MD SB 306 (2025) - MyMatrixx Comments to House Eco

Uploaded by: Adam Fowler

Position: FAV

MyMatrixx
By EVERNORTH

Maryland House Economic Matters Committee

March 24, 2025

Re: MyMatrixx Comments on Senate Bill 306

MyMatrixx, an Evernorth Company, appreciates the opportunity to submit comments to the House Economic Matters Committee on Senate Bill 306. By way of background, MyMatrixx is one of the largest workers' compensation pharmacy benefit management (PBM) companies in the country, providing PBM services to thousands of client groups, including workers' compensation insurance carriers, employers, third-party administrators, and public sector payers. We take a strategic approach to workers' compensation, structuring customized client solutions around best-in-class core services, supported by advanced trend-management and clinical-review programs, to ensure safety for injured workers, while aggressively controlling costs.

Support

MyMatrixx supports SB 306 as it would establish a needed uniform fee schedule for reimbursement of pharmaceuticals in the Maryland workers' compensation system. While contracting with networks of pharmacies through PBMs is one of the most effective ways of controlling costs for medications in the system and most transactions flow through a network today, not all providers accept contracted rates. These non-contracted "out of network" instances are where state fee schedules can assist to place a ceiling on pharmaceutical costs to ensure they are reasonable.

Under the current state workers' compensation reimbursement structure, there is no uniform fee schedule. Existing Code of Maryland Regulations 14.09.08.04, instead, permits individual insurers to base their reimbursement for dispensed medications to pharmacies and dispensing physicians on "nationally recognized and published relative value studies, or on the values assigned for services involving similar work and resources." The reimbursement value chosen by that individual insurer is then subject to review by the Workers' Compensation Commission and has led to many disputes between parties. This contrasts with most other states' workers' compensation systems, which establish fee schedules for dispensed pharmaceuticals, thereby reducing disputes, adding more certainty to providers and payers, and ensuring injured worker access to needed medications for their workplace injury. SB 306 would resolve this issue by requiring such a fee schedule.

We also support amendments made to the bill in the Senate that allow the Commission to include in the fee schedule any percentage increase or decrease it determines and clarify the bill would not prohibit parties from agreeing to rates other than the fee schedule or from agreeing to use other pricing indexes. We believe these provisions will provide flexibility to the Commission and stakeholders to adjust to market realities and further address cost concerns.

Ensure Coverage

In addition to our support for establishing a pharmaceutical fee schedule, we also encourage legislators and the Workers' Compensation Commission to ensure that all dispensed medications are covered under the fee schedule. By this, we mean all national drug codes (NDCs) for both prescription and non-prescription medications and all providers that may dispense those NDCs.

Though subject to subsequent Commission determination, it is our understanding that the chief "index" based on acquisition cost available to adopt by the Commission would likely be the National Average Drug Acquisition Cost (NADAC). As you may be aware, NADAC is the result of a survey process the federal Centers for Medicare and Medicaid Services (CMS) uses to estimate pharmacy pricing for drugs acquired by retail pharmacies that state Medicaid programs can utilize to set reimbursement rates to pharmacies. Given the voluntary survey nature of this index and its connection specifically with Medicaid, it does not cover all medications dispensed within the workers' compensation system. This gap, the percentage of transactions without a NADAC, can be as high as 15 percent based on prior data we gathered, with the collective dollar cost of those medications representing an even higher percentage of total medication costs (some more expensive drugs dispensed in the workers' compensation system may not have a NADAC).

Wholesale Acquisition Cost (WAC) may also fit within the bill's "acquisition cost" framework. WAC is generally a more comprehensive published index that could be used to account for many of the NADAC gaps. However, though rarer, there are some medications which also do not have a WAC.

Given these gaps, we support the ability of the Commission to adopt secondary or tertiary published reimbursement indexes to avoid potential loopholes. Practically, that may need to include other published indexes available in the industry that are not necessarily tied to an "acquisition cost." The most important aspects of this would be that any such 'backup' index is published, available to stakeholders to use, and updated frequently to account for market realities. Granting the Commission the authority to do adopt such backup sources will ensure all medications have a fee schedule rate tied to them and avoid the current subjective system of disputes and uncertainty. In lieu of that, the Commission should still be granted authority to cap reimbursement for these gap medications, even if not tied to an acquisition cost index.

Additionally in terms of coverage, we support applying this fee schedule to all dispensing providers – including physicians who may dispense medications to their injured patients. Physician dispensing has continued to be a notable concern in many states for workers' compensation for several years. A 2024 Workers' Compensation Research Institute report showed that physician-dispensed medications accounted for over half

of total medication payments in the Maryland worker's compensation system.[1] We believe the practice of physician dispensing bypasses the benefits of a PBM and ignores critical patient safety alerts that are typically identified and communicated to retail pharmacies before medications are dispensed. We believe it important to hold dispensing physicians to the same standards as dispensing pharmacists, including reimbursement.

SB 306 in its introduced form would have applied to all "prescription drugs and pharmaceutical services," including dispensing physicians; however, subsequent amendments to the bill in the Senate limit application of the fee schedule to licensed pharmacies. We believe the fee schedule should also apply to dispensing physicians to avoid creating a loophole for those providers to inflate medication costs for the state's employers. The amended bill also now requires a study of workers' compensation prescription drug affordability challenges, which we hope will shed more light on costs associated with physician dispensing.

Collaboration
MyMatrixx remains committed and willing to collaborate with the committee and the Workers' Compensation Commission to ensure that any changes made enable us to process the required medications at the appropriate costs without negative impacts to our payer clients and the injured workers we serve. Thank you for your consideration of our comments. If you have questions regarding our comments, please contact me for further discussion.

Sincerely,

Adam Fowler
Director, Workers' Compensation Regulatory Affairs
MyMatrixx by Evernorth
MyMatrixx.com
Adam.Fowler@MyMatrixx.com

[1] WCRI: "Interstate Variations and Trends in Workers' Compensation Drug Payments, 5th Edition" (June 2024)

SB306_SUPPORT_Balt Co.pdf
Uploaded by: Amanda Kontz Carr
Position: FAV

KATHY KLAUSMEIER
County Executive

PAT RODDY
Director of Government Affairs

BILL NO: SB 306

TITLE: Worker's Compensation – Prescription Drug and Pharmaceutical Services – Reimbursements

SPONSOR: Senator Beidle

COMMITTEE: Economic Matters

POSITION: **SUPPORT**

DATE: March 26, 2025

Baltimore County **SUPPORTS** Senate Bill 306 – Worker's Compensation – Prescription Drug and Pharmaceutical Services – Reimbursements. The legislation requires the State Workers' Compensation Commission to regulate the reimbursement charges for prescription drugs and pharmaceutical services by establishing a cost index.

While medical bills are currently regulated by a fee schedule for worker's compensation, no such framework currently exists for prescription drugs. Workers' compensation claims remain a significant cost driver for Baltimore County government, and the absence of an established fee schedule or guide for prescription drug charges results in higher costs to the county and higher insurance premiums for our employees.

Maryland county governments are already facing unprecedented challenges, including federal and state budget cuts, declining revenues, and dramatically increased costs. SB 306 is a reasonable and meaningful proposal that if enacted will benefit Baltimore County by curbing excessive costs and aligning prescription drug pricing with industry standards.

Accordingly, Baltimore County urges a **FAVORABLE** report on SB 306 from the Economic Matters Committee. For more information, please contact Amanda Carr, Office of Government Affairs at acarr@baltimorecountymd.gov

SB 306 - MML - FAV 1.pdf
Uploaded by: Bill Jorch
Position: FAV

Maryland Municipal League
The Association of Maryland's Cities and Towns

TESTIMONY

March 26, 2025

Committee: House Economic Matters Committee

Bill: SB 306 - Workers' Compensation - Prescription Drug and Pharmaceutical Services - Reimbursements

Position: Favorable

Reason for Position:

The Maryland Municipal League (MML) supports Senate Bill 306. The bill requires the Workers Compensation Commission (WCC) to regulate fees based on a certain index or indices, with some discretion, and establishes a study to research prescription drug affordability challenges related to workers compensation claims.

Today, the WCC has no fee guide for pharmaceutical services which has led to municipal governments and insurers being overcharged through artificially inflated acquisition costs. Currently, about 125 municipal governments use Chesapeake Employers Insurance Company for workers compensation coverage. According to numbers from Chesapeake, SB 306 would save local governments millions of dollars by using existing indices as pricing guides, while still allowing the WCC some flexibility on altering the reimbursement rates. The legislation is carefully crafted so that reimbursement rates would likely not be so low that certain drugs would cease to be offered in the marketplace.

Additionally, it is important to note that municipal governments tend to offer excellent benefits, including health care, to the more than 23.000 municipal employees. In the rare instance when an employee's claim is denied, they still have the recourse to use their employer-sponsored health care coverage to acquire the same prescription at a subsidized rate.

For these reasons, the Maryland Municipal League respectfully requests a favorable report on Senate Bill 306. For more information, please contact Bill Jorch, Director, Public Policy and Research at billj@mdmunicipal.org. Thank you in advance for your consideration.

SB0306 - House_FAV_MedChi_Workers' Comp - Prescrip

Uploaded by: Danna Kauffman

Position: FAV

MedChi

The Maryland State Medical Society

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www.medchi.org

House Economic Matters Committee
March 26, 2025
Senate Bill 306 – *Workers' Compensation – Prescription Drug and Pharmaceutical Services – Reimbursements*
POSITION: SUPPORT

The Maryland State Medical Society (MedChi), the largest physician organization in Maryland, supports Senate Bill 306. As amended by the Senate, this bill requires the Workers' Compensation Commission (WCC) to regulate all fees and other charges for the reimbursement of prescription drugs and pharmaceutical services provided by pharmacies through the workers' compensation system. The bill also requires the Prescription Drug Advisory Board to conduct a study on prescription drug affordability challenges related to workers' compensation claims that includes: (i) an overview of prescription drug prescribing and billing practices and trends that are specialized to the workers' compensation market; (ii) research into specific prescribing, billing, and dispensing practices.

MedChi appreciates the acknowledgment that physicians who dispense medications should not be treated the same as pharmacies. Physicians who dispense medications are not regulated by the Maryland Board of Pharmacy but by the Maryland Board of Physicians under distinct rules. There are only approximately 600 dispensing physicians in Maryland who work in private practices and urgent care centers, and not all treat injured workers through the workers' compensation system. Physicians who dispense medications often treat patients with acute conditions who receive them during their medical appointments. To continue to receive medications, the patient must return to the physician's office, ensuring that the patient is adhering to the medication regime, which results in better outcomes. Physicians do not have the equivalent purchasing power as pharmacies and should not be treated as such. For these reasons, we appreciate the change in Senate Bill 306 and support the study.

For more information, call:
Danna L. Kauffman
J. Steven Wise
Andrew G. Vetter
Christine K. Krone
410-244-7000

Anne Arundel County _FAV_SB306_ECM.pdf
Uploaded by: Ethan Hunt
Position: FAV

ANNE ARUNDEL COUNTY
MARYLAND
County Executive Steuart Pittman

March 26, 2025

Senate Bill 306
Workers' Compensation - Prescription Drug and Pharmaceutical Services - Reimbursements
House Economic Matters Committee

Position: FAVORABLE

Anne Arundel County **SUPPORTS** Senate Bill 306 – Workers' Compensation – Prescription Drug and Pharmaceutical Services – Reimbursements. This Bill requires the State Workers' Compensation Commission to regulate the reimbursement charges for prescription drugs and pharmaceutical services by establishing a cost index.

