REPORT 7 OF THE COUNCIL ON MEDICAL SERVICE (A-26)
Private Insurance Coverage of Anti-Obesity Medications

EXECUTIVE SUMMARY

Resolution 230-A-25, "Advocating to Expand Private Insurance Coverage of Anti-Obesity Medications," was introduced by the Endocrine Society, American Association of Clinical Endocrinology, American Society for Reproductive Medicine, American Society for Metabolic and Bariatric Surgery, Obesity Medicine Association, and American College of Physicians. The resolution asked that existing Policy H-440.801 be amended. Subclauses 1f and 1h were adopted while Subclauses 1e and 1g were referred. These referred subclauses ask the following:

> RESOLVED, that our American Medical Association (AMA) amend policy H-440.801, Advocacy Against Obesity-Related Bias by Insurance Providers, by addition to read as follows:
> 1. Our AMA will urge individual state delegations to directly advocate for their state insurance agencies and insurance providers in their jurisdiction to:
>   e. Eliminate coverage exclusions for the pharmacologic treatment of obesity.
>   g. Support and cover chronic treatment with anti-obesity medications to maintain weight loss.

This report discusses the persistence of obesity, the marketplace and coverage of anti-obesity medications (AOMs), guidelines for the treatment of obesity, and includes several policy recommendations. Obesity is a chronic, progressive disease and a global public health challenge. While seven medications are currently approved for weight loss, the next generation of AOMs will enter the market within the next few years and are considered more effective with fewer side effects. Despite an increasing body of evidence to suggest that AOMs are effective treatments, coverage for obesity remains limited. The World Health Organization and Institute for Clinical and Economic Review recently released reports providing guidance on the use of glucagon-like peptide-1 (GLP-1) medications, strategies to guide market action, policy solutions, and federal policy interventions to improve access. Furthermore, the regulatory environment has been dynamic, with GLP-1s included in the Trump Administration's priority to lower prescription drug prices.

The Council on Medical Service recommends new policy supporting potential innovative payment arrangements and pilot programs which allow for demonstration projects that cover emerging medications which aid in obesity management. The Council also recommends the long-term coverage of AOMs to maintain weight loss through consistent drug pricing, formulary tiering, benefit structures, and coverage criteria in private insurance and employer-sponsored insurance to offset cost variability. Furthermore, the Council recommends equitable access to comprehensive disease management, health promotion, and prevention interventions targeting the general population and those who are at elevated risk for obesity. Additionally, the Council recommends reaffirming Policy H-110.997 and Policy H-110.959 to emphasize the AMA's support for affordable access to prescription drugs. The Council also recommends reaffirming Policy H-110.987 to highlight the AMA's support to ensure that drug prices are affordable to patients and Policy D-330.954 and Policy D-110.987 to underscore the AMA's support and recognition for the Centers for Medicare & Medicaid Services (CMS) to negotiate pharmaceutical pricing for all applicable medications covered by CMS and efforts to increase pharmacy benefit manager transparency and regulation. Lastly, the Council recommends reaffirming Policy H-150.953 to highlight the AMA's recognition of obesity as a complex health disorder.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 7-A-26

Subject: Private Insurance Coverage of Anti-Obesity Medications

Presented by: Betty Chu, MD, MBA, Chair

Referred to: Reference Committee G

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This report discusses the persistence of obesity, the emerging marketplace and coverage of anti-obesity medications (AOMs), guidelines for the treatment of obesity, and includes several policy recommendations.

BACKGROUND

Defined by the World Health Organization (WHO) as a chronic, progressive, and relapsing disease, obesity is a global public health challenge affecting more than one billion people worldwide and contributing to millions in preventable deaths each year. In the United States (U.S.), the prevalence of obesity among adults increased from 34.7 million (19.3 percent) in 1990 to 107 million (42.5 percent) in 2022.[1,2] Adults with severe obesity accounted for 9.2 percent (over twenty-two million by total population) in 2020.[3] By 2035, an estimated 46.9 percent of the adult population (126 million) will be categorized as obese.[4] The percentage of U.S. children and adolescents affected by obesity has more than tripled from 1965 (5 percent) to 2018 (19 percent).[5] Obesity is costly to the U.S. health care system, with an estimated $172 billion annually attributed in medical costs, representing 5 to 7 percent of all health care expenditures.[6] Despite obesity being a significant chronic disease for all populations, prevalence varies by race and ethnicity. In 2022, non-Hispanic Black females were estimated to have the highest prevalence of obesity, at 56.9 percent followed by Hispanic females at 49.4 percent.[7] The increasing prevalence of obesity also varied by race and ethnicity. For instance, obesity has risen least for non-Hispanic Black males, with an increase in prevalence from 22.0 percent in 1990 to 40.4 percent in 2022.[8] Additionally, there are state-level differences, with prevalence highest in Midwestern and Southern states and variance by age, with

obesity prevalence highest among middle-aged adults and large increases in the youngest adult ages, especially for females.[9]

While the WHO defines obesity as having a body mass index (BMI) of 30.0 or higher in adults, the Lancet Commission recently announced a new definition that moves beyond BMI to classify it as a chronic disease.[10] Obesity is associated with and can result in an increased risk of comorbidities such as hypertension, diabetes, hypercholesterolemia, coronary heart disease, gallbladder disease, osteoarthritis, certain cancers, and liver disease. Severe obesity, defined as having a BMI of 40 or higher, can shorten life expectancy by up to 14 years, similar to smoking.[11] Moderately obese and severely obese individuals are estimated to have 14 to 25 percent more visits to their physicians, respectively, with visits to primary physicians to be 38 percent higher for those who are obese.[12]

Previously, obesity was thought to be an imbalance between energy intake and expenditure. However, recent research has suggested that genetic, physiological, and behavioral factors play a significant role.[13] Variations in genes that affect metabolic processes, appetite regulation, body fat distribution, and environmental factors such as geography, food and physical activity environment, and socioeconomic status are consequential in the development of obesity.[14] While traditional strategies focused on individual behavior have been insufficient, prevention efforts targeting obesity-related noncommunicable diseases have never been more important. For instance, prevention efforts can include the promotion of healthy eating, active lifestyles, and early intervention to reduce risks of diabetes, heart disease, and cancer. People with obesity continue to face social stigma with weight bias and discrimination persisting as significant factors in understanding the impact of and providing treatment through pharmacological methods.[15] Additionally, weight bias has led to delays in diagnosis and treatment and contributes to poorer health outcomes leading to a profound effect on all aspects of patients' lives and those of their families.[16]

