programs? 2022. Good Rx. https://www.goodrx.com/healthcare-access/patient-advocacy/what-are-patient-assistance-programs?srsltid=AfmBOooOKIaUEmZJvT4TrTKs6wz8AIuZ8oyUwwIrJCI32x0wk57uQwaI

[24.] Murphy M, Rodis J. Prescription discount cards: Who do they benefit? Who do they hurt? Ohio State University College of Pharmacy. 2025. https://pharmacy.osu.edu/news/prescription-discount-cards-who-do-they-benefit-who-do-they-hurt
[25.] Disease Fund. PAN Foundation. https://www.panfoundation.org/find-disease-fund/
[26.] Hilas O. A Pharmacist's Primer on Prescription Discount Cards. *US Pharm.* 2021;46(10):21-23. https://www.uspharmacist.com/article/a-pharmacists-primer-on-prescription-discount-cards
[27.] Ryan E, Fitts E. The Hidden Costs of Discount Cards: Understanding Copay Accumulator Adjustment. 2020. DiaTribe Learn. https://diatribe.org/diabetes-medications/hidden-costs-discount-cards-understanding-copay-accumulator-adjustment
[28.] Long M, Salaga M, Pestaina K. Copay Adjustment Programs: What Are They and What Do They Mean for Consumers? 2024. KFF. https://www.kff.org/health-costs/copay-adjustment-programs-what-are-they-and-what-do-they-mean-for-consumers/
[29.] Issue Brief: Alternative Funding Programs. AMA. 2025. https://www.ama-assn.org/system/files/issue-brief-alternative-funding-programs.pdf
[30.] Legal Alert: Drug Discount Programs in Conflict with Federal Regulations. 2021. Alera Group. https://aleragroup.com/news/legal-alert-drug-discount-programs-conflict-federal-regulations
[31.] HHS Drops Appeal in Drug Coupon Case. 2024. Groom Law Group. https://www.groom.com/resources/hhs-drops-appeal-in-drug-coupon-case/
[32.] Illinois Public Act 101-0452. https://www.ilga.gov/documents/legislation/publicacts/101/101-0452.htm
[33.] Kentucky Governor Beshear Signs New Copay Accumulator Law. 2021. Aimed Alliance. https://aimedalliance.org/kentucky-governor-beshear-signs-new-copay-accumulator-law/
[34.] Texas HB 999-88th Legislative Session. 2023. https://capitol.texas.gov/BillLookup/History.aspx?LegSess=88R&Bill=HB999
[35.] US District Court. HIV and Hepatitis Policy Institute et al., v. United States Department of Health and Human Services et al. 2023. https://bit.ly/48zbAJN
[36.] Copayment Adjustment Programs. 2025. National Center for State Legislators. https://www.ncsl.org/health/copayment-adjustment-programs/maptype/tile#toggleContent-12877

Council on Medical Service Report 5-A-26
Inclusion of Discounted Prescription Medication in Patient Cost-Sharing
Policy Appendix

Co-Pay Accumulators D-110.986
Our AMA will develop model state legislation regarding Co-Pay Accumulators for all pharmaceuticals, biologics, medical devices, and medical equipment, and support federal and state legislation or regulation that would ban co-pay accumulator policies, including in federally regulated ERISA plans. (Res. 205, I-19; Appended: Res. 212, I-20)

Non-Formulary Medications and the Medicare Part D Coverage Gap H-125.977
1. Our American Medical Association will advocate for the inclusion of out of pocket, non-formulary, prescription medication expenses in calculating a patient's contributions toward the Medicare Part D coverage gap, after which coverage resumes.
2. Our AMA will advocate for economic assistance, including coupons (and other discounts), for patients, whether they are enrolled in government health insurance programs, enrolled in commercial insurance plans, or are uninsured. (Res. 826, I-14; Reaffirmation I-15; Reaffirmation: I-17; Reaffirmation: A-22)

Ethical Pricing Procedures that Protect Insured Patients D-110.982
1. Our American Medical Association advocates for policies that limit the cost of a medications or durable medical equipment to an insured patient with coverage to the lower range of prices that a non-covered patient can achieve at cash price either before or after application of a non-manufacturer's free discount card (such as GoodRx).
2. Our AMA will write a letter to lawmakers and other pertinent stakeholders describing the ethical dilemma of the medication pricing process and how it adversely affects insured patients. (Res. 012, A-24)

Alternative Funding Programs D-110.983
Our American Medical Association will educate employers, benefits administrators, and patients on alternative funding programs (AFPs) and their negative impacts on patient access to treatment and will advocate for legislative and regulatory policies that would address negative impacts of AFPs. (Res. 707, A-24)

Additional Mechanisms to Address High and Escalating Pharmaceutical Prices H-110.980
1. Our American Medical Association will advocate that the use of arbitration in determining the price of prescription drugs meet the following standards to lower the cost of prescription drugs without stifling innovation:
    a. The arbitration process should be overseen by objective, independent entities.
    b. The objective, independent entity overseeing arbitration should have the authority to select neutral arbitrators or an arbitration panel.
    c. All conflicts of interest of arbitrators must be disclosed and safeguards developed to minimize actual and potential conflicts of interest to ensure that they do not undermine the integrity and legitimacy of the arbitration process.
    d. The arbitration process should be informed by comparative effectiveness research and cost-effectiveness analysis addressing the drug in question.
    e. The arbitration process should include the submission of a value-based price for the drug in question to inform the arbitrator's decision.
    f. The arbitrator should be required to choose either the bid of the pharmaceutical manufacturer or the bid of the payer.