Unlike medical bills, there is currently no established fee schedule or guide for prescription drug charges for workers' compensation. As a result, vendors can charge the county whatever amount they want. Often, there can be significant discrepancies between the amount a vendor charges for a prescription and the reasonable price of that prescription. It is no longer surprising to see vendors charge for every bill at least five to ten times the upper range that a Maryland resident would typically pay when walking in without a prescription card or plan. When these disagreements occur, the county is obligated to negotiate a more reasonable price in order to ensure that our public funds are used efficiently.

In order to combat these price discrepancies, Anne Arundel County secured a prescription review vendor. The vendor reviews all of our prescriptions and reduces the charges based on what is usual, customary, and reasonable from a price standpoint and based on the diagnosed injury. This model has been very successful and, as a result, the County has avoided paying inflated charges.

Although Anne Arundel County has had some success with our prescription review process, exorbitant prescription charges are still a common and serious issue. Counties should not have to significantly overpay for workers' compensation-related prescription drug reimbursements. Creating a cost index calculated based on per unit acquisition cost and accounting for the dispensing fee will establish a uniform, predictable, and reasonable cost for each prescription.

This Bill will disincentivize vendors from overbilling, help county departments pay what is customary and reasonable for prescription drugs and services, and save taxpayer money. Accordingly, Anne Arundel County respectfully requests a **FAVORABLE** report on Senate Bill 306.

Steuart Pittman
County Executive

Ethan Hunt, Director of Government Affairs Phone: 410-222-3687 Email:exhunt23@aacounty.org

SB 306_Workers' Compensation - Prescription Drug a
Uploaded by: Hannah Allen
Position: FAV

MARYLAND
Chamber of Commerce

LEGISLATIVE POSITION:
Favorable
Senate Bill 306 - Workers' Compensation - Prescription Drug and Pharmaceutical Services - Reimbursements
House Economic Matters Committee
Wednesday, March 26, 2025

Dear Chair Wilson and Members of the Committee:

Founded in 1968, the Maryland Chamber of Commerce is the leading voice for business in Maryland. We are a statewide coalition of more than 7,000 members and federated partners working to develop and promote strong public policy that ensures sustained economic health and growth for Maryland businesses, employees, and families.

Senate Bill 306 (SB 306) requires the Workers' Compensation Commission (WCC) to establish a medical fee guide for prescription drug reimbursements under the state workers' compensation system.

Maryland's workers' compensation system lacks a standardized fee guide for prescription medications, leading to cost disparities and inefficiencies. While medical services in workers' compensation claims are already subject to a regulated fee schedule, prescription drug costs are not, resulting in inconsistent pricing and unnecessary litigation.

Currently, many prescriptions are reimbursed based on the Average Wholesale Price (AWP) plus additional fees, which inflates costs well beyond the actual acquisition price. For example, a 30-day supply of Duloxetine is often priced at over $700 under the AWP model, while the acquisition-cost-based price is around $39. This disparity places unnecessary financial burdens on employers, who fund workers' compensation claims, and leads to costly litigation to dispute excessive charges, further delaying claims resolution.

By having a defined reimbursement structure and requiring prescription reimbursements to be based on acquisition cost, SB 306 will create a fair, uniform, and predictable payment system that reduces claims costs without impacting injured workers' access to necessary medications.

For these reasons, the Maryland Chamber of Commerce respectfully requests a **favorable report** on **SB 306**.

SB 306 FAV FCG OCE LS25.pdf
Uploaded by: Jessica Fitzwater
Position: FAV

Jessica Fitzwater
County Executive

FREDERICK COUNTY GOVERNMENT

OFFICE OF THE COUNTY EXECUTIVE

SB 306 – Workers' Compensation - Prescription Drug and Pharmaceutical Services - Reimbursements

DATE:	March 26, 2025
COMMITTEE:	House Economic Matters Committee
POSITION:	Favorable
FROM:	The Office of Frederick County Executive Jessica Fitzwater

As the County Executive of Frederick County, I urge the committee to give **SB 306 – Workers' Compensation - Prescription Drug and Pharmaceutical Services – Reimbursements** a favorable report. This bill would require the State Workers' Compensation Commission to regulate fees for prescription drug and other pharmaceutical services reimbursements.

As we work across the State to cut costs at the State and Local levels, examining unfair pricing practices is an important place to start. Currently, there is no established fee schedule or guide for prescription drug and pharmaceutical services charges for workers' compensation. This is misaligned with medical workers' compensation, which has a guide for pricing to ensure counties are charged fairly. Without a framework or guide, counties can currently be charged rates that are much higher than what may be charged for those without insurance for prescription drugs and pharmaceutical services.

SB 306 takes an important step in addressing these discrepancies by directing the Workers' Compensation Commission to regulate fees for prescription drugs and pharmaceutical services, leading to reduced expenses for county governments. As we face a difficult fiscal climate, it is crucial that we find ways to save counties money while ensuring continuation of services. SB 306 cuts costs while ensuring that those receiving workers' compensation benefits retain the same level of care.

Thank you for your consideration of SB 306. I urge you to advance this bill with a favorable report.

Jessica Fitzwater, County Executive
Frederick County, MD

SB0306-ECM_MACo_SUP.pdf
Uploaded by: Karrington Anderson
Position: FAV

Senate Bill 306

Workers' Compensation - Prescription Drug and Pharmaceutical Services - Reimbursements

MACo Position: **SUPPORT**

To: Economic Matters Committee

Date: March 26, 2025

From: Karrington Anderson

The Maryland Association of Counties (MACo) **SUPPORTS** SB 306 as an essential reform to Maryland's workers' compensation system. This bill would establish a clear and sustainable fee guide for the reimbursement of prescription drugs and pharmaceutical services under the Workers' Compensation Commission.

Currently, the Commission regulates fees for medical services but lacks a similar framework for prescription drugs, dental services, or durable medical equipment. This gap has led to excessive and inconsistent pricing, particularly from out-of-network pharmacies and physician-dispensed medications, with some drugs seeing markups as high as 77%. Workers' compensation claims remain a significant cost driver for counties, and the absence of pricing regulations results in inflated costs that burden local government budgets and increase insurance premiums.

SB 306 seeks to address this issue by directing the Commission to develop a pharmaceutical fee guide based on actual acquisition costs, along with a fixed dispensing fee. This structure would help ensure fair and transparent pricing while promoting financial sustainability within the workers' compensation system. By curbing excessive costs and aligning pricing with industry standards, counties stand to realize substantial savings that can be redirected to other critical public services.

Importantly, this bill will also benefit employees by ensuring timely and consistent access to necessary medications without inflated costs driving unnecessary delays or disputes in care. A well-regulated fee guide will promote fairness, efficiency, and better health outcomes for injured workers relying on the system for recovery.

MACo urges the Committee to issue a **FAVORABLE** report on SB 306 to establish reasonable and predictable pharmaceutical pricing under Maryland's workers' compensation laws.

MD Comments of AAPAN in Support of SB306 (Beidle).
Uploaded by: Lisa Anne Hurt-Forsythe
Position: FAV

AAPAN | AMERICAN ASSOCIATION OF PAYERS, ADMINISTRATORS AND NETWORKS

March 14, 2025

Maryland General Assembly
House Economic Matters Committee
230 Taylor House Office Building
Annapolis, MD 21401

Attn: Delegate C. T. Wilson, Chair and Delegate Brian M. Crosby, Vice Chair

Re: Statement of AAPAN in Support of SB306 (Beidle; Workers' Compensation Fee Schedule) for 3/26/25 Hearing, 1:00pm

Submitted via MyMGA 3/24/25

Thank you for the opportunity to voice our support for SB306 (Beidle), scheduled for hearing in your committee on March 26, 2025. I apologize that I am unable to testify directly before the committee, as I will unfortunately be in flight at the scheduled hearing time, so I thank you in advance for your consideration of our written support.

I am writing on behalf of the American Association of Payers, Administrators and Networks (AAPAN), to represent our members' perspectives on key points addressed in the proposed legislation. AAPAN is the leading national association of preferred provider organizations ("PPO's"), networks, pharmacy benefit managers, payers, and administrators in the workers' compensation sector. Through our members, we help thousands of injured workers access medical and pharmacy services throughout the country, including in Maryland.

AAPAN is committed to promoting public policies and regulations that preserve and strengthen injured workers' access to medical care. We strive to ensure that legislators, regulators and employers understand the valuable role managed medical and pharmacy care plays in enabling access to that care.

We are very appreciative of the efforts Sen. Beidle has made to introduce and advance SB306 to facilitate the delivery of pharmaceuticals to injured workers in Maryland while also being mindful of needed controls to curb escalating costs. SB306 provides a mechanism for the State Workers' Compensation Commission to implement a fee schedule for pharmacy-dispensed medications, tied to an acquisition-based benchmark, and adds an additional provision to

require the Maryland Prescription Drug Affordability Board to conduct a study of prescription drug prescribing and billing practices, as well as overall drug spend trends that are specific to the workers' compensation market. The results of the study will be used to tailor future legislation to target problematic dispensing trends. While we would ideally support having the scope of the Workers' Compensation Commission expanded to set prices for ALL medications dispensed or provided to injured for outpatient use (including compounds, topicals and physician-dispensed medications), we understand that SB306 provides an important first step.

We would also like to express our support for recent amendments to SB306 that allow payers to contract with Workers' Compensation pharmacy benefit managers and/or pharmacy networks for rates that vary from the fee schedule rates established by the Commission. Addition of this provision will ensure that those payers that have already undertaken cost containment measures by way of pharmacy contracting arrangements are able to continue doing so.

Finally, we would respectfully request that one additional provision be added to SB306, to specifically grant authority to the Commission to establish maximum reimbursement rates for medications that do not have an established fee rate in the acquisition-based data set(s). We have noticed in our data analyses that some of the largest cost drivers in the system are medications that do not have established rates.

In summary, we would like to express our overall support for SB306 and to thank Sen. Beidle for her efforts to ensure that medications are provided to Maryland's injured workers while maintaining a conscientious effort to reign in unnecessary costs. We respectfully ask you for your "aye" vote on this important piece of legislation.

We are happy to answer any additional questions that the committee may have. Please feel free to reach out to us as an industry resource representing preferred provider organizations ("PPO's"), networks, pharmacy benefit managers, payers, and administrators in the workers' compensation sector in Maryland.