Multiple public health interventions, such as school nutrition and exercise programs, taxes on unhealthy foods, and health system requirements for nutritional counseling programs[17] have had limited success, requiring health care to evolve to meet the needs of the population more adequately. Currently, comprehensive care for obesity includes nutrition therapy, physical therapy, behavioral counseling, and pharmacotherapy.[18] There are multiple methods for treating obesity including lifestyle modifications (e.g., diet, physical activity, and behavioral modifications), medications, and bariatric surgery, usually in combination.[19]

ANTI-OBESITY MEDICATIONS

Initially developed for the treatment of type-2 diabetes, GLP-1 receptor agonist and glucose-dependent insulinotropic polypeptides (GIP)/GLP-1 dual agonist therapies have emerged as potential AOMs. By targeting mechanisms that reduce appetite and enhance satiety along with other physiological effects, GLP-1 medications provide a complementary treatment to traditional behavioral interventions and important innovations to address obesity.[20] Additionally, clinical benefits associated with GLP-1 therapies have demonstrated improvements for major cardiovascular events, heart failure with preserved ejection fraction, diabetes prevention, systolic blood pressure and low-density lipoprotein cholesterol, obstructive sleep apnea, peripheral artery disease, kidney disease, metabolic dysfunction-associated steatohepatitis, and neurodegenerative diseases.[21] Similar results can be seen for patients with diabetes: improved glycemic control, significant weight loss, cardiovascular risk reduction, renal and liver production, a reduced need for other medications, lowered blood pressure, and improved cholesterol profiles.[22] The pleiotropic effects are beneficial for patients with multiple chronic conditions, especially for older patients, because it can help reduce polypharmacy and increase adherence to pharmacological treatments.[23]

There has also been emerging evidence to suggest their utility in treating neurodegenerative diseases, reducing stroke risk, liver disease, and substance use disorders.[24] However, there are potential unintended consequences through the long-term use of GLP-1 medications. For instance, there is emerging clinical and paraclinical evidence that suggests that the agents may contribute to a reduction in skeletal muscle mass, potentially exacerbating or precipitating sarcopenic obesity, particularly in older or frail individuals with limited muscular reserves.[25] Therefore, the preservation of muscular health through nutritional support, exercise, and pharmacological therapies are important supplementary treatments, especially for older patients.

At the time this report was written, there were seven medications approved for weight loss by the Food & Drug Administration (FDA), with varying effectiveness and occurrences of side effects. Earlier generations of obesity medications had lower degrees of effectiveness with higher incidences of side effects. Appendix A highlights the FDA approved GLP-1 medications for the treatment of obesity. There may be potential benefits to prescribing and administering earlier generations of AOMs.[26] For instance, access to second generation AOMs remains limited because of restricted insurance coverage and high out-of-pocket costs. While Wegovy and Zepbound are listed at $16,188 and $12,720 per year, respectively, Qsymia and Contrave are $1,465 and $2,095, respectively.[27] Additionally, significant shortages of GLP-1 medications can make it difficult to prescribe the second generation of AOMs and further inhibit access for certain patients. Furthermore, some patients may be nonresponders to semaglutide (or tirzepatide) or have difficulty tolerating GLP-1 based medications.[28] Some patients may require multiple medications in addition to semaglutide or tirzepatide to achieve significant weight loss or second generation AOMs might be too powerful and result in too much weight loss, loss of lean muscle mass, and concern of increased frailty.[29]

The next generation of AOMs are set to enter the market within the next several years–with 40 manufacturers in the process of developing GLP-1 drugs and 16 AOMs expected to be approved from 2026 to 2029–and are considered more effective with fewer side effects.[30] Similarly, non-GLP-1 medications are part of this emerging market and include melanocortin-4 receptor agonists, amylin analogs, and mitochondrial uncouplers.[31] Non-GLP-1 medications can be appealing for patients who do not respond to GLP-1s or have specific metabolic needs. Some of these new medications provide an oral alternative targeting similar pathways without requiring injections, thereby improving accessibility and patient adherence. Further, the dosing schedule for some of these new medicines is easily adherable. The emergence of these medications, their efficacy, favorable effects on metabolism and obesity-related complications, and recognition of obesity as a chronic health condition, has led to a rapid expansion in their use. GLP-1-based prescriptions among people without diabetes have risen by 700 percent between 2019 to 2023.[32] Pervasive media attention has led some to theorize whether AOMs could be a potential solution to the obesity epidemic. In December 2025, Novo Nordisk released a pill version of Wegovy and, in less than three weeks, 150,000 prescriptions were filled.[33] According to the manufacturer, most prescriptions are from new patients and 9 out of 10 paid out of pocket.[34]

Pervasive media attention has also led GLP-1s to being used off-label for non-obese patients to lose small amounts of weight.[35] While GLP-1s are being used off-label by individuals who do not meet obesity criteria, there are significant considerations required in prescribing an AOM. There is a marked difference between AOMs being prescribed for chronic, long-term use and for short-term use without the guidance of a medical professional. Compounded versions of the GLP-1 injectables were made available in early 2022 when brand name versions were in short supply. Under Section 503A and 503B of the Federal Food, Drug, and Cosmetic (FD&C) Act, compounded drugs are allowed when the brand-name drug is on the FDA's official Drug Shortages list. While the FDA provides some flexibility, the agency may act if an outsourcing facility continues to fill new orders

for more than 60 days after the drug has been removed from the Drug Shortages list. In the case of GLP-1 medications, the FDA removed the injectables from the list in February 2025 but allowed a brief window for compounders to wind down operations with 503A pharmacies allowed to continue until April 22, 2025 and 503B outsourcing facilities until May 22, 2025.[36] Despite the timeline, and the FDA warning telehealth companies against illegal marketing of compounded GLP-1s, Hims & Hers was still offering its versions of injectable weight-loss drugs until March 2026 when it struck a deal with Novo Nordisk to sell Wegovy at a discounted rate.[37,38]

Treatment discontinuation of tirzepatide and semaglutide remains high and is a significant issue as it is associated with increased risks of cardiovascular events and mortality. Randomized trials, such as SURMOUNT-4, demonstrate that discontinuation of pharmacotherapy leads to weight re-gain reinforcing the chronic nature of obesity treatment.[39] Cost or insurance-related (insurance denial, expiration of manufacturer discount coupon, or out-of-pocket cost) hurdles were cited as the most common reason, by half of respondents (47.6 percent).[40] Side effects were the second most cited reason with 14.6 percent of respondents. For comparison, side effects and efficacy are cited as the most common reason for treatment discontinuation of medication for chronic medical conditions.[41] In general, high-risk, non-oral medications for conditions like diabetes, asthma, and glaucoma often have higher initial discontinuation rates.[42] Furthermore, younger patients, those with comorbidities, and patients who are non-White may have higher rates of discontinuation.[43]