   g. The arbitration process should be used for pharmaceuticals that have insufficient competition; have high list prices; or have experienced unjustifiable price increases.
   h. The arbitration process should include a mechanism for either party to appeal the arbitrator's decision.
   i. The arbitration process should include a mechanism to revisit the arbitrator's decision due to new evidence or data.
2. Our AMA will advocate that any use of international price indices and averages in determining the price of and payment for drugs should abide by the following principles:
   a. Any international drug price index or average should not be used to determine or set a drug's price, or determine whether a drug's price is excessive, in isolation.
   b. The use of any international drug price index or average should preserve patient access to necessary medications.
   c. The use of any international drug price index or average should limit burdens on physician practices.
   d. Any data used to determine an international price index or average to guide prescription drug pricing should be transparent and updated regularly.
3. Our AMA supports the use of contingent exclusivity periods for pharmaceuticals, which would tie the length of the exclusivity period of the drug product to its cost-effectiveness at its list price at the time of market introduction. (CMS Rep. 4, I-19; Reaffirmed: CMS Rep. 3, I-20; Modified: CMS Rep. 4, A-22)

Pharmaceutical Costs H-110.987

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 percent 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 percent 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. (CMS Rep. 2, I-15; Reaffirmed in lieu of: Res. 817, I-16; Appended: Res. 201, A-17; Reaffirmed in lieu of: Res. 207, A-17; Modified: Speakers Rep. 01, A-17; Appended: Alt. Res. 806, I-17; Reaffirmed: BOT Rep. 14, A-18; Appended: CMS Rep. 07, A-18; Appended: BOT Rep. 14, A-19; Reaffirmed: Res. 105, A-19; Appended: Res. 113, I-21; Reaffirmed in lieu of: Res. 810, I-22; Reaffirmed: Res. 801, I-23; Reaffirmed: Res. 801, I-23; Reaffirmed: CMS Rep. 04, I-24; Reaffirmed: CMS Rep. 06, A-25)

Incorporating Value into Pharmaceutical Pricing H-110.986

1. Our American Medical Association supports value-based pricing programs, initiatives and mechanisms for pharmaceuticals that are guided by the following principles:
   a. value-based prices of pharmaceuticals should be determined by objective, independent entities;
   b. value-based prices of pharmaceuticals should be evidence-based and be the result of valid and reliable inputs and data that incorporate rigorous scientific methods, including clinical trials, clinical data registries, comparative effectiveness research, and robust outcome measures that capture short- and long-term clinical outcomes;
   c. processes to determine value-based prices of pharmaceuticals must be transparent, easily accessible to physicians and patients, and provide practicing physicians and researchers a central and significant role;
   d. processes to determine value-based prices of pharmaceuticals should limit administrative burdens on physicians and patients;
   e. processes to determine value-based prices of pharmaceuticals should incorporate affordability criteria to help assure patient affordability as well as limit system-wide budgetary impact; and
   f. value-based pricing of pharmaceuticals should allow for patient variation and physician discretion.

2. Our AMA supports the inclusion of the cost of alternatives and cost-effectiveness analysis in comparative effectiveness research.
3. Our AMA supports direct purchasing of pharmaceuticals used to treat or cure diseases that pose unique public health threats, including hepatitis C, in which lower drug prices are assured in exchange for a guaranteed market size. (CMS Rep. 05, I-16; Reaffirmed in lieu of: Res. 207, A-17; Reaffirmed: CMS-CSAPH Rep. 01, A-17; Reaffirmed: CMS Rep. 07, A-18; Reaffirmed: CSAPH Rep. 2, I-19; Reaffirmed: CMS Rep. 4, I-19; Reaffirmed: CMS Rep. 6, I-20; Reaffirmed: Res. 113, A-23)

Prescription Drug Prices and Medicare D-330.954

1. Our American Medical Association 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. (Res. 211, A-04; Reaffirmation I-04; Reaffirmed in lieu of Res. 201, I-11; Appended: Res. 206, I-14; Reaffirmed: CMS Rep. 2, I-15; Appended: Res. 203, A-17; Reaffirmed: CMS Rep. 4, I-19; Reaffirmed: CMS Rep. 3, I-20; Reaffirmed: Res. 113, I-21; Reaffirmed: CMS Rep. 4, A-22; Reaffirmed in lieu of: Res. 810, I-22)

Inappropriate Actions by Pharmacies and Pharmacy Benefit Managers D-120.988
Our AMA, in cooperation with pharmacy benefit managers, pharmacy companies, and other drug retailing organizations, shall develop model procedures that physicians may use when prescribing off-formulary pharmaceuticals that are medically indicated and that these procedures be in compliance with the Health Insurance and Portability and Accountability Act of 1996. (Res. 528, A-02; Reaffirmation I-04; Reaffirmation A-06; Reaffirmed: CSAPH Rep. 01, A-16)

Evaluating Actions by Pharmacy Benefit Manager and Payer Policies on Patient Care D-120.934
1. Our American Medical Association will take steps to implement AMA Policies H-120.947 and D-35.981 that prescriptions must be filled as ordered by physicians or other duly authorized/licensed persons, including the quantity ordered.
2. Our AMA will work with pharmacy benefit managers, payers, relevant pharmacy associations, and stakeholders to: (a) identify the impact on patients of policies that restrict prescriptions to ensure access to care and urge that these policies receive the same notice and public comment as any other significant policy affecting the practice of pharmacy and medicine; and (b) prohibit pharmacy actions that are unilateral medical decisions.
3. Our AMA will report back at the 2018 Annual Meeting on actions taken to preserve the purview of physicians in prescription origination. (Res. 233, I-17; Reaffirmed: CMS Rep. 05, A-23)