Sincerely,

Lisa Anne Hurt-Forsythe
Vice President, Government Affairs
American Association of Payers Administrators and Networks (AAPAN)

Cc: Mr. Julian Roberts, CEO, AAPAN

SB 306 in ECM_Chesapeake-IWIF Testimony_Pharmacy F
Uploaded by: Lyndsey Meninger
Position: FAV

House Economic Matters Committee
March 26, 2025

Testimony of Chesapeake Employers' Insurance Company and Injured Workers' Insurance Fund in Support of Senate Bill 306 being heard in the House Economic Matters Committee

Senate Bill 306, being heard in the House Economic Matters Committee, proposes to amend Labor and Employment, § 9-663, mandating the Workers' Compensation Commission to regulate fees and other charges for the reimbursement of prescription drugs and pharmaceutical services. This will be achieved by directing the Commission to utilize cost indexes based on acquisition costs, with a percentage increase or decrease, and establishing dispensing fees within a pharmaceutical fee guide. Additionally, the Bill directs the Maryland Prescription Drug Affordability Board to conduct a study on drug affordability in workers' compensation by March 1, 2026, before the pharmaceutical fee guide that is due no later than September 1, 2026.

For the following reasons, Chesapeake Employers' Insurance Company and the Injured Workers' Insurance Fund support the bill.

At present, the Commission has a medical fee guide for medical services but does not have a fee guide for pharmaceutical services, dental services, or durable medical equipment. Without a fee guide for pharmaceutical services, certain pharmacies have exploited the system, resulting in excessive pricing disparities and rampant overcharging of insurers, counties, municipalities, and the State. The pricing disparities result from certain pharmacies utilizing "Average Wholesale Price (AWP)", usually with a percentage increase, which represents an artificial price set by manufacturers that that does not reflect actual purchasing transactions.

For example, using data from all pharmaceutical paid fills in 2023 and 2024, Chesapeake Employers' Insurance Company and the Injured Workers' Insurance Fund paid $4,153,225.37 for 37,362 prescriptions. Had AWP been utilized, the cost would have been $10,416,555.49.

Chesapeake Employers' Insurance Company and the Injured Workers' Insurance Fund have committed not to pass these pharmaceutical costs onto our policyholders, counties, municipalities, and the State. By aligning our payments more in line with acquisition costs, as proposed by Senate Bill 306, the cost for the same prescriptions would have been $3,032,031.51, excluding administrative and dispensing fees.

Unfortunately, many community stakeholders lack the resources or legislative mandate that Chesapeake Employers' Insurance has. Consequently, billed prices are often paid.

Pharmacies exploiting the lack of a prescription fee guide often provide prescriptions for Labor and Employment, § 9-503 presumption claims, such as hypertension and heart disease for police officers and firefighters. These pharmaceuticals are commonly seen outside of workers' compensation claims, but the prices charged to insurers, counties, municipalities, and the State are significantly higher than acquisition or reasonable pricing, as illustrated in the chart below.

Medication	**Use**	**Q**	**D S**	**Pharmacy Submitted Amount**	**AWP**	**NADAC [1]**	**WAC**	**MCCPD**	**Cash (low to high)**	**Medi-Cal**	**Paid Amount**
Lisinopril 10 MG Tablet	High blood pressure/ACE inhibitor	90	90	$111.60	$89.10	$1.71	$6.30	$11.76	$6-31	$8.96	$17.79
Atorvastatin 20 MG Tablet	High Cholesterol (Lipitor)	90	90	$623.70	$519.63	$2.49	$8.13	$11.69	$10-38	$19.68	$12.88
Sildenafil 100 MG Tablet	Erectile Dysfunction	12	30	$957.12	$797.57	$1.73	$3.20	$10.97	$7-28	N/A	$99.51
Tadalafil 20 MG Tablet	Erectile Dysfunction	6	30	$524.46	$432.86	$1.52	$4.00	$11.20	$10-73	N/A	$247.75
Valsartan 160 MG Tablet	High blood pressure/heart disease	90	90	$563.40	$469.13	$13.89	$35.66	$17.21	$26-108	$52.86	$109.62
Amlodipine Besylate 10 MG Tab	High blood pressure/heart disease (Norvasc)	90	90	$271.80	$213.89	$1.49	$3.96	$11.80	$12-34	$10.48	$154.95

Of note, although Chesapeake Employers' Insurance Company and the Injured Workers' Insurance Fund paid the "paid amount" in this chart, for the same prescription, Prince George's County, Baltimore County, Charles County, and Washington County would pay the "pharmacy

[1] **AWP:** Average Wholesale Price. When it was created in the late 1960s, it was meant to describe the average price at which wholesalers sell drugs to pharmacies. However, it is now outdated and inaccurate. It is often manipulated by manufacturers or wholesalers, and no longer an accurate reflection of actual pricing paid.
NADAC: National Average Drug Acquisition Cost (considered acquisition pricing). This is without a dispensing fee that Senate Bill 306 allows.
WAC: Wholesaler Acquisition Cost (considered acquisition pricing). This is without a dispensing fee that Senate Bill 306 allows.
MCCPD: Mark Cuban's CostPlus Drugs. This price is inclusive of manufacturing cost, plus 15%, plus processing and shipping, and is publicly available.
CASH: The price in which a person could walk in and pay for their drugs in Maryland with no prescription card or plan.
MEDI-CAL: Pricing in California using their workers' compensation prescription rates (erectile dysfunction medications are not included in Medi-Cal rates). Pricing includes a $7.25 dispensing fee.

submitted amount", Montgomery County and Anne Arundel County would pay the "AWP amount", and Baltimore City will pay what they believe is a value assigned for services involving similar work and resources. SB 306 will ensure that all stakeholders have clear visibility into the charges and payments for the same drug, akin to the transparency provided by the current medical fee guide, and therefore all of our counties and insureds will pay the same amount.

While many states have established pharmaceutical fee guides for workers' compensation, numerous guides were created over two decades ago and were created with outdated information. As the nation progresses towards better healthcare pricing, workers' compensation must ensure that stakeholders are accurately charged for pharmaceuticals. Notably, California and Massachusetts have adopted acquisition pricing for workers' compensation, and Medicaid in all states, including Maryland, has also transitioned to acquisition pricing.

Maryland's businesses, counties, municipalities, and the State cannot financially sustain the current pricing structures within the workers' compensation system. Workers' compensation was designed to provide no-fault insurance to injured workers, facilitating the efficient delivery of medical and disability payments. However, this no-fault insurance was also intended to guarantee cost containment for Maryland's businesses, counties, municipalities, and the State. Legislation should aim to uphold this principle, and Senate Bill 306 reinforces the grand bargain at the core of Maryland's workers' compensation system.

For these reasons, Chesapeake Employers' Insurance Company and the Injured Workers' Insurance Fund support Senate Bill 306 as being heard in the House Economic Matters Committee.

Contact: *Carmine G. D'Alessandro, Esq.*
Chief Legal Officer
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Lyndsey Beidle Meninger, Esq.
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SB 306 - MoCo_Elrich_FAV (GA 25) (House).pdf
Uploaded by: Marc Elrich
Position: FAV

OFFICE OF THE COUNTY EXECUTIVE

Marc Elrich
County Executive

March 26, 2025

TO: The Honorable C. T. Wilson
Chair, Economic Matters Committee

FROM: Marc Elrich
County Executive

RE: Senate Bill 306, *Workers' Compensation – Prescription Drug and Pharmaceutical Services – Reimbursements*

Support

I am writing to express my strong support for Senate Bill 306*, Workers' Compensation – Prescription Drug and Pharmaceutical Services – Reimbursements*, which addresses a missing link in the State's comprehensive workers' compensation system by requiring that the Workers' Compensation Commission (Commission) develop a fee schedule for prescription drugs and pharmaceutical services. While medical services in workers' compensation claims are already subject to a regulated fee schedule, there is no standardized fee schedule for prescription medications, which has led to cost disparities and inefficiencies throughout the State.

Currently, many prescriptions are reimbursed based on the Average Wholesale Price (AWP) plus additional charges, which inflates costs well beyond the actual acquisition price. The disparity between acquisition prices and AWP prices places unnecessary financial burdens on employers, who fund workers' compensation claims, and can lead to costly litigation to dispute excessive charges, further delaying claims resolution.

To address these concerns, the bill requires the Commission to develop a pricing index based on acquisition costs, which may include reasonable dispensing fees and any other percentage increase or decrease as determined by the Commission. This type of framework would help to ensure fair and transparent pricing while promoting financial sustainability within the workers' compensation system. By reducing excessive costs and aligning pricing with industry standards, counties would realize substantial savings that could be redirected to other public services.

Importantly, the bill does not prohibit an employer from contracting with a pharmacy benefits manager or network of pharmacies for different reimbursements rates. This component of the bill is important for retaining flexibility for employers who are able to negotiate better pricing than what the Commission's approved index specifies.

To support the efforts of the Commission, which is required to develop the pricing index by September 1, 2026, the bill requires the Maryland Prescription Affordability Board to study a variety of related issues and report its findings and recommendations by March 1, 2026. This type of support is important to ensure that the Commission has all necessary data before finalizing the pricing index.

I respectfully request that the Economic Matters Committee give this bill a favorable report.

cc: Members of the Economic Matters Committee

SB 306 WC Drugs Index House Econ FAE 032626 APCIA
Uploaded by: Nancy Egan
Position: FAV

Testimony of

American Property Casualty Insurance Association (APCIA)

Senate Finance Committee

Senate Bill 306 - Workers' Compensation - Prescription Drug and Pharmaceutical Services - Reimbursements

March 26, 2025

Favorable

The American Property Casualty Insurance Association (APCIA) is a national trade organization whose members write approximately 67% of the U.S. property and casualty insurance market, including 90% percent of Maryland's workers' compensation market. APCIA appreciates the opportunity to provide written comments in support of Senate Bill 306.

This bill would require the State Workers' Compensation Commission to regulate fees and other charges for the reimbursements of-services and prescription drugs provided by a pharmacy permit holder; and limiting covered reimbursements to a cost index or indexes. This would establish a pricing index using actual acquisition costs or something similar as long as the price base is the cost of drug plus a dispensing fee, and any other percentage increase or decrease determined by the Commission. The bill also authorizes the Maryland Prescription Drug Affordability Board to conduct a study on prescription drug affordability challenges related to workers' compensation claims.

This bill will help regulate drug costs which could result in cost savings under workers' compensation policies which would be translated into lower costs for the employers and the public. The bill would also reduce the uncertainty in drug reimbursement amounts and thus greatly reduce the amount of delays and disputes in the pharmaceutical reimbursement process

For these reasons, APCIA urges the Committee to provide a favorable report on Senate Bill 306.

Nancy J. Egan,

State Government Relations Counsel, DC, DE, MD, VA, WV

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SB306 House Testimony.pdf
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PAMELA G. BEIDLE
Legislative District 32
Anne Arundel County

Chair, Finance Committee
Executive Nominations Committee

Joint Committee on Gaming Oversight
Joint Committee on Management of Public Funds
Spending Affordability Committee

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THE SENATE OF MARYLAND
ANNAPOLIS, MARYLAND 21401

March 24, 2025

Senate Bill 306
Workers' Compensation
Prescription Drug and Pharmaceutical Services - Reimbursements

Good afternoon Chair Wilson, Vice Chair Crosby and Member of the Economic Matters Committee;

Thank you for the opportunity to present Senate Bill 306, Workers' Compensation, Prescription Drug and Pharmaceutical Services – Reimbursements. In 2022, I attended an NCOIL conference. In fact, Delegate Mike Rogers was there also. We learned that most states, 37 of them, had prescription fee schedules for Workers Compensation. As a retired insurance agent that sold Workers' Compensation, a lot of Workers' Compensation, for 38 years, this really got my attention. I know that the cost of prescriptions is about 50% of most Workers' Compensation claims. I know that expensive Workers' Compensation Claims increase the cost of Workers' Compensation insurance for our businesses, particularly our small businesses and more importantly, for our counties, many of whom are self-insured. If a reasonable fee schedule is adopted it can save our counties MILLIONS of dollars, while still ensuring our injured workers receive the medications needed.