COVERAGE OF ANTI-OBESITY MEDICATIONS

Despite an increasing body of evidence to suggest that emerging AOMs are effective treatments, coverage of GLP-1s for obesity treatment remains limited. Indeed, coverage is sparse for individuals through Medicaid, Affordable Care Act (ACA) Marketplace plans, and those who work in large employer firms, and coverage in Medicare for treatment of obesity is, for now, prohibited.[44,45,46] While all Medicaid programs cover GLP-1s for the treatment of diabetes, coverage is optional for the treatment of obesity. As of October 2025, 16 state Medicaid programs covered GLP-1s for obesity treatment, 11 states cover GLP-1s for weight loss under their state employee health plan, and five provide coverage under both programs.[47] Some of these Medicaid programs, however, have already announced they will discontinue coverage or restrict those who can qualify. North Carolina Medicaid, for example, ended coverage of GLP-1s for obesity in October 2025, citing shortfalls in state funding.[48] Additionally, California, New Hampshire and South Carolina will end coverage at the beginning of 2026.[49] Further, starting next year, Michigan Medicaid will limit coverage to people who are "morbidly obese," (BMI of 40 or higher).[50] Lastly, Pennsylvania, Rhode Island and Wisconsin are also considering new restrictions.[51]

Private insurance coverage is often based on the insurance plan or employer decision to include the benefit; even if the coverage is offered, its initial and continued coverage is restricted by stringent prior authorization criteria. As of 2025, 39.4 percent of individuals with private insurance and 45.1 percent of individuals with employee sponsored insurance had at least one GLP-1 medication covered by their plan.[52] Drugs solely approved to treat obesity have minimal to no coverage on most ACA Marketplace formularies. Among ACA Marketplace plans with these drugs on formulary, prior authorization is required by most plans (greater than 98 percent).[53] Step therapy, a utilization management tool that requires patients to try and fail lower cost medications before coverage is provided for more expensive medications, is less commonly used, with 1 in 4 marketplace plans requiring it.[54] Quantity limits are imposed in most plans among those including these drugs.[55] With such a high demand for and short supply of GLP-1 agonists, some patients have taken to procuring them from alternative sources, such as online vendors, medical spas, or compounding pharmacies selling products not evaluated by the FDA, some of which may contain different ingredients.[56] The FDA is increasing enforcement against compounded GLP-1 drugs, as

many shortages have been resolved, removing the exemption that allowed pharmacies to create copies of branded drugs.[57] The agency is targeting companies, including telehealth providers, for selling non-FDA-approved, mass-marketed "copycat" versions that pose safety risks.[58]

Despite a notable increase in employers covering GLP-1 medications for weight loss, the high costs associated with obesity medications raise significant concerns. While recognizing their benefit, many employers are considering scaling back coverage due to their high cost and higher than expected use. Approximately 34 percent of non-elderly people with employer-sponsored health insurance (36.2 million) have a body mass that would medically qualify them for GLP-1 drugs.[59] The share of firms with 5,000 or more workers covering these medications for weight loss increased significantly (from 28 percent in 2024 to 43 percent in 2025).[60] However, only 19 percent of firms with 200 or more workers cover GLP-1 drugs for weight loss in their largest health plan in 2025.[61] Furthermore, for those firms that cover GLP-1s for weight loss, about a third require enrollees to meet with a dietician, case manager, therapist, or participate in a lifestyle program.[62]

While insurance coverage of GLP-1 medications for obesity remains lower than other medications, there is a roadmap to broader access with comparable treatments. Bariatric surgery coverage has evolved from a rarely covered, high-risk procedure in the early 1990s to a widely accepted, insurance-covered treatment for severe obesity. Driven by improved safety and proven metabolic benefits, a major milestone occurred when the Centers for Medicare & Medicaid Services (CMS) expanded Medicare coverage in 2006 for patients with specific comorbidities.[63] Currently, bariatric surgery is generally covered for obesity when deemed medically necessary, a specific BMI threshold is met with obesity-related comorbidities like diabetes and sleep apnea. Additionally, coverage requires documentation of failed, previous weight loss attempts, a supervised diet program, and mental health evaluations.[64]

Rebates for GLP-1 medications are widespread and, as of 2025, are estimated to be 40 percent or higher for major products like Wegovy and Zepbound.[65] They are most readily used by pharmacy benefit managers (PBMs) to secure formulary placement, reducing high list prices to lower net costs for payers. The rebates are a primary tool used to secure preferred coverage on insurer formularies, with some discounts at 50 percent.[66] Additionally, states received substantial rebates for brand-name GLP-1s, with usage growing and accounting for eight percent of Medicaid prescription drug spending before rebates in 2024.[67] However, these manufacturer-to-payer rebates do not always translate directly into lower out-of-pocket costs for individual users and frequently rely on copay assistance coupons to manage costs.

PBMs play a central, controversial role in the high cost of GLP-1 medications. By controlling access via formularies and negotiating large, often opaque rebates, PBMs are criticized for favoring higher-priced drugs for larger rebates and, therefore, keeping net costs high for employers.[68,69] PBMs argue their negotiating power is used to counterbalance high list prices set by manufacturers, sometimes securing lower out-of-pocket costs for members. However, limited transparency makes it difficult to distinguish how and if the discounts are passed on to employers or patients.[70] PBMs can also implement strict utilization controls including mandatory prior authorization, step therapy, and BMI requirements to limit access and manage costs.[71] While utilization controls can be useful, it is argued that PBMs may use unfair criteria or a patient facing restricted access despite it being a clinically appropriate treatment.

A study from 2025 showed that there was significant disparities in AOM prescription rates based on gender, race/ethnicity, age, insurance type, insurance carrier, and adjusted gross income (AGI).[72,73] For instance, Black patients, Hispanic individuals, and those of other racial or ethnic backgrounds had lower prescription rates, compared with white patients.[74] Furthermore, men had

lower rates than women and, compared with privately insured individuals those with Medicaid, traditional Medicare, Medicare Advantage, self-paying, and other insurance types had lower rates of prescription.[75] Lastly, those with the highest level of income had the highest prescription rate compared to those with the lowest income.[76] Patients filling their prescription differed as well, though less significantly than those receiving an AOM prescription. While Hispanic patients were less likely to fill their prescription compared with White patients, Black patients had similar filling rates.[77] Patients who were older or women were more likely to fill their prescription higher odds of AOM fill.[78] Furthermore, Medicaid, traditional Medicare and Medicare Advantage insurance types were associated with lower odds of AOM fill, compared with private insurance category.[79] Interestingly, insurance carriers or AGI did not produce any significant difference in filling rates.[80]

