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VIA ELECTRONIC SUBMISSION

The Honorable C.T. Wilson
Chair, House Economic Matters Committee
230 Taylor House Office Building
Annapolis, Maryland 21401

Re.: Opposition to Senate Bill 306 - Unfavorable

Dear Chair Wilson:

My name is Brennan McCarthy, and I have been an attorney in Maryland since 1999. I am also barred in the United States District Court for the District of Maryland, the United States District Court for the District of Columbia, the United States Tax Court, the United States Court of Appeals for the District of Columbia Circuit, the United States Court of Appeals for the Fourth Circuit and the Supreme Court of the United States. In my career as an attorney, I have tried hundreds of cases in all areas of law, including family law, criminal defense and business torts. Since 2013, I have represented pharmacies before the Maryland Workers' Compensation Committee ("WCC") for reimbursements. I initially represented Injured Workers' Pharmacy ("IWP"), and I currently represent EZ Scripts and RescueMeds.

These hearings before the WCC have taken a familiar tone. My clients are reimbursed based on a "contract" rate with these carriers, yet do not have any such contract. The pharmacies bring issues before the WCC, and at hearing the carriers provide various hypothetical reimbursement models including GoodRX, a coupon service that reflects co-pays, National Drug Acquisition Cost ("NADAC"), an ingredient-based model for the cost of drugs, and CostPlus, a drug manufacturer based in Dallas, TX that ships low-cost generic drugs and operates currently at a steep loss. None of these are the basis of the short pays rendered by these carriers to my clients, and none of these models reflect a typical reimbursement rate to a pharmacy. As an example, GoodRX prices reflect the amount the individual pays as a co-pay to a retail pharmacy, but on the "back end" of this transaction is a PBM payment to the pharmacy, with GoodRX taking a service fee for the transaction. My clients are not retail pharmacies.

In preparing for this area of practice, I have studied various reimbursement models for pharmacies in the injured workers space, and have represented my clients in thousands of claims

against Chesapeake Workers' Insurance/IWIF, and to a lesser extent the City of Baltimore. These three (3) entities are the sole insurance providers that contest reimbursement rates. An occasional case will arise when the other 80 carriers in the State may contest a prescription, but this is usually based on an argument that the drugs shipped are unnecessary, not within the ambit of the injured worker's award, etc. Further, all but these three (3) insurance carriers primarily reimburse my client at Average Wholesale Price ("AWP") as set forth in Medispan and Red Book and often at plus 20%. It is important to note that the objection to pricing comes solely from Chesapeake/IWIF and the City of Baltimore in almost all cases. Further, the vast majority of prescriptions paid by these entities through their Pharmacy Benefit Managers ("PBM's") for pharmaceuticals is to in-network pharmacies at a contract rate, with the carriers paying the PBM at their own rate (usually AWP - .19%), with the PBM keeping the "spread." Thus, payment is through a third party PBM, and the difference between what is paid by the PBM and the reimbursement from the insurance carrier for that drug to that PBM is the PBM's profit.

I have also noted that my clients provide a unique and beneficial service for injured workers in the State of Maryland. Their model is based on the receipt of a prescription from a doctor, and the shipping of that prescription directly to the patient. My clients then seek reimbursement from the insurance carrier as an out-of-network provider. This doctor to patient model stands in direct contrast to the model employed by insurance carriers, which involves provision of prescriptions by a doctor to the carrier, a review of the pharmaceuticals prescribed by the carrier and/or the PBM, and approval or disapproval of the prescription upon review. This costs crucial time for any patient who should be receiving their medications, and places the injured worker's health in limbo while their medications are subjected to this review process. While this assures a maximizing of profits for the carrier, the needs and health of the patient are more often than not held hostage to the process itself. No patient's health should be placed on hold and at risk for a review process by an insurance carrier.

I have reviewed State Senate Bill 306, and its proposal to set the price for reimbursement at acquisition cost of a drug plus an undefined dispensing fee. I note that SB 306 overtly targets solely independent pharmacies with the language "[n]ot later than September 1, 2026, the Commission shall regulate fees and others charges for the reimbursement of prescription drugs and pharmaceutical services under this subtitle provided by a person who holds a pharmacy permit under Title 12, Subtitle 4 of the Health Occupations Article." SB 306 sets that rate as follows:

> "[r]eimbursement under subparagraph (I) of this paragraph shall; be limited to an index or indexes based on acquisition cost, calculated on a per unit basis, as of the date of dispensing and may include:..reasonable dispensing fee, and…any other percentage increase or decrease determined by the Commission.

The law's true beneficiaries are then carved out of this radical proposal when SB 306 states:

> "[t]his paragraph does not prohibit an insurance carrier or employer from contracting with a pharmacy benefits manager, a network of pharmacies, or dispensing provider:…for reimbursement rates different than those established by the Commission; or…to use pricing index or indexes different than those selected by the Commission."

In plain meaning, this limits the application of this particular statute to small, independent pharmacies that hold a pharmacy license in this State and who are not PBM's or part of a "network or a dispensing provider." I have quite honestly never seen a bill more inartfully crafted to benefit large businesses while solely applying to small businesses. Indeed, on its face SB 306 smacks of overt favoritism, and unequal treatment in favor of entities that already enjoy a massive competitive advantage in the marketplace.