Later, in 2023, I attended a SAWCA conference with our Workers' Compensation Commission, I learned the Commission was considering a fee schedule like 37 other states. We heard from a nationally renowned speaker on the cost of prescriptions that adopting a fee schedule would create tremendous savings. One of the things he said—and this is important—we will get back to this later. "Do not use AWP when deciding on a fee schedule—it is a joke, it does not mean anything."

Ultimately the Workers' Compensation Commission could not come to agreement on what method to use for their fee schedule, so they did nothing in 2023.

Senate Bill 306 does not tell the Commission which fee schedule to adopt—we would not want to put that in the statute, then it could only be changed by legislation. But the bill does give the Commission some guidance and requests that the Commission decide on a fee schedule by September 1, 2026. The guidance allows them to add a percentage for the cost of dispensing. The bill also requires that the Maryland Prescription Drug Affordability Board conduct a study on specific things including prescribing high-cost formulations and dispensing practices that also increases the cost of Workers Compensation. This study is due March 1, 2026, before the prescription fee guide is due to be in effect by September 1, 2026, and can help guide the way.

We all have fee schedules or networks for our health insurance. Medicaid has a fee schedule; Medicare has a fee schedule. Only Workers' Compensation gets away with charging whatever they want to charge. And our Maryland insureds, particularly our counties are paying what they are being charged, no matter the price.

I understand that this committee has received information that AWP is the method that the Commission should use. However, AWP has fallen out of favor. AWP does not represent the real cost of a drug. Google AWP and you will read things like:

- AWP is typically higher than the actual price paid by purchasers due to discounts, rebates, and other pricing negotiations.
- AWP is often criticized for being an inflated and inaccurate benchmark, as it can be easily manipulated by manufacturers and PBMs.

BUT:

- The National Average Drug Acquisition Cost (NADAC) is an alternative metric that calculates the average price that pharmacies pay for prescription drugs, using invoice prices rather than a fabricated value.

I know many of you have seen the Optum Resource Guide and it shows many different ways to use a fee schedule. Many of the fee guides in the Optum Guide were made over 15 years ago, when AWP still had some meaning (although even then, we knew AWP was inflated, but there was a lack of other available price indexes). In 2025, besides AWP there are many other choices for a fee guide.

FUL - Federal Upper Limit
WAC - Wholesaler Average Cost
EAC - Estimated Average Cost
NADAC - National Average Drug Acquisition Cost
AAC - Average Acquisition Cost

The counties are the most affected by the lack of a fee schedule. Here is a short chart simply comparing the Average Cost per Fill of the Workers Compensation Prescriptions.

Average Cost Per Fill:	
$298.07	Anne Arundel County
$217.72	Baltimore City
$200.09	Charles County
$315.67	Montgomery County
$465.64	Prince George's County

Included is a detailed example of what Prince George's County pays for Workers Compensation prescriptions by provider. Take notice of the amount paid over an acquisition price model. This is one County. Prince George's County paid $10,294,373.66 for 22,108 scripts in two years, the acquisition price would have been $2,561,068.95. There is similar data for all the self-insured counties. Do you want your county paying millions of dollars more than the actual cost of the prescriptions?

For all Paid Scripts in 2023 and 2024 in PG County:

	Amount Billed	Amount Paid	AWP	NADAC	WAC
22108	$11,925,378.54	$10,294,373.66	$10,928,800.34	$2,561,068.95	$2,421,764.44

For PG County Paid Scripts in 2023 and 2024 with Out of Network Pharmacies:

	Number of Scripts	Amount Billed	Amount Paid	AWP	NADAC	WAC
EZScripts (formerly MailMyMeds and Public Safety Rx)	4103	$2,452,989.10	$2,370,139.01	$2,249,106.38	$699,558.36	$424,895.18
RescueMeds	7339	$3,815,563.02	$3,970,726.21	$3,564,468.89	$1,034,828.24	$710,383.29
Injured Workers' Pharmacy	1968	$1,532,330.67	$1,213,444.48	$1,008,285.33	$284,428.85	$210,738.44

* In the data submitted by Prince Georges County 743 claims show zero paid in lieu of actual amount paid. Therefore, the number in the amount billed column is lower than should be.

And to be clear, this statute allows the Commission to pick more than one price index to ensure that ALL workers' compensation drugs have a price point. Additionally, the bill allows for a percentage increase or decrease from the price index as well as reasonable dispensing fees. There will be a chance for pharmacies to make a profit, but it's a reasonable profit, not the 60-88% profit we are often seeing in the data today.

Just to reinforce the issue, let's look at a particular drug that is commonly filled. High blood pressure is commonly treated in Workers Compensation for our public safety employees. This is just one example.

Atorvastatin, 20 MG, 90 Tablets, which is generic Lipitor:
Pharmacy Submitted Amount – $623.90
AWP – $519.63
NADAC - $2.49, the cost of the pills per pharmacy surveys from the manufacturer, without a percentage increase or dispensing fee that SB 306 allows.
WAC - $8.13
MCCPD (Costs Plus Drugs) – $11.69 – this includes the cost of drugs, processing, and shipping.
Cash price in Maryland - $10 - $38 – walking into a pharmacy with a prescription and no insurance in Maryland
Medi-Cal – $19.68 (this is California workers' compensation rate and includes a 7.25 dispensing fee)

And to be clear, Prince George's County filled various quantities and milligrams of Atorvastatin 612 times in 2023 and 2024. Montgomery County filled it 351 times. You can see how the price differentials would add up quickly. You can see why we need to take action to move this along.

Just to summarize:
SB 306 mandates that the WCC set a fee schedule.
SB 306 Does NOT limit anyone's prescription.
SB 306 Does NOT remove any pharmacy from providing medication in workers' compensation.
SB 306 Does NOT make any prescription unavailable.
SB 306 DOES save millions of dollars to your counties annually.
SB 306 DOES provide consistency in pricing for all.

The Senate voted this bill 47-0, I respectfully request a favorable report on this important bill.

Senate Bill 306_Data Powerpoint (003).pdf
Uploaded by: Pamela Beidle
Position: FAV

Senate Bill 306

EXAMPLES OF PHARMACEUTICAL PRICING IN WORKERS' COMPENSATION

Based on Submitted Data:

Average Cost Per Fill:	
$298.07	Anne Arundel County
$217.72	Baltimore City
$111.16	CEIWC/State
$200.09	Charles County
$315.67	Montgomery County
$465.64	Prince George’s County

Prince George's County Data for 2023 and 2024 Paid Fills

# of Scripts	Amount Billed*	Amount Paid	Acquisition Pricing Example**	AWP
22108	$11,925,378.54	$10,294,373.66	$2,561,068.95	$10,928,800.34

Prince George's County Data for Paid Fills in 2023 and 2024 for Several Mail-Order Pharmacies

For PG County Paid Scripts in 2023 and 2024 with Out of Network Pharmacies:						
	Number of Scripts	Amount Billed*	Amount Paid	AWP	NADAC	WAC
EZScripts (formerly MailMyMeds and Public Safety Rx)	4103	$2,452,989.10	$2,370,139.01	$2,249,106.38	$699,558.36	$424,895.18
RescueMeds	7339	$3,815,563.02	$3,970,726.21	$3,564,468.89	$1,034,828.24	$710,383.29
Injured Workers' Pharmacy	1968	$1,532,330.67	$1,213,444.48	$1,008,285.33	$284,428.85	$210,738.44

Montgomery County Data for 2023 and 2024 Paid Fills

	# of Scripts	Submitted Amount	Paid Amount
2024	10320	$6,193,142.09	$3,406,457.85
2023	9497	$4,735,884.82	$2,849,113.35
Totals:	19817	$10,929,026.91	$6,255,571.20

Montgomery County Data for Paid Fills in 2023 and 2024 for Several Mail-Order Pharmacies

	# of Scripts	Submitted Amount	Paid Amount
RescueMeds*	1434	$711,379.12	$585,162.71
EZ Scripts* (PublicSafety Rx)	304	$66,551.11	$55,562.85
Injured Workers' Pharmacy*	993	$480,700.13	$267,542.40

Baltimore City Data for 2023 and 2024

	Transactions	AWP	Bill Amount	Pharmacy Submitted Amount
INN	15,094	$4,859,679	$2,947,260	$2,947,260
OON	4,426	$2,970,489	$1,302,719	$2,943,558
Total	**19,520**	**$7,830,168**	**$4,249,979**	**$5,890,818**

Cost Savings Overview

	Retail	Mail Order	OON	TOTAL
Script Count	2610	80	0	2690
Fee Schedule	$1,905,072.92	$36,431.51	$0.00	$1,941,504.43
Total Paid Amount	$788,095.57	$13,700.03	$0.00	$801,795.60
Program Savings	$1,116,977.35	$22,731.48	$0.00	$1,139,708.83

Anne Arundel County Data from October 1, 2023 to September 23, 2024

Chesapeake Employers' Insurance Company and the Injured Workers' Insurance Fund Overall Data for Paid Fills in 2023 and 2024

	Script Count:	Cost of Fills:	AWP Price:	Acquisition Pricing Example (NADAC, if not WAC)*
State:	20,144	$2,268,944.87	$5,162,360.88	$1,341,590.75
CEIWC:	17,218	$1,884,280.50	$5,254,194.61	$1,690,440.76
Total:	37,362	$4,153,225.37	$10,416,555.49	$3,032,031.51

	Script Count:	Cost of Fills:	AWP Price:	Pharmacy Submitted Price:	Acquisition Pricing Example (NADAC, if not WAC)*
State:	3491	$659,842.40	$1,155,673.33	$1,582,474.71	$282,939.63
CEIWC:	2147	$369,282.98	$663,107.77	$882,346.68	$164,767.07
Total:	5638	$1,029,125.38	$1,818,781.10	$2,464,821.39	$447,706.70

Chesapeake Employers' Insurance Company and the Injured Workers' Insurance Fund Data for Paid Fills in 2023 and 2024 for Mail-Order Pharmacies

Chesapeake Employers' Insurance Company County Policyholders Paid Fills from 2023 - 2024

	AWP	Acquisition Pricing Example (NADAC, if not WAC)*	Pharmacy Submitted Amt	Paid Amt
Wicomico County	$55,675.94	$12,880.57	$60,369.07	$18,341.99
Calvert County	$157,856.87	$32,804.18	$213,270.79	$78,876.38
Caroline County	$4,276.61	$173.11	$5,593.41	$384.04
Somerset County	$13,459.63	$3,944.48	$15,055.72	$4,698.68
Kent County	$33,886.11	$12,544.83	$42,296.60	$13,333.32
Worchester County	$5,249.32	$631.94	$6,647.44	$1,563.84
Dorchester County	$19,858.97	$1,280.85	$21,403.82	$4,430.84
Talbot County	$1,768.48	$457.81	$2,279.22	$825.82
Totals:	$292,031.92	$64,717.76	$366,916.07	$122,454.91