WORLD HEALTH ORGANIZATION GUIDELINES ON THE USE OF GLP-1 THERAPIES[81]

In December 2025, and in response to requests from its member nations, the WHO published an evidence-informed guideline on the use of GLP-1 therapies in the treatment of obesity in adults. The guideline outlines a strategic foundation to help countries accelerate their response to the obesity crisis, brings together the current evidence base, details the development process, and distills the implications for expanding equitable access to these medications while shaping a more comprehensive ecosystem for obesity management. In the report, two practice statements were outlined with partnering recommendations. First, obesity was recognized as chronic, complex disease that requires lifelong care beginning in clinical assessment and early diagnosis. It was recommended that in adults living with obesity, GLP-1 receptor agonists or GIP/GLP-1 dual agonists may be used as long-term treatment for obesity. Second, people living with obesity should receive context-appropriate counselling on behavioral and lifestyle changes as an initial step toward more structured behavioral interventions. Thus, it was recommended that in adults living with obesity who are prescribed GLP-1 receptor agonists or GIP/GLP-1 dual agonists, intensive behavioral therapy may be provided as a co-intervention within a comprehensive multimodal clinical algorithm.

The guideline emphasizes the importance of fair access to GLP-1 therapies and preparing health systems for use of obesity medicines. Without deliberate policies, the WHO suggests access to GLP-1 therapies could exacerbate existing health disparities. Additionally, in September 2025, the WHO added GLP-1 therapies to its Essential Medicines List for managing type 2 diabetes in high-risk groups.[82] With the guideline, the WHO issues conditional recommendations for using therapies to support people living with obesity, as part of a comprehensive approach that includes healthy diets, regular physical activity, and support from health professionals.

INSTITUTE FOR CLINICAL AND ECONOMIC REVIEW REPORT: AFFORDABLE ACCESS TO GLP-1 OBESITY MEDICATIONS[83]

In April 2025, the Institute for Clinical and Economic Review (ICER) released the report Affordable Access to GLP-1 Obesity Medications: Strategies to Guide Market Action and Policy Solutions. In the report, ICER presented potential strategies to guide market action, policy solutions, and federal policy interventions to improve access to GLP-1 medications, and AOMs in general.

Five market strategies were suggested, informed by ICER's interviews with different stakeholders and their advantages and limitations are outlined for each option in Appendix B. For instance, temporary coverage denial was a solution, suggesting that some purchasers and insurers have concluded that they do not have the budget flexibility to provide coverage for GLP-1s for treatment of obesity at current prices. For those that are seeking a more affordable and long-term way to provide coverage for expensive drugs, such as GLP-1s, purchasers and insurers may apply enhanced utilization and could include coverage criteria. Some coverage criteria included BMI and clinical comorbidities, additional clinical or genetic factors, and/or duration of coverage. Another suggestion was that managing the network of clinical providers may improve results while controlling costs. While some purchasers may consider temporary non-coverage of GLP-1 drugs, another solution may be to utilize alternative payment arrangements to help individuals afford treatment. The last market solution that the report outlined was carve-out programs. Many purchasers or payers are delegating obesity management to a comprehensive program offered by a PBM or to an independent obesity management company.

Five federal policy interventions were suggested as potential policy reforms that the federal government could enact to address access to GLP-1 medications and the overall cost of obesity treatment. One potential policy reform was increased access through coverage of obesity drugs in Medicare. While the Trump Administration announced the coverage of GLP-1 medications for the treatment of obesity, federal law still bans Medicare from covering weight-loss drugs and requires a pilot program to evaluate coverage. At a federal level, in lieu of Medicare coverage of GLP-1s for obesity, another way to broaden coverage would be to ask the United States Preventive Services Task Force to evaluate GLP-1s and deem them as preventive treatments worthy of a rating of "A" or "B" that creates a mandate for coverage by all private insurers with no patient cost sharing. The third cited policy reform was reducing costs through aggressive drug price negotiation by the federal government. The Trump Administration, as will be outlined, recently negotiated the price for GLP-1 medications covered through Medicare and Medicaid. Additionally, the federal government negotiated during its second round of Medicare's Drug Price Negotiation Program, created by the Inflation Reduction Act (IRA) of 2022, which included diabetes and obesity drugs Ozempic and Wegovy. The fourth reform was to reduce costs through federal subsidies for private insurance coverage of obesity treatments. The federal government, it is suggested, could negotiate significant price concessions like the affordable prices that were negotiated for COVID-19 vaccines and treatments during the pandemic in exchange for federal subsidies to private insurers. Along with negotiating lower prices through the IRA process, the fifth intervention is to require that drugmakers license GLP-1 drugs to generic manufacturers for the express purpose of providing more affordable versions for public payers, including state Medicaid programs and state employee health plans.

RECENT REGULATORY ACTIVITY

In May 2025, the Trump Administration issued Executive Order No. 14297, Delivering Most-Favored-Nation Prescription Drug Pricing to American Patients which instructed drug

manufacturers to reduce the prices of brand-name drugs to match the lowest price among selected high-income countries as part of its aim to deliver its most-favored-nation (MFN) drug pricing.[84] In November 2025, the Trump Administration announced an agreement with pharmaceutical manufacturers Eli Lilly and Novo Nordisk to offer their weight-loss drugs for individuals receiving Medicare and Medicaid as part of its MFN policy.[85] As part of this plan, the Medicare price for Ozempic, Wegovy, Mounjaro, and Zepbound will be $245, with Wegovy and Zepbound covering patients with obesity and related comorbidities for the first time. Further, in December 2025, CMS published its voluntary Better Approaches to Lifestyle and Nutrition for Comprehensive hEalth (BALANCE) Model.[86] The BALANCE Model will allow CMS to negotiate drug pricing and coverage terms with manufacturers of GLP-1 medications on behalf of state Medicaid agencies and Medicare Part D plan sponsors. Medicaid agencies can join the model beginning in May 2026, and Part D plans in January 2027. However, as previously mentioned, federal law still bans Medicare from coverage of weight-loss drugs and will require demonstration programs and waivers to proceed. Furthermore, it is unclear whether states will find the model appealing. For instance, due to recent budget cuts, many states are facing tighter budget constraints. Additionally, it is unknown how the new lower costs compare to the net prices state Medicaid programs already pay after rebates. Lastly, state interest in expanding coverage of obesity drugs has been waning due to their significant budgetary impact and sustainability.