And this is a crucial point to consider. In its excellent Report titled *Pharmacy Benefit Managers: The Powerful Middlemen Inflating Drug Costs and Squeezing Main Street Pharmacies*, July, 2024[1], the FTC set forth the finding that "[d]ue to decades of mergers and acquisitions, **the three largest PBMs now manage nearly 80 percent of all prescriptions filled in the United States**." [Emphasis added]. Correspondingly, the FTC noted:

> PBMs also exert substantial influence over independent pharmacies, who struggle to navigate contractual terms imposed by PBMs that they find confusing, unfair, arbitrary, and harmful to their businesses. Between 2013 and 2022, about ten percent of independent retail pharmacies in rural America closed. Closures of local pharmacies affect not only small business owners and their employees, but also their patients. In some rural and medically underserved areas, local community pharmacies are the main healthcare option for Americans, who depend on them to get a flu shot, an EpiPen, or other lifesaving medicines.

In order to understand just how concentrated prescription fulfillment has become, the FTC Report goes to state:

> Over the past two decades, the PBM industry has undergone substantial change as a result of horizontal consolidation and vertical integration. The top three PBMs processed nearly 80 percent of the approximately 6.6 billion prescriptions dispensed by U.S. pharmacies in 2023, while the top six PBMs processed more than 90 percent.

[1] https://www.ftc.gov/system/files/ftc_gov/pdf/pharmacy-benefit-managers-staff-report.pdf

Thus, SB 306 does absolutely nothing in terms of cost savings for the reimbursement of medicines in the injured workers' marketplace, as it exempts more than 90% of the drugs shipped. It applies solely to three mail order pharmacies that provide prescriptions to injured workers and any other independent pharmacy in the community that make up less than 10% of that market.

Instead, the effect of SB 306 being passed is to take an already concentrated marketplace, and to eliminate the sole competitors that these PBM's and their insurance company clients do not control. Nor should the Committee operate under any misguided belief that a PBM bases its reimbursement as a middleman on acquisition cost. As previously stated, the current arrangement between Express Scripts, itself a mail order pharmacy and captive of MyMatrixx, is based on AWP - .19. This common arrangement was also found to exist by the FTC in its report.

I have spoken to my clients, and while they do not oppose a reimbursement fee schedule for pharmaceuticals, the model proposed is self-fulfilling, does not apply equally across the board to all pharmacies and PBM's, and the proposed reimbursement is radically low. Such a low reimbursement rate would adversely affect smaller pharmacies, including my clients, who ship prescriptions to injured workers in the State of Maryland. In other words, and in my opinion, this would drive any pharmacy, and particularly smaller community pharmacies, out of this space and would adversely affect care for any injured worker making claims under the Labor & Employment Article. It is an example where a bad result comes from the best of intentions. Moreover, this would artificially place the patient in a market with fewer options, as smaller independent pharmacies would simply refuse to fill prescriptions to injured workers, and the entire control of their care would lie on the hands of the carrier. While the patient can certainly file "issues" before the WCC, this takes time while the patient is not receiving pharmaceuticals to ensure they are healed from their injuries. This creates health inequity of the highest order, where the community-based pharmacies are once again driven from the market for the benefit of PBM's and their captive pharmacies who are reimbursed at a higher rate.

The more prudent and equitable solution would be to have the matter of pharmacy reimbursements as a market wide practice considered by the WCC, with all shareholders in the market having an equal voice on the fee guide committee. The previous Committee while quite well represented by Chesapeake Employers' Insurance, the largest injured worker provider in the State, did not have a single pharmacy representative, independent or otherwise, in its ranks. Through an inclusionary process, the unique challenges and reimbursement rates that make sense for all parties, including independent pharmacies, can be considered when the WCC reaches its fee guide for reimbursement rates. Favoritism for none and fairness for all should be the ultimate objective. I note that SB 306 defies that tried-and-true maxim.

I am confident that the WCC can meet its obligations for review through a study that involve bringing together all of the parties and material experts that would be most affected by such a guide, including pharmacies, carriers and PBM's, to identify what a fair fee guide should be moving forward. I would also note that 36 states use AWP plus or minus as their reimbursement model. Yet in the states that I have reviewed, each of these formulas were reached following a robust debate and study process, which included pharmacies who are uniquely positioned to address the particular challenges in their industry. Moreover, I have serious issues with this law in the first place, when from my experience and training a regulation would be more advisable.

In conclusion:

1. The current SB 306 overtly favors PBM's and insurance carriers at the expense of independent pharmacies that are not members of their network;

2. SB 306 fails to address pharmaceutical costs in any meaningful way as it avoids by its very terms addressing more than 90% of the pharmaceuticals shipped to patients;

3. SB 306 if passed would create a *de facto* direction of care model, driving independent pharmacies from the marketplace and leaving patients to fend against insurance carriers and their PBM's review process before gaining "permission" to receive their medications;

4. SB 306 would result in health inequity, driving independent pharmacies, including those targeted by SB 306, from the marketplace that is already stacked heavily towards the entities favored by SB 306.

Thank you for your kindly consideration.

Respectfully,

/s/ Brennan C. McCarthy

Brennan C. McCarthy

BCM