Top 15 for all Out of Network Mail Order Pharmcies	Average Submitted Amount by Out of Network Pharmacies	Average Paid Amount	Average NADAC, if not WAC plus $15	Average AWP Amount
OXYCODONE HCL (IR) 10 MG TAB	$91.65	$40.22	$25.90	$54.85
CYCLOBENZAPRINE 10 MG TABLET	$114.17	$41.11	$16.23	$65.20
AMLODIPINE BESYLATE 10 MG TAB	$266.16	$153.67	$16.44	$207.05
TIZANIDINE HCL 4 MG TABLET	$288.18	$131.23	$20.24	$188.78
GABAPENTIN 300 MG CAPSULE	$170.49	$29.19	$19.80	$102.21
OXYCODONE-ACETAMINOPHEN 5-325	$50.41	$8.34	$18.27	$39.76
TRAMADOL HCL 50 MG TABLET	$69.36	$9.10	$16.50	$45.16
SILDENAFIL 100 MG TABLET	$1,656.07	$490.36	$20.21	$1,364.73
CELECOXIB 200 MG CAPSULE	$539.44	$80.51	$20.78	$376.50
LIDOCAINE 5% PATCH	$735.06	$238.91	$101.83	$465.33
IBUPROFEN 800 MG TABLET	$150.38	$45.24	$22.95	$88.55
MELOXICAM 15 MG TABLET	$223.67	$46.33	$15.67	$152.22
AMLODIPINE BESYLATE 5 MG TAB	$195.03	$40.90	$15.92	$145.25
TRAZODONE 100 MG TABLET	$87.87	$22.56	$18.04	$65.28

Top Drugs filled by Out of Network Pharmacies per Chesapeake Employers' Insurance and Injured Workers' Insurance Fund in 2023 and 2024

Examples of Common Prescription under §9-503 Presumption Claims

Medication	Use	Q	DS	Pharmacy Submitted Amount	AWP	NADAC	WAC	MCCPD	Cash (low to high)	Medi-Cal
Lisinopril 10 MG Tablet	High blood pressure/ACE inhibitor	90	90	$111.60	$89.10	$1.71	$6.30	$11.76	$6-31	$8.96
Atorvastatin 20 MG Tablet	High Cholesterol (Lipitor)	90	90	$623.70	$519.63	$2.49	$8.13	$11.69	$10-38	$19.68
Sildenafil 100 MG Tablet	Erectile Dysfunction	12	30	$957.12	$797.57	$1.73	$3.20	$10.97	$7-28	N/A
Tadalafil 20 MG Tablet	Erectile Dysfunction	6	30	$524.46	$432.86	$1.52	$4.00	$11.20	$10-73	N/A
Valsartan 160 MG Tablet	High blood pressure/heart disease	90	90	$563.40	$469.13	$13.89	$35.66	$17.21	$26-108	$52.86
Amlodipine Besylate 10 MG Tab	High blood pressure/heart disease (Norvasc)	90	90	$271.80	$213.89	$1.49	$3.96	$11.80	$12-34	$10.48

- Prince George's County, Charles County, Washington County, and Baltimore County pay the "pharmacy submitted amount" in this chart.
- Montgomery County and Anne Arundel County would pay the "AWP amount" in this chart.
- The State and Baltimore City will pay what they believe is a value assigned for services involving similar work and resources (per COMAR).

Sample Exhibit from Baltimore City Prescription Hearing

Date	Name	NDC	Dosage	Pill Count	Cost Plus	NADAC	California	Alt. pricing (low)	Alt. pricing (high)	Billed	AWP	Paid Per Optum
5/18/2021	Valsartan	33342 0064 10	160mg	180	$ 29.80	$ 53.09	$ 82.04	$ 42.00	$ 207.00	$ 450.00	$ 375.30	$ 188.65
8/12/2021	Valsartan	51660 0142 90	160mg	180	$ 29.80	$ 50.64	$ 89.65	$ 42.00	$ 207.00	$ 118.80	$ 99.28	$ 50.64
	Totals				**$ 59.60**	**$ 103.73**	**$ 171.69**	**$ 84.00**	**$ 414.00**	**$ 568.80**	**$ 474.58**	**$ 239.29**
10/26/2022	Valsartan	59746036290	160mg	180	$ 29.80	$ 43.61	$ 252.57	$ 42.00	$ 207.00	$ 1,067.40	$ 890.72	$ 446.36
	Totals				**$ 29.80**	**$ 43.61**	**$ 252.57**	**$ 42.00**	**$ 207.00**	**$ 1,067.40**	**$ 890.72**	**$ 446.36**
10/17/2023	Valsartan	43547036909	160 mg	180	$ 29.80	$ 32.78	$ 86.92	$ 42.00	$ 207.00	$ 1,114.20	$ 928.50	$ 465.29
7/20/2023	Valsartan	43547036909	160mg	180	$ 29.80	$ 36.37	$ 86.92	$ 42.00	$ 207.00	$ 1,114.20	$ 928.50	$ 465.29
4/24/2023	Valsartan	43547036909	160mg	180	$ 29.80	$ 39.39	$ 86.92	$ 42.00	$ 207.00	$ 1,114.20	$ 928.50	$ 465.29
	Totals				**$ 89.40**	**$ 108.54**	**$ 260.76**	**$ 126.00**	**$ 621.00**	**$ 3,342.60**	**$ 2,785.50**	**$ 1,395.87**

	Cost Plus	NADAC	California	pricing (low)	pricing (high)	Billed	AWP	Paid Per Optum
Combined totals	**$ 178.80**	**$ 255.87**	**$ 685.02**	**$ 252.00**	**$ 1,242.00**	**$ 4,978.80**	**$ 4,150.80**	**$ 2,081.52**

Sample Exhibit from Baltimore City Prescription Hearing

Date	Name	Dosage	NDC	Pill Count	Cost Plus	NADAC	California	Alt. Cash Price (low)	Alt. Cash Price (high)	Billed	AWP	Paid Per Optum
1/25/2023	Amlodipine	5mg	67877019810	90	$ 11.80	$ 0.95	$ 9.12	$ 9.00	$ 46.00	$198.00	$161.00	$198.00
5/20/2022	Amlodipine	5mg	29300039705	90	$ 11.80	$ 0.96	$ 9.12	$ 9.00	$ 46.00	$191.70	$155.65	$78.83
6/15/2022	Losartan	100mg	31722070290	90	$ 16.30	$ 9.04	$ 12.58	$ 14.00	$ 73.00	$335.70	$275.60	$137.64
9/8/2022	Losartan	100mg	43547036211	90	$ 16.30	$ 7.84	$ 12.58	$ 14.00	$ 73.00	$340.20	$279.00	$139.48
2/27/2023	Losartan	100mg	31722070210	90	$ 16.30	$ 6.64	$ 12.58	$ 14.00	$ 73.00	$335.70	$275.60	$137.64
	Totals				**$ 72.50**	**$ 25.43**	**$ 55.98**	**$ 60.00**	**$ 311.00**	**$ 1,401.30**	**$ 1,146.85**	**$ 691.59**

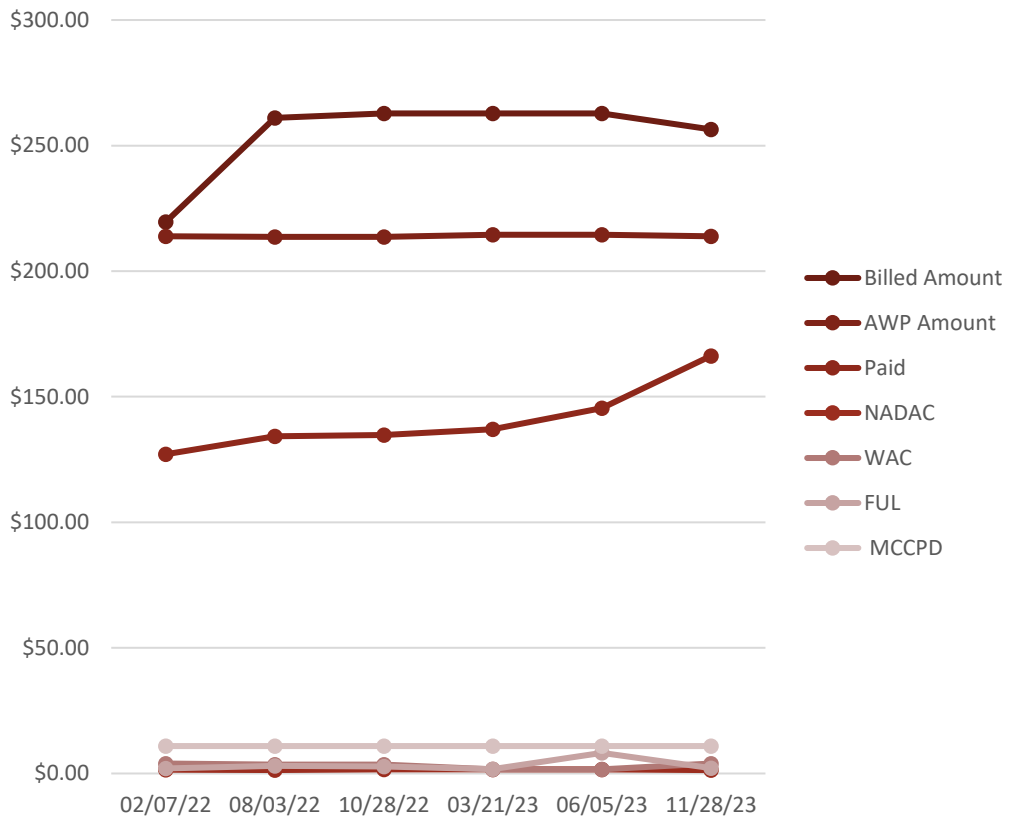
Sample Exhibit from a State of Maryland Prescription Hearing

Medication: AMLODIPINE BESYLATE 10 MG TAB

Use: High Blood Pressure/Heart Disease

Quantity: 90/**Days Supply:** 90

Fill Date	Billed Amount	AWP Amount	Paid	NADAC	WAC	FUL	MCCPD	Cash
02/07/22	$219.60	$213.89	$127.10	$1.43	$3.96	$1.95	$10.91	$12-34
08/03/22	$261.00	$213.65	$134.27	$1.36	$3.47	$3.01	$10.91	$12-34
10/28/22	$262.80	$213.65	$134.81	$1.57	$3.47	$2.74	$10.91	$12-34
03/21/23	$262.80	$214.50	$137.06	$1.65	$1.64	$1.73	$10.91	$12-34
06/05/23	$262.80	$214.50	$145.49	$1.58	$1.64	$8.20	$10.91	$12-34
11/28/23	$256.50	$213.89	$166.26	$1.33	$3.96	$2.10	$10.91	$12-34
Totals:	$1,525.50	$1,284.07	$844.99	$8.91	$18.15	$19.74	$65.46	$72-204