Legal challenges and negative feedback from stakeholders led to the withdrawal of prior proposals introduced during the first Trump Administration: International Pricing Index (IPI) Model and MFN Model. The IPI Model sought to lower drug costs and reduce out-of-pocket costs for patients. CMS solicited public comments on options considered for testing changes to payment for separately payable Medicare Part B drugs to align with international prices more closely. Similarly, the proposed MFN Model negotiated for the lowest price that drug manufacturers received in other similar countries for high-cost Medicare Part B drugs. While both were withdrawn, these policies provided the outline for the Trump Administration's second attempt to lower prescription drug costs.

While Novo Nordisk and Eli Lilly have committed to lowering the prices for private insurance and group health plans, it is unclear how the negotiated prices will affect them. The agreement does not include pricing obligations in the commercial market. Some experts suggest price reductions will transition over to group health plans and private insurance, while others believe manufacturers will make up the difference by lowering rebates or increasing prices. Others have expressed concern over MFN policies, suggesting that price controls trade short-term benefits for long-term risk. Further, while the Trump Administration has indicated its desire to codify MFN pricing, it is unclear if Congress will be agreeable citing concern potential threats to medical innovation, reduced access to new medicines, and increased government intervention in the health care market.

In November 2025, CMS announced the prices that the federal government negotiated during its second round of Medicare's Drug Price Negotiation Program (MDPNP), created by the IRA, which included Ozempic and Wegovy.[87] According to a spokesperson for CMS, MFN prices will supersede MDPNP prices and that MFN drug prices will supersede "maximum fair prices" negotiated under the IRA where there is a conflict.

Finally, the Trump Administration launched TrumpRx in February 2026 – a government run, direct to consumer website designed to deliver MFN prices directly from manufacturers. Not all medications will be available, with five manufacturers participating and 40 of the nation's highest-cost brand-name drugs listed on the website. For instance, not all AOM are available for purchase - Wegovy and Zepbound are listed while Saxenda is not. Details are still emerging, and questions remain regarding who will benefit.

AMA POLICY

Policy H-110.997 supports programs whose purpose is to contain the rising costs of prescription drugs, most notably that: all patients have access to all prescription drugs necessary to treat their illnesses and physicians have the freedom to prescribe the most appropriate drug and method of delivery. Additionally, Policy H-110.997 encourages physicians to stay informed about the availability and therapeutic efficacy of generic drugs, to consider the prescribing of the least expensive drug product, and to become familiar with the price in their community of the medications they prescribe.

Policy H-110.959 supports efforts to ensure that patients have affordable access to medications and encourages all payers to establish a reasonable and affordable cap on patient out-of-pocket prescription costs.

Policy H-110.987 encourages prescription drug price and cost transparency among pharmaceutical companies, pharmacy benefit managers and health insurance companies, encourages the Federal Trade Commission actions to limit anticompetitive behavior by pharmaceutical companies attempting to reduce competition, and supports legislation to shorten the exclusivity period for biologics.

Policy D-110.987 supports the active regulation of PBMs under state departments of insurance, supports improved transparency of PBM operations, and details that the AMA will develop model state legislation addressing the state regulation of PBMs, which shall include provisions to maximize the number of PBMs under state regulatory oversight.

Policy H-150.953 urges physicians and managed care organizations and other third-party payers to recognize obesity as a complex disorder and all payers to ensure coverage parity for evidence-based treatment of obesity, including FDA-approved medications without exclusions or additional carve-outs.

Policy D-330.954 supports federal legislation which gives the Secretary of the Department of Health and Human Services (HHS) the authority to negotiate contracts with manufacturers of covered Part D drugs, works toward eliminating Medicare prohibition on drug price negotiation, and prioritizes the AMA's support for CMS to negotiate pharmaceutical pricing for all applicable medications covered by CMS.

Finally, Policy H-440.801, which is amended by Resolution 230, urges state delegations to directly advocate for their insurance agencies and insurance providers to, most notably: allow a patient's physician to prescribe anti-obesity medication and have it covered by insurance and reduce the prior authorization burden for the coverage of anti-obesity medications.

DISCUSSION

The Council recognizes the changing landscape of AOMs, their role in the treatment of obesity, and the emergence of GLP-1s as a "game-changing" pharmacological treatment for patients with obesity, diabetes, and comorbid conditions. Their clinical efficacy is clear, but they are expensive. Although many employer-sponsored insurance or private insurance plans do not cover GLP-1 medications for the treatment of obesity, that could change in the future as there have been several developments toward improved affordability and access. Starting in July 2026, Medicare will significantly expand coverage for GLP-1 medications for patients with obesity and comorbid conditions. Patients will have access to these drugs with copays capped at $50 per month,

supported by the short-term demonstration program acting as a bridge to the broader BALANCE model launching in 2027 which will also serve as a pilot program for state Medicaid programs. Moreover, the proliferation of direct-to-consumer marketplaces, which bypass traditional insurance and retail pharmacies, offer lower list prices and enhance medication access. Likewise, the recently approved pill versions of Wegovy and soon to be approved non-peptide GLP-1 called Orforglipron enhance affordability. Additionally, the emergence of more effective AOMs set to enter the marketplace within the next few years will improve their affordability and access. Furthermore, while some states have rescinded coverage of GLP-1 medications for the treatment of obesity, the demand for AOMs and potential payment structures lessening variability may improve access organically.

Nonetheless, the Council recognizes the importance of more immediate coverage and the potential value of the market strategies and policy reforms outlined in the ICER report. Therefore, the Council recommends several new policies to supplement AOM affordability and access. The Council recommends support for innovative payment arrangements and pilot programs consistent with several recently announced Medicare and Medicaid demonstrations intended to increase the affordability of GLP-1 medications.

It also is becoming more evident that patients with chronic obesity may need to take these medications long-term. As such, the Council supports the long-term coverage of AOMs to maintain weight loss through consistent drug pricing, formulary tiers, and benefit structures. The Council also acknowledges pharmacological treatment may not be effective, in some cases, without concurrent disease management treatment which may not be accessible for all patients. With that in mind, the Council supports equitable access to comprehensive disease management, nutritional therapies, health promotion, and prevention interventions targeting the general population, those who are at elevated risk for obesity, and patients being treated for obesity.

Medication affordability and access continue to be significant concerns for many patients, including those that need AOMs for chronic obesity. As such, the Council recommends reaffirming Policy H-110.987, which supports efforts to ensure drug prices are affordable to patients, and Policy H-110.959, which encourages all payers to establish a reasonable and affordable cap on patient out-of-pocket prescription drug spending in a manner that does not increase patient premiums. The Council also recognizes the contribution of PBMs to high drug costs and their lack of clarity on rebate driven formularies. Therefore, the Council recommends reaffirming Policy D-110.987, which supports efforts to increase PBM transparency and regulation. Additionally, the Council notes that negotiating for Medicare drug prices is crucial to reducing high out-of-pocket costs for seniors and lowering government health care spending. Thus, the Council recommends reaffirming Policy D-330.954, which supports CMS negotiating pharmaceutical pricing for all applicable medications covered by CMS and indicates the AMA's support for federal legislation giving the Secretary of HHS the authority to negotiate contracts with manufacturers of covered Medicare Part D drugs. The Council appreciates the important role of the physician in the treatment of chronic obesity and, as such, recommends reaffirming Policy H-110.997, which supports programs whose purpose is to contain the rising costs of prescription drugs, physicians having the freedom to prescribe the most appropriate drug and method of delivery, and encourages all physicians to become familiar with the price in their community of the medications they prescribe.

Lastly, the Council recognizes the complexity, prevalence, and impact of obesity and, therefore, recommends reaffirming Policy H-150.953, which recognizes obesity as a complex health disorder, urges all payers to ensure coverage parity for evidence-based treatment of obesity, including FDA-approved medications without exclusions or additional carve-outs, and appropriate federal agencies

work with organized medicine to develop coding and payment mechanisms for the evaluation and management of obesity.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Subclauses 1e and 1g of Resolution 230-A-25, and the remainder of the report be filed:

1. That our American Medical Association (AMA) support:
    a. Potential innovative payment arrangements to help individuals afford treatment for emerging anti-obesity medications (AOMs);
    b. Pilot programs which allow for demonstration projects that cover emerging medications which aid in obesity management, such as glucagon-like peptide-1 and glucose-dependent insulinotropic polypeptide-based medications;
    c. The long-term coverage of AOMs to maintain weight loss through consistent drug pricing, formulary tiering, benefit structures, and coverage criteria in private insurance and employer-sponsored insurance to offset cost variability;
    d. Equitable access to comprehensive disease management, nutritional therapies, health promotion, and prevention interventions targeting the general population, those who are at elevated risk for obesity, and patients being treated for obesity. (New HOD Policy)

2. That our AMA reaffirm Policy H-110.987, which supports efforts to ensure drug prices are affordable to patients. (Reaffirm HOD Policy)

3. That our AMA reaffirm Policy D-110.987, which supports efforts to increase PBM transparency and regulation. (Reaffirm HOD Policy)

4. That our AMA reaffirm Policy H-110.959, which supports efforts to ensure patients have affordable access to medications and encourages all payers to establish a reasonable and affordable cap on patient out-of-pocket prescription drug spending in a manner that does not increase patient premiums. (Reaffirm HOD Policy)

5. That our AMA reaffirm Policy H-110.997, which supports programs whose purpose is to contain the rising costs of prescription drugs, that all patients have access to all prescription drugs necessary to treat their illnesses, and physicians have the freedom to prescribe the most appropriate drug and method of delivery. (Reaffirm HOD Policy)

6. That our AMA reaffirm Policy D-330.954, which supports Centers for Medicare & Medicaid Services (CMS) negotiating pharmaceutical pricing for all applicable medications covered by CMS, AMA working toward the elimination Medicare prohibition on drug price negotiation, and indicates the AMA's support for federal legislation giving the Secretary of the Department of Health and Human Services the authority to negotiate contracts with manufacturers of covered Part D drugs. (Reaffirm HOD Policy)

7. That our AMA reaffirm Policy H-150.953, which recognizes obesity as a complex health disorder, urge all payers to ensure coverage parity for evidence-based treatment of obesity, including FDA-approved medications without exclusions or additional carve-outs, and

appropriate federal agencies work with organized medicine to develop coding and payment mechanisms for the evaluation and management of obesity**.** (Reaffirm HOD Policy)

Fiscal Note: Minimal

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Appendix A
GLP-1 Obesity Medications Approved by the FDA

Drug	Effectiveness	FDA Approval Indication	Year Approved
Liraglutide (Saxenda) GLP-1 Receptor Agonist Daily subcutaneous injection	63% lost at least 5% reduction of body weight	Adjunct to a reduced-calorie diet and increased physical activity for chronic weight management in: 1) Adult patients with an initial body mass index (BMI) of •30 kg/m2 or greater (obese), or •27 kg/m2 or greater (overweight) in the presence of at least one weight-related comorbid condition; 2) Pediatric patients aged 12 years and older with body weight above 60 kg and an initial BMI corresponding to 30 kg/m2 for adults (obese) by international cut-offs	2014
Semaglutide (Wegovy) GLP-1 Receptor Agonist Weekly subcutaneous injection	80% lost at least 5% reduction of body weight	GLP-1 receptor agonist indicated in combination with a reduced calorie diet and increased physical activity: •to reduce the risk of major adverse cardiovascular events in adults with established cardiovascular disease and either obesity or overweight • to reduce excess body weight and maintain weight reduction long term in: 1) Adults and pediatric patients aged 12 years and older with obesity; 2) Adults with overweight in the presence of at least one weight-related comorbid condition	2021
Semaglutide (Wegovy) GLP-1 Receptor Agonist Once-daily oral administration	76% lost at least 5% reduction of body weight	GLP-1 receptor agonist indicated in combination with a reduced calorie diet and increased physical activity: • chronic weight management in adults with obesity (BMI ≥ 30) or overweight (BMI ≥ 27) with weight-related conditions; • reduced calorie diet/exercise to lower cardiovascular risk in adults with established heart disease and to treat MASH	2025
Tirzepatide (Zepbound) Combined GLP-1/GIP Receptor Agonist	85% lost at least 5% reduction of body weight	GIP receptor and GLP-1 receptor agonist indicated as an adjunct to a reduced-calorie diet and increased physical activity for chronic weight management in indicated in combination with a reduced-calorie diet and increased physical activity:	2023

Weekly subcutaneous injection		• to reduce excess body weight and maintain weight reduction long term in adults with obesity or adults with overweight in the presence of at least one weight-related comorbid condition. • to treat moderate to severe obstructive sleep apnea (OSA) in adults with obesity.	