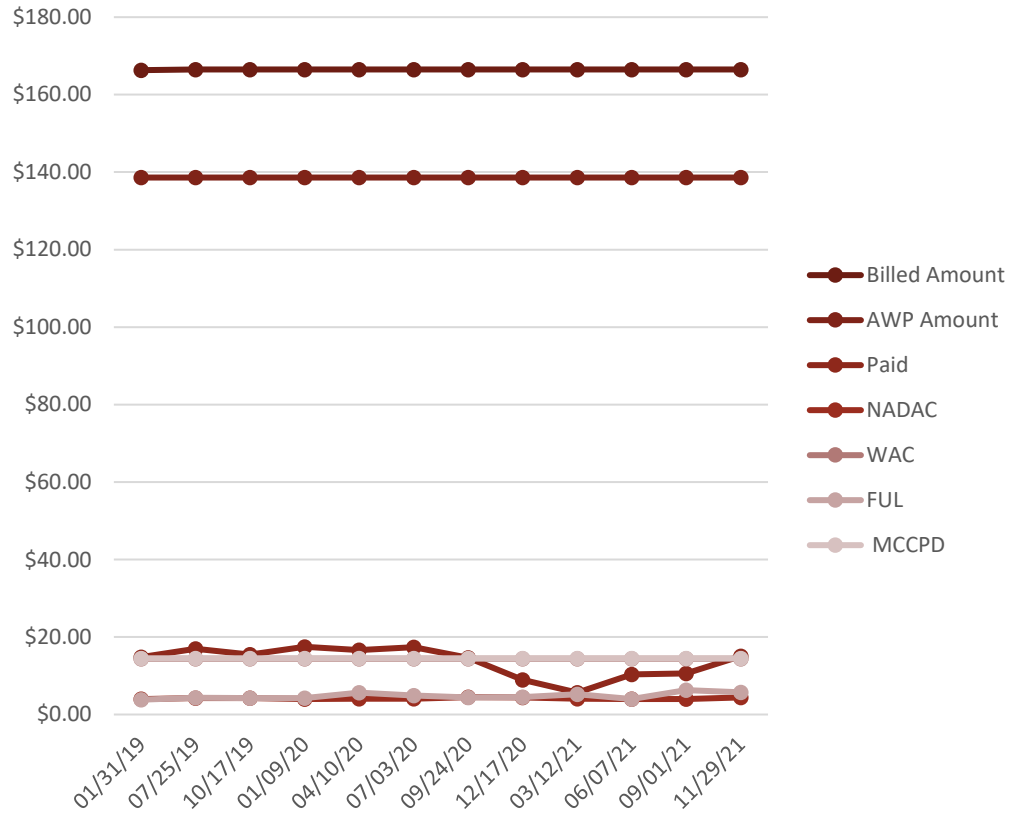
Sample Exhibit from a State of Maryland Prescription Hearing

Medication: LISINOPRIL 40 MG TABLET

Use: High Blood Pressure/Heart Disease

Quantity: 90 and **Days Supply:** 90

Fill Date	Billed Amount	AWP Amount	Paid	NADAC	WAC	FUL	MCCPD	Cash
01/31/19	$166.32	$138.60	$14.81	$3.98	$14.40	$3.83	$14.50	$11-27
07/25/19	$166.50	$138.60	$16.97	$4.21	$14.40	$4.33	$14.50	$11-27
10/17/19	$166.50	$138.60	$15.48	$4.26	$14.40	$4.26	$14.50	$11-27
01/09/20	$166.50	$138.60	$17.48	$4.03	$14.40	$4.20	$14.50	$11-27
04/10/20	$166.50	$138.60	$16.64	$4.10	$14.40	$5.62	$14.50	$11-27
07/03/20	$166.50	$138.60	$17.34	$4.10	$14.40	$4.94	$14.50	$11-27
09/24/20	$166.50	$138.60	$14.64	$4.48	$14.40	$4.45	$14.50	$11-27
12/17/20	$166.50	$138.60	$8.91	$4.37	$14.40	$4.46	$14.50	$11-27
03/12/21	$166.50	$138.60	$5.65	$4.04	$14.40	$5.22	$14.50	$11-27
06/07/21	$166.50	$138.60	$10.39	$4.02	$14.40	$4.02	$14.50	$11-27
09/01/21	$166.50	$138.60	$10.59	$4.03	$14.40	$6.29	$14.50	$11-27
11/29/21	$166.50	$138.60	$15.10	$4.40	$14.40	$5.73	$14.50	$11-27
Totals:	$1,997.82	$1,663.20	$164.00	$50.03	$172.80	$57.36	$174.00	$132-324



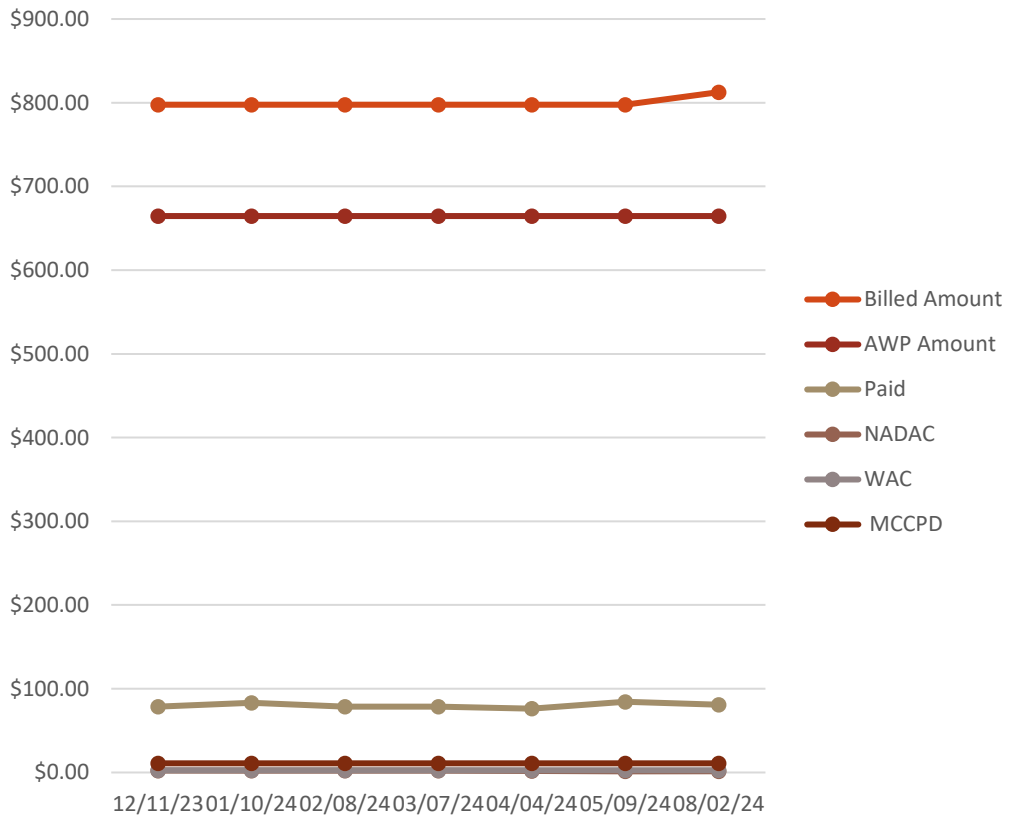
Sample Exhibit from a State of Maryland Prescription Hearing

Medication: SILDENAFIL 100 MG TABLET

Use: Erectile Dysfunction

Quantity: 10/**Days Supply:** 30

Fill Date	Billed Amount	AWP Amount	Paid	NADAC	WAC	MCCPD	Cash
12/11/23	$797.60	$664.64	$78.79	$2.32	$2.67	$10.90	$7-21
01/10/24	$797.60	$664.64	$83.26	$2.19	$2.67	$10.90	$7-21
02/08/24	$797.60	$664.64	$78.79	$2.04	$2.67	$10.90	$7-21
03/07/24	$797.60	$664.64	$78.79	$2.00	$2.67	$10.90	$7-21
04/04/24	$797.60	$664.64	$76.21	$1.91	$2.67	$10.90	$7-21
05/09/24	$797.60	$664.64	$84.45	$1.34	$2.67	$10.90	$7-21
08/02/24	$812.60	$664.64	$80.82	$1.36	$2.67	$10.90	$7-21
Totals:	$5,598.20	$4,652.48	$561.11	$13.16	$18.67	$76.30	$49-147



Common Terms:

AWP: Average Wholesale Price. When it was created in the late 1960s, it was meant to describe the average price at which wholesalers sell drugs to pharmacies. However, it is now outdated and inaccurate. It is often manipulated by manufacturers or wholesalers, and no longer an accurate reflection of actual pricing paid.

NADAC: National Average Drug Acquisition Cost (considered acquisition pricing). This is without a dispensing fee. Senate Bill 306 allows a dispensing fee and an increase or decrease in the percentage.

WAC: Wholesaler Acquisition Cost (considered acquisition pricing). This is without a dispensing fee. Senate Bill 306 allows a dispensing fee and an increase or decrease in the percentage.

MCCPD: Mark Cuban's CostPlus Drugs. This price is inclusive of manufacturing cost, plus 15%, plus processing and shipping, and is publicly available.

CASH: The price in which a person could walk in and pay for their drugs in Maryland with no prescription card or plan.

MEDI-CAL: Pricing in California using their workers' compensation prescription rates (erectile dysfunction medications are not included in Medi-Cal rates). Pricing includes a $7.25 dispensing fee.

PGCex_Support_SB 306.pdf
Uploaded by: Sasha Desrouleaux
Position: FAV

THE PRINCE GEORGE'S COUNTY GOVERNMENT

OFFICE OF THE COUNTY EXECUTIVE

BILL:	**Senate Bill 306: Workers' Compensation - Prescription Drug and Pharmaceutical Services - Reimbursements**
SPONSOR:	**Senator Pamela Beidle**
COMMITTEE:	**Economic Matters**
HEARING DATE:	**March 26, 2025 at 1:00 PM**
CONTACT:	**Intergovernmental Affairs Office, 301-780-8411**
POSITION:	**SUPPORT**

The Office of the Acting Prince George's County Executive urges **SUPPORT** of **Senate Bill 306: Workers' Compensation - Prescription Drug and Pharmaceutical Services – Reimbursements,** which seeks to encourage the affordability of prescription drugs by regulating fees and other charges for the reimbursements of prescription drugs and pharmaceutical services under the Workers' Compensation Commission, among other actions. As a self-insured employer, the administration believes this proposal could create opportunities for budget savings.

Under the County's currently model, Prince George's is one of many Maryland jurisdictions currently paying close to the average wholesale price for prescription drugs according to opaque pricing methods imposed by the industry. As a result, between 2023 and 2024, Prince George's County was billed $11.9M in wholesale purchase costs, for which the acquisition cost was $2.5M. Even after reasonable mark-ups this is significantly higher than the cost of the drugs and higher than what is experienced in other jurisdictions or even by the state. Due to the County's status as self-insured, our taxpayers are held responsible, therefore any potential cost savings are directly impactful to the County.