Appendix B
Potential Strategies to Guide Market Action: Institute for Clinical and Economic Review (ICER) Report

1) Temporary Coverage Denial: Some purchasers and insurers have concluded that they do not have the budget flexibility to provide coverage for GLP-1s for treatment of obesity at current prices. Some purchasers believe that, within a year or two, providers will be more efficient and effective, more will be known about how to maintain long-term use of all AOMs, and competition may bring lower pricing.
    a. Advantages: For purchasers with high employee turnover and limited resources, this perspective can provide a compelling argument for holding off on providing coverage until the landscape changes. Additionally, individuals may be able and willing to bear the cost of GLP-1 drugs outside of insurance, although much of that access was made possible through far less expensive, and less reliable, compounded versions.
    b. Limitations: Clinical trials have demonstrated relatively rapid reductions in cardiac events among patients with existing cardiac conditions after treatment initiation and, therefore, temporary non-coverage may be untenable for those with serious medical conditions. Additionally, the broader societal goal of reducing disparities in access to effective treatments for obesity across socioeconomic and racial categories may make temporary non-coverage insupportable. Furthermore, there is an equity concern about requiring people with one medical condition to bear the financial burden alone when most costs of other conditions are covered by insurance.
2) Enhanced Prior Authorization and Formulary Management: For those seeking a more affordable and long-term way to provide coverage for expensive drugs, such as GLP-1s, purchasers and insurers may apply enhanced utilization and could include coverage criteria. Some coverage criteria included BMI and clinical comorbidities, additional clinical or genetic factors, and/or duration of coverage. Two additional formulary management options were suggested: covering only a single GLP-1 drug; or step therapy through earlier AOMs.
    a. Advantages: Using more restrictive BMI and comorbidity thresholds for coverage can be seen as a principled, evidence-based approach to targeting coverage to those individuals at highest risk for short-term adverse events and who therefore stand to benefit most from treatment.
    b. Limitations: Coverage criteria narrower than the FDA label language can be criticized by clinicians and patients as being inappropriately restrictive. For example, BMI, the main patient characteristic being used for limiting coverage eligibility, is an imperfect measure of obesity-related health risks. Additionally, data from clinical trials suggest that patients stopping GLP-1 treatment often regain much or all the weight lost. Furthermore, some patients who merit treatment will face delays or other barriers to effective care.
3) Network Management: Managing the network of clinical providers may improve results while controlling costs. Some options include - open prescribing with attendant tighter utilization management could allow all primary care providers to prescribe GLP-1 drugs as part of their practice, limiting prescribing by a curated expert network with lighter or no utilization management, or carve-out clinical care and prescribing to external weight loss management firms.
    a. Advantages: Open prescribing maximizes access to the most effective obesity treatment, thereby reducing disparities in access across socioeconomic, racial, and other categories. In addition, integrating GLP-1 prescribing into primary care helps keep medication use coordinated across other clinical conditions, such as diabetes and

hypertension. Limited prescribing has the opposite advantages of an open prescribing model. Setting up a "Centers of Excellence" approach to obesity medication prescribing maximizes the likelihood of appropriate comprehensive care for patients with obesity, including the use of GLP-1 drugs.

   b. Limitations: The drawbacks of open prescribing begin with the likelihood that a certain proportion of GLP-1 drugs will be prescribed for patients who could do well with other, less expensive AOMs. Combining open prescribing with tight utilization management criteria is one way to try to provide wide access without producing high rates of inappropriate use. Negatives to limited prescribing are that there are nowhere near enough obesity specialists to manage the number of people seeking GLP-1 treatment and long waiting lists would result.

4) Innovative Payment Arrangements: While some purchasers may consider temporary non-coverage of GLP-1 drugs, another solution may be to utilize alternative payment arrangements to help individuals afford treatment. For instance, performance agreements by linking rebates to a weight goal, to a particular percentage weight loss target, or to adherence to treatment are an option. Other options include volume-based rebates and subscription models.
   a. Advantages: Performance agreements sometimes include aligned patient incentives to maintain adherence or to achieve clinical goals. Additionally, subscription models guarantee financial certainty for purchasers but also guarantee recurring revenue for manufacturers.
   b. Limitations: There are many reasons that patients might not reach their goal, whether from lack of drug availability, ineffectiveness of the drug, side effects, or financial barriers. Furthermore, some performance agreements have little study on their efficacy.
5) Carve Out Programs: Many purchasers or payers are delegating obesity management to a comprehensive program offered by a PBM or to an independent obesity management company. The common features of these programs are a national network of clinical experts who engage with patients virtually, clinical algorithms that help identify patients for whom less expensive treatment options are appropriate, an integration of interventions on diet and activity as part of lifestyle management, and a per member per month payment model, often with guarantees on adherence to medication use and overall cost reductions.
   a. Advantages: Carve-out companies can bring not only clinical expertise but a more comprehensive approach to ensuring that all patients receive individualized care, including appropriate lifestyle management interventions
   b. Limitations: One challenge is the distribution of rebate dollars - rebates from GLP-1 manufacturers in many cases go directly to the carve-out program and not to the purchaser. Additionally, carving out obesity care runs the risk of creating a lack of coordination with the care for other conditions. Lastly, obesity carve-out companies have been using compounded versions of GLP-1 drugs as another way to achieve lower overall costs of care.

Council on Medical Service Report 7-A-26
Private Insurance Coverage of Anti-Obesity Medications
Policy Appendix

Advocacy Against Obesity-Related Bias by Insurance Providers H-440.801

1. Our American Medical Association will urge individual state delegations to directly advocate for their state insurance agencies and insurance providers in their jurisdiction to:
    a. Revise their policies to ensure that bariatric surgery are covered for patients who meet the appropriate medical criteria.
    b. Eliminate criteria that place unnecessary time-based mandates that are not clinically supported nor directed by the patient's medical provider.
    c. Ensure that insurance policies in their states do not discriminate against potential metabolic surgery patients based on age, gender, race, ethnicity, socioeconomic status.
    d. Advocate for the cost-effectiveness of all obesity treatment modalities in reducing healthcare costs and improving patient outcomes.
    e. Reduce the prior authorization burden for the coverage of anti-obesity medications, to include not requiring a new prior authorization for every dose change.
    f. Allow a patient's physician to prescribe anti-obesity medication and have it covered by insurance, without a requirement that patients must receive the prescription only from contracted disease management companies.
2. Our AMA will support and provide resources to state delegations in their efforts to advocate for the reduction of bias against patients that suffer from obesity for the actions listed.

(Res. 224, A-23; Appended: Res. 230, A-25)

Obesity as a Major Public Health Problem H-150.953

1. Our American Medical Association will urge physicians as well as managed care organizations and other third party payers to recognize obesity as a complex disorder involving appetite regulation and energy metabolism that is associated with a variety of comorbid conditions.
2. Our AMA will work with appropriate federal agencies, medical specialty societies, and public health organizations to educate physicians about the prevention and management of overweight and obesity in children and adults, including education in basic principles and practices of physical activity and nutrition counseling; such training should be included in undergraduate and graduate medical education and through accredited continuing medical education programs.
3. Our AMA will urge federal support of research to determine:
    a. the causes and mechanisms of overweight and obesity, including biological, social, and epidemiological influences on weight gain, weight loss, and weight maintenance;
    b. the long-term safety and efficacy of voluntary weight maintenance and weight loss practices and therapies, including surgery;
    c. effective interventions to prevent obesity in children and adults; and
    d. the effectiveness of weight loss counseling by physicians.
4. Our AMA will encourage national efforts to educate the public about the health risks of being overweight and obese and provide information about how to achieve and maintain a preferred healthy weight.
5. Our AMA will urge physicians to assess their patients for overweight and obesity during routine medical examinations and discuss with at-risk patients the health consequences of further weight gain; if treatment is indicated, physicians should encourage and facilitate weight maintenance or reduction efforts in their patients or refer them to a physician with special interest and expertise in the clinical management of obesity.

6. Our AMA will urge all physicians and patients to maintain a desired weight and prevent inappropriate weight gain.
7. Our AMA will encourage physicians to become knowledgeable of community resources and referral services that can assist with the management of overweight and obese patients.
8. Our AMA will urge the appropriate federal agencies to work with organized medicine and the health insurance industry to develop coding and payment mechanisms for the evaluation and management of obesity.
9. Our AMA will urge all payers to ensure coverage parity for evidence-based treatment of obesity, including FDA-approved medications without exclusions or additional carve-outs.

(CSA Rep. 6, A-99; Reaffirmation A-09; Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmation A-10; Reaffirmation I-10; Reaffirmation A-12; Reaffirmed in lieu of Res. 434, A-12; Reaffirmation A-13; Reaffirmed: CSAPH Rep. 3, A-13; Reaffirmation: A-19; Appended: Res. 806, I-23)

Prescription Medication Price Negotiation H-110.959

1. Our AMA supports efforts to ensure that patients have affordable access to medications.
2. Our AMA encourages all payers, both public and private, in efforts to establish a reasonable and affordable cap on patient out-of-pocket prescription drug spending in a manner that does not increase patient premiums.
3. Our AMA opposes drug payment methodologies that result in physician practices being paid at less than the cost of acquisition, inventory, storage, and administration of relevant drugs and other necessary related clinical services.

(CMS Rep. 06, A-25; Reaffirmed: CMS Rep. 04, I-25)

Cost of Prescription Drugs H-110.997

1. Our American Medical Association 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.
2. Our AMA reaffirms the freedom of physicians to use either generic or brand name pharmaceuticals in prescribing drugs for their patients and encourages physicians to supplement medical judgments with cost considerations in making these choices.
3. Our AMA encourages physicians to stay informed about the availability and therapeutic efficacy of generic drugs and will assist physicians in this regard by regularly publishing a summary list of the patient expiration dates of widely used brand name (innovator) drugs and a list of the availability of generic drug products.
4. Our AMA encourages expanded third party coverage of prescription pharmaceuticals as cost effective and necessary medical therapies.
5. Our AMA will monitor the ongoing study by Tufts University of the cost of drug development and its relationship to drug pricing as well as other major research efforts in this area and keep the AMA House of Delegates informed about the findings of these studies.

6. Our AMA encourages physicians to consider prescribing the least expensive drug product (brand name or FDA A-rated generic).
7. Our AMA encourages all physicians to become familiar with the price in their community of the medications they prescribe and to consider this along with the therapeutic benefits of the medications they select for their patients.

(BOT Rep. O, A-90; Sub. Res. 126 and Sub. Res. 503, A-95; Reaffirmed: Res. 502, A-98; Reaffirmed: Res. 520, A-99; Reaffirmed: CMS Rep. 9, I-99; Reaffirmed: CMS Rep.3, I-00; Reaffirmed: Res. 707, I-02; Reaffirmation A-04; Reaffirmed: CMS Rep. 3, I-04; Reaffirmation A-06; Reaffirmed in lieu of Res. 814, I-09; Reaffirmed in lieu of Res. 201, I-11; Reaffirmed in lieu of: Res. 207, A-17; Reaffirmed: BOT Rep. 14, A-18; Reaffirmed: CMS Rep. 04, I-24)

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% or more each year or per course of treatment and provide justification for the price increase;
    b. legislation that authorizes the Attorney General and/or the Federal Trade Commission to take legal action to address price gouging by pharmaceutical manufacturers and increase access to affordable drugs for patients; and
    c. the expedited review of generic drug applications and prioritizing review of such applications when there is a drug shortage, no available comparable generic drug, or a price increase of 10% or more each year or per course of treatment.
11. Our AMA advocates for policies that prohibit price gouging on prescription medications when there are no justifiable factors or data to support the price increase.

12. Our AMA will provide assistance upon request to state medical associations in support of state legislative and regulatory efforts addressing drug price and cost transparency.
13. Our AMA supports legislation to shorten the exclusivity period for FDA pharmaceutical products where manufacturers engage in anti-competitive behaviors or unwarranted price escalations.
14. Our AMA supports legislation that limits Medicare annual drug price increases to the rate of inflation.

(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)

The Impact of Pharmacy Benefit Managers on Patients and Physicians D-110.987

1. Our AMA supports the active regulation of pharmacy benefit managers (PBMs) under state departments of insurance.
2. Our AMA will develop model state legislation addressing the state regulation of PBMs, which shall include provisions to maximize the number of PBMs under state regulatory oversight.
3. Our AMA supports requiring the application of manufacturer rebates and pharmacy price concessions, including direct and indirect remuneration (DIR) fees, to drug prices at the point-of-sale.
4. Our AMA supports efforts to ensure that PBMs are subject to state and federal laws that prevent discrimination against patients, including those related to discriminatory benefit design and mental health and substance use disorder parity.
5. Our AMA supports improved transparency of PBM operations, including disclosing:
- Utilization information;
- Rebate and discount information;
- Financial incentive information;
- Pharmacy and therapeutics (P&T) committee information, including records describing why a medication is chosen for or removed in the P&T committee's formulary, whether P&T committee members have a financial or other conflict of interest, and decisions related to tiering, prior authorization and step therapy;
- Formulary information, specifically information as to whether certain drugs are preferred over others and patient cost-sharing responsibilities, made available to patients and to prescribers at the point-of-care in electronic health records;
- Methodology and sources utilized to determine drug classification and multiple source generic pricing; and
- Percentage of sole source contracts awarded annually.
6. Our AMA encourages increased transparency in how DIR fees are determined and calculated.

(CMS Rep. 05, A-19; Reaffirmed: CMS Rep. 6, I-20; Reaffirmed: CSAPH Rep. 02, I-24; Reaffirmed: CMS Rep. 06, A-25; Reaffirmed: CMS Rep. 04, I-25)

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)