For the reasons stated above, the Office of the Acting Prince George's County Executive **SUPPORTS SB 306** and asks for a **FAVORABLE** report.

Chesapeake Announces $55 Million Divide...pdf
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Position: FWA

Chesapeake Announces $55 Million Dividend, 8% Rate Decrease

Monday, March 3, 2025 | 0

The board of directors for Maryland's Chesapeake Employers' Insurance Co. declared the company's highest-ever policyholder dividend of $55 million for 2025.

At the same time, the carrier announced that it filed an 8% rate decrease with the Maryland Insurance Administration, effective April 1.

Chesapeake said it will begin distributing its eighth consecutive dividend in May. The carrier said that with the latest dividend, it will have returned $175 million to employers since 2018.

Dividends are based on performance and are not guaranteed.

The policyholder dividend was approved by the Maryland Insurance Administration.

drugstores closing (1).pdf
Uploaded by: Colleen Shields
Position: FWA

Democracy Dies in Darkness

Drugstore closures are leaving millions without easy access to a pharmacy

Over the past two years, Rite Aid, CVS and Walgreens have signaled plans to shutter more than 1,500 stores, and public health experts say there's already been fallout

October 22, 2023

By Aaron Gregg and Jaclyn Peiser

After decades of expansion, the nation's largest drugstore chains are closing hundreds of stores as they reorient their operations against rising competition, a crush of opioid lawsuits and other forces — turning many already vulnerable communities into pharmacy deserts.

Rite Aid, which filed for Chapter 11 bankruptcy protection last week, CVS and Walgreens have signaled over the past two years plans to collectively shutter more than 1,500 stores. Public health experts have already seen the fallout, noting that the first neighborhoods to lose their pharmacies are often predominantly Black, Latinx and low-income.

"According to our estimates, about one in four neighborhoods are pharmacy deserts across the country," said Dima Qato, an associate professor at the University of Southern California who studies pharmacy access and health equity. "These closures are disproportionately affecting communities that need pharmacies most."

Pharmacies can be lifelines in rural or low-income areas, particularly in food deserts — areas that have limited access to healthy and affordable food. Pharmacists are often the most accessible health care professional for these communities, said Lorece Edwards, a professor of public health at Morgan State University who focuses on health disparities.

But for national pharmacy chains, retrenchment has been a long time coming, retail analysts say, as increased competition, changing consumer behaviors, retail crime, staffing shortages and minimal store investment come to a head. They're also feeling a comedown from pandemic-era sales of coronavirus vaccines, at-home test kits and other products.

“The economics of running those stores have just unraveled, and they’re not as profitable as they once were,” said Neil Saunders, managing director of the analytics company GlobalData Retail. “Retailers are looking to offload them.”

Pharmacies facing whiplash

In a different era, the corner drugstore was the model of convenience, the place to not only fill prescriptions but also buy snacks, birthday cards and household staples. In the 1990s and early 2000s, CVS and Walgreens started putting down roots across the country, edging out the independents. Today, the nation’s two largest pharmacy chains have more than 9,000 and 8,700 locations, respectively, and a combined $455.2 billion in sales in 2022.

But now consumers have more options, analysts say, many of which are cheaper and more convenient. They’re also more cautious as inflation — which shot up to 40-year highs in 2022 and remains elevated — weighs on discretionary spending.

“Now we’ve got players like Dollar General that’s moved in, we’ve got expansion of supermarkets, and Walmart is more of a destination in many of these areas. So that’s really cleaned off some of the trade of these stores,” Saunders said.

And moving more merchandise behind plexiglass barriers to discourage theft and violence has lent a dystopian feel to some locations. Front-of-store sales at Rite Aid fell 4.4 percent in the latest quarter. CVS saw a nearly 2 percent sales decline.

Meanwhile, retail giants like Amazon and Walmart have beefed up their pharmacy and medical treatment offerings, and typically offer more competitive pricing on such household essentials as toothpaste, paper towels and laundry detergent. (Amazon founder Jeff Bezos owns The Washington Post, whose interim chief executive, Patty Stonesifer, sits on Amazon’s board.)

Nor has the sector been immune to the labor unrest that set off a frenzy of activism from Hollywood writers to Detroit autoworkers. Pharmacy employees at CVS and Walgreens have staged walkouts, alleging that poor working conditions are putting them and patients at risk. Pharmacists, technicians and support staff claim that increased demands on understaffed teams — such as administering vaccines while battling hundreds of backlogged prescriptions — have become untenable and are impeding their ability to do their jobs responsibly.

Drugstore chains are “shooting themselves in the foot” by failing to invest in pharmacy staffing, Saunders said, because the pharmacy is the one thing about these chains that sets them apart from other retail competitors. If service is bad or prescriptions are delayed, it will put customers off even further, he said.

The pharmacy giants have sought to shore up their positions through consolidation and by syncing up with insurance companies in ways that steer patients back to them. Aetna patients can go to any pharmacy, but they'll get a better deal at CVS, which acquired the insurer in 2018. Blue Cross Blue Shield clients have a similar setup with Walgreens. Rite Aid, has no such relationship with an insurer.

Independent pharmacies with no corporate umbrella, which make up 19,432 locations nationally as of Oct. 15 — more locations than any one branded pharmacy chain — are also left out in the cold, industry officials say.

"This landscape of vertical integration of businesses across different services has put pharmacies who cannot participate at a huge disadvantage," said Mariana Socal, associate scientist at Johns Hopkins University's Bloomberg School of Public Health.

The 'urban health penalty'

For Patrice La Vigne, a freelance journalist in rural Healy, Alaska, filling a prescription means a two-hour drive.

The town has no year-round clinic, hospital or drugstore, she says. That means her husband, who has a chronic illness, must head north to Fairbanks for in-person treatments. It's a familiar trip for most of Healy's roughly 1,000 year-round residents, who use Facebook to coordinate trips to Walgreens, Safeway, Fred Meyer or Costco.

"For us, it's a trade-off of living in a remote area of Alaska," La Vigne, 45, said. "I think for the most part the community … would prefer to have a pharmacy here."

A rural area can be considered a pharmacy desert if residents are more than five miles from the nearest drugstore, Qato said. But in urban centers, where residents may be reliant on public transportation, the radius shrinks to half a mile.

Though the number of pharmacies in the United States has hovered near 64,000 since 2014, there's been a "distribution shift," according to Jenny Guadamuz, an assistant professor of public health at the University of California at Berkeley. Pharmacies are leaving low-income and majority Black and Latinx neighborhoods and expanding in predominantly White and middle- to higher-income areas, she said.

Public health experts are concerned this redistribution could worsen long-standing racial and economic disparities in health care outcomes, too. It's what Edwards calls the "urban health penalty."

"This has been going on historically, and that pretty much just exacerbates preexisting health disparities," she said. "It interrupts care and interrupts all the access to medical advice, access to vaccines, access to food, access to staples."

Racial minorities in the United States already are at a higher risk of diabetes and high blood pressure, for example. Children in low-income areas have higher rates of asthma and mental health issues, Edwards said.

And studies have shown that pharmacy access directly affects how closely people adhere to medication regimes set out by their doctors, Guadamuz said. Seniors with complicated health issues are more prone to become dependent on a pharmacist with whom they have a face-to-face relationship.

“Patients have long-term relationships with their pharmacies,” Guadamuz said. “When a pharmacy closes, they have to find a new one that meets all their needs, that takes their insurance and is affordable, but in neighborhoods with people of color, and rural areas … they’re just less likely to exist anymore.”

Pharmacies also offer needed medical equipment, over-the-counter drugs and food, Edwards said, and many also have self-service blood pressure monitoring machines.

“All of these things are coming out of communities that are already distressed,” Edwards said.

More closures coming

The retailers have also grappled with a wave of lawsuits tied to the opioid epidemic, which has claimed more than 300,000 lives in the United States since 2000.

Walgreens and CVS reached settlements of $10 billion with multiple states, and Kroger agreed to pay $1.2 billion. Rite Aid reached a $30 million opioid settlement in 2022 with the West Virginia attorney general’s office but faces numerous consolidated cases in U.S. District Court for the Northern District of Ohio and with the Justice Department.

Rite Aid, which said it lost $1 billion in the months leading up to its Oct. 15 bankruptcy filing, is shutting 154 locations of its remaining 2,100 stores, according to a filing Thursday in U.S. Bankruptcy Court in New Jersey. This includes 39 locations in Pennsylvania, 31 in California, 20 in New York, 19 in Michigan and six in Maryland. Many of the initial closures appear in suburban outposts of major metro areas, including Detroit, Los Angeles and Philadelphia. This is on top of the more than 200 stores the Philadelphia-based retailer has closed over the past two years.

In a statement to The Post, Rite Aid said it is committed to improving access to critical health services across its markets. “Our small-format store pilot is specifically designed to provide access to pharmacy services in ‘pharmacy deserts’ and underserved communities.”

As part of its bankruptcy court-supervised store closures, the company said that it has “conducted additional research to help ensure we do not create pharmacy deserts in the communities we serve.”

Walgreens, which announced in June that 150 U.S. locations would close by the end of next summer, said in a statement that it is committed to driving equitable access to its pharmacy care and that it utilizes targeted pharmacy services like same-day prescription delivery to help underserved areas.

“We also engage in key alliances to reach vulnerable populations, as we have a long history of working with local churches, civic groups and national public service organizations to deliver lifesaving vaccines to medically underserved populations.”

In 2021, CVS announced it would shut down approximately 900 stores over the next three years. From 2018 to 2020, it closed 244 locations. CVS did not respond to The Post’s request for comment.

Independent pharmacies are under pressure, too, due to many of the same forces buffeting their corporate competitors. A recent survey from the National Community Pharmacists Association shows independent pharmacies reported the slimmest profit margins since the organization started collecting that data 10 years ago.

Upcoming changes to how the government handles Medicare payments could worsen matters, says Ronna Hauser, senior vice president for the trade group. A rule taking effect Jan. 1 is expected to reduce pharmacy payments, she said.

“Cash flow is going to be a real concern” the first three to six months of 2024, Hauser said. “We are concerned that there could be closures due to this cash flow crunch … and we’re very concerned about access points for patients.”

David Ovalle contributed to this report.

house oversight committeePBM-Report-FINAL-with-Red

Uploaded by: Colleen Shields

Position: FWA

The Role of Pharmacy Benefit Managers in Prescription Drug Markets

Report Prepared by the House Committee on Oversight and Accountability Staff

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Executive Summary

Pharmacy Benefit Managers' (PBMs) role as intermediaries between drug manufacturers and health insurance providers should have made them, in theory, the best positioned entities to decrease the cost of prescription drugs.[1] The three largest PBMs, CVS Caremark (Caremark), Cigna Express Scripts (Express Scripts), and UnitedHealth Group's Optum Rx (Optum Rx), control more than 80 percent of the market and are vertically integrated with health insurers, pharmacies, and providers.[2] As large health care conglomerates, some have argued that these PBMs' vertical integration with insurers and pharmacies would better position them to improve patient access and decrease the cost of prescription drugs.[3] **Instead, the opposite has occurred: patients are seeing significantly higher costs with fewer choices and worse care.**

Americans spend more today on prescription drugs than any other country, and prescription drug prices in the U.S. are more than double the cost of identical drugs in other high-income nations.[4] In 2023, the U.S. health care system spent $772.5 billion on prescription drugs, including $307.8 billion on retail drugs.[5] This mammoth spending is largely driven by a small number of high-cost products; brand name drugs accounted for 80 percent of prescription drug spending, despite the fact that 80 percent of prescriptions in the U.S. are for generic drugs.[6] Additionally, the cost of specialty drugs, which accounted for 54 percent of spending in 2023,[7] has increased more than 40 percent since 2016.[8] Patient out-of-pocket costs for prescriptions were $91 billion in 2023 alone.[9] Higher drug utilization and new drugs are also contributing to higher costs, with Americans being prescribed more and paying for more prescription drugs.[10]

This report describes the Committee on Oversight and Accountability's findings that PBMs inflate prescription drug costs and interfere with patient care for their own financial benefit.

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[1] U. S. FED. TRADE COMM'N, INTERIM STAFF REP., PHARMACY BENEFIT MANAGERS: THE POWERFUL MIDDLEMEN INFLATING DRUG COSTS AND SQUEEZING MAIN STREET PHARMACIES, 8 (Jul. 2024).
[2] Adam J. Fein, *Mapping the Vertical Integration of Insurers, PBMs, Specialty Pharmacies, and Providers: A May 2023 Update*, DRUG CHANNELS (May 10, 2023).
[3] Matthew Fiedler, Loren Adler, and Richard G. Frank, *A brief look at current debates about pharmacy benefit managers*, THE BROOKINGS INSTITUTION (Sept. 7, 2023).
[4] Andrew Mulcahy et al., *International Prescription Drug Price Comparisons: Current Empirical Estimates and Comparisons with Previous Studies*, RAND Corporation (2021).
[5] Eric M. Tichy, et al., *National Trends in Prescription Drug Expenditures and Projections for 2024*, 81 AM. J. OF HEALTH-SYSTEM PHARMACY 583 (2024).
[6] Sonal Parasrampuria & Stephen Murphy, *Trends in Prescription Drug Spending, 2016-2021*, Assistant Secretary for Planning and Evaluation Office of Science & Data Policy (Sept. 30, 2022).
[7] IQVIA Inst. for Human Data Science, *The Use of Medicines in the U.S. 2024: Usage and spending trends and outlook for 2028* (Apr. 2024).
[8] *Supra* note 6
[9] *Supra* note 7.
[10] CONG. BUDGET OFF., 57050, PRESCRIPTION DRUGS: SPENDING, USE, AND PRICES, 9 (Jan. 2022); *Supra* note 5.

Key Findings

- **The three largest PBMs have used their position as middlemen and integration with health insurers, pharmacies, providers, and recently manufacturers, to enact anticompetitive policies and protect their bottom line.**
  The Committee found evidence that PBMs share patient information and data across their many integrated companies for the specific and anticompetitive purpose of steering patients to pharmacies a PBM owns. Furthermore, the Committee found that PBMs have sought to use their position to artificially reduce reimbursement rates for competing pharmacies.

- **PBMs frequently tout the savings they provide for payers and patients through negotiation, drug utilization programs, and spread pricing, even though evidence indicates that these schemes often *increase* costs for patients and payers.**
  The Committee identified numerous instances where the federal government, states, and private payers have found PBMs to have utilized opaque pricing and utilization schemes to overcharge plans and payers by hundreds of millions of dollars.

- **The largest PBMs force drug manufacturers to pay rebates in exchange for the manufacturers' drugs to be placed in a favorable tier on a PBM's formulary, making it difficult for competing, lower-priced prescriptions (often generics or biosimilars) to get on formularies.**
  The Committee has found evidence that PBMs regularly place higher cost medications in more preferable positions based on their formularies, even when there are lower-cost and equally safe and effective competing options.

- **As many states and the federal government weigh and implement PBM reforms, the three largest PBMs have begun creating foreign corporate entities and moving certain operations abroad to avoid transparency and proposed reforms.**
  The Committee found that these PBMs have created group purchasing organizations (GPOs) to centralize the negotiation of rebates and fees in Switzerland and Ireland. They have also created companies in Ireland and the Cayman Islands to manufacture and market certain highly profitable generics and biosimilars. The creation of entities in locations well known for their lack of financial transparency and movement of operations that would be subject to impending regulations only heightens concerns that PBMs will do anything to avoid transparency.

- **The largest PBMs' use of tools such as prior authorizations, fail first policies, and formulary manipulations have significant detrimental impacts on Americans' health outcomes.**
  The Committee found that the use of these tools enables PBMs to slow the market uptake of cheaper generics and biosimilars. Furthermore, the Committee found that these tools often delay and negatively impact patient care.

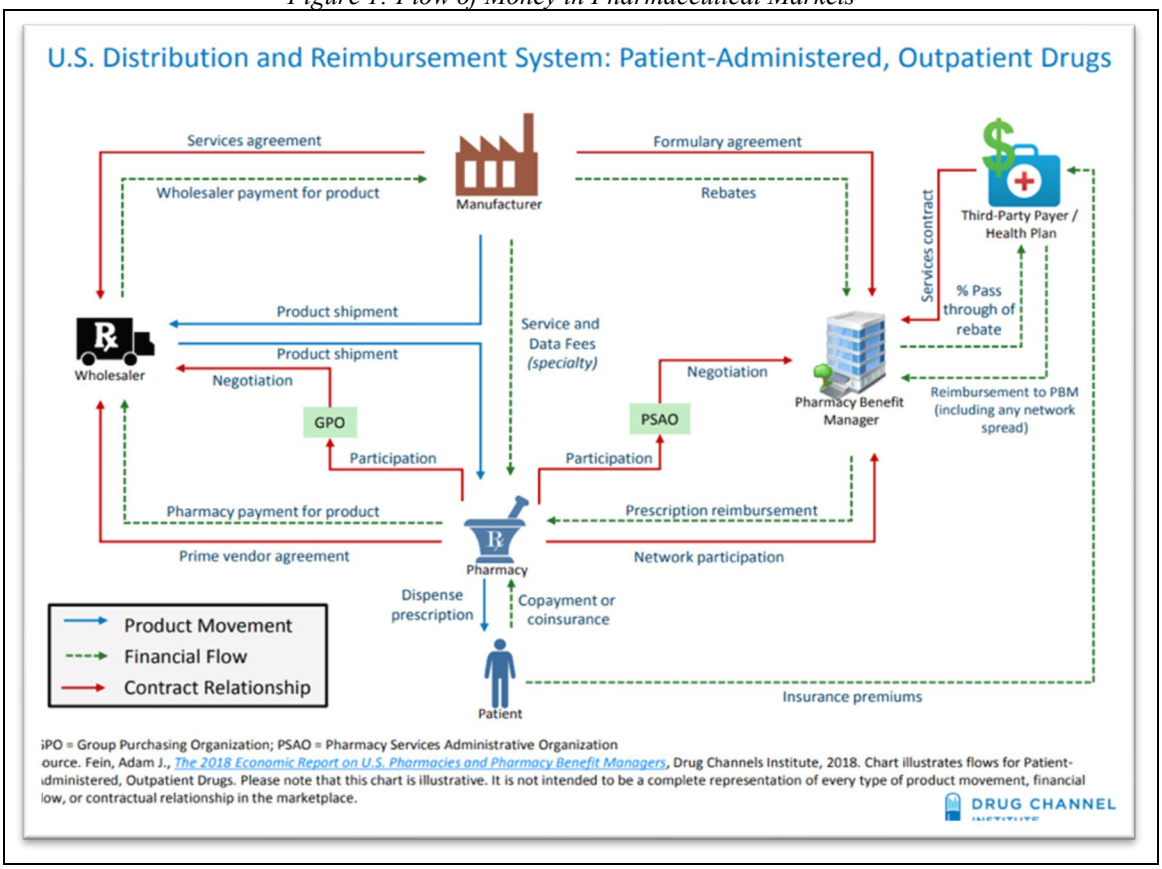
- **The anti-competitive policies of the largest PBMs have cost taxpayers and reduced patient choice.**
  The Committee found that PBMs have intentionally overcharged or withheld rebates and fees from many taxpayer-funded health programs. Additionally, the Committee found that in these taxpayer-funded health programs, PBMs use their position as middlemen to steer patients to the pharmacies they own rather than pharmacies that may have closer proximity or provide better care.

Background

I. The Role of Pharmacy Benefit Managers

PBMs are companies that manage prescription drug benefits for health insurers, Medicare Part D drug plans, self-insured employers, and other payers, such as state Medicaid programs (collectively known as "payers").[11] When they were originally created in the 1960s, PBMs functioned as passive processors of prescription drug claims.[12] However, as the pharmaceutical industry has evolved, the role of PBMs has evolved with it.[13] Today, PBMs have a more significant role and function as intermediaries between drug manufacturers, payers, and pharmacies. PBMs' central role in the pharmaceutical market is clearly observable in Figure 1:

Figure 1: Flow of Money in Pharmaceutical Markets[14]



PBMs' primary responsibilities include negotiating prices with drug manufacturers and pharmacies on behalf of payers.[15] When negotiating with a drug manufacturer, PBMs will frequently offer to place the manufacturer's drug in a lower tier on an insurance plan's

[11] *Supra* note 3.
[12] Robin J. Strongin, *The ABCs of PBMs*, NAT. HEALTH POLICY FORUM, Issue Brief, No. 749 (Oct. 27, 1999).
[13] *Id.*
[14] Brandt Dietary, *Pharmacy Benefit Manager Regulation: What Happens Now?*, Michael Best Strategies, (Jan. 14, 2019).
[15] *Supra* note 3.

formulary, making the drug more accessible to a wider range of patients; in return, the drug manufacturer will give the PBM a discount, or rebate, on the drug.[16] These rebates are frequently "calculated as a percentage of a drug's list price."[17] This creates a perverse incentive wherein PBMs prioritize more expensive drugs so they can get a larger rebate.[18]

PBMs also negotiate with individual pharmacies by offering a pharmacy a place in the plan's network, increasing the pharmacy's potential for business.[19] In return, the PBM reimburses pharmacies at a set amount for dispensing prescriptions.[20] Additionally, PBMs operate electronic systems that process prescription drug claims at the pharmacy.[21]

A PBM's compensation is determined by its business model. One such model is based on health plans paying PBMs for services directly by establishing an administrative fee contract.[22] Another route is spread pricing, where a health plan pays a PBM an agreed-upon price for each prescription that is filled and the PBM retains the difference between the health plan's price and the pharmacy's price.[23] Finally, PBMs may keep portions of manufacturer rebates as a form of compensation.[24]

II. The Current Marketplace

There are currently 66 PBMs operating in the United States; however, the three largest PBMs—CVS Caremark, Express Scripts, and Optum Rx—control approximately 80 percent of the market.[25] Collectively, the largest six PBMs collectively control approximately 96 percent of the market.[26] Moreover, the largest PBMs are now vertically integrated with health insurers, group purchasing organizations (GPOs), and retail, mail-order, and specialty pharmacies, forming a consolidated marketplace.[27] This vertical integration can be seen in Figure 2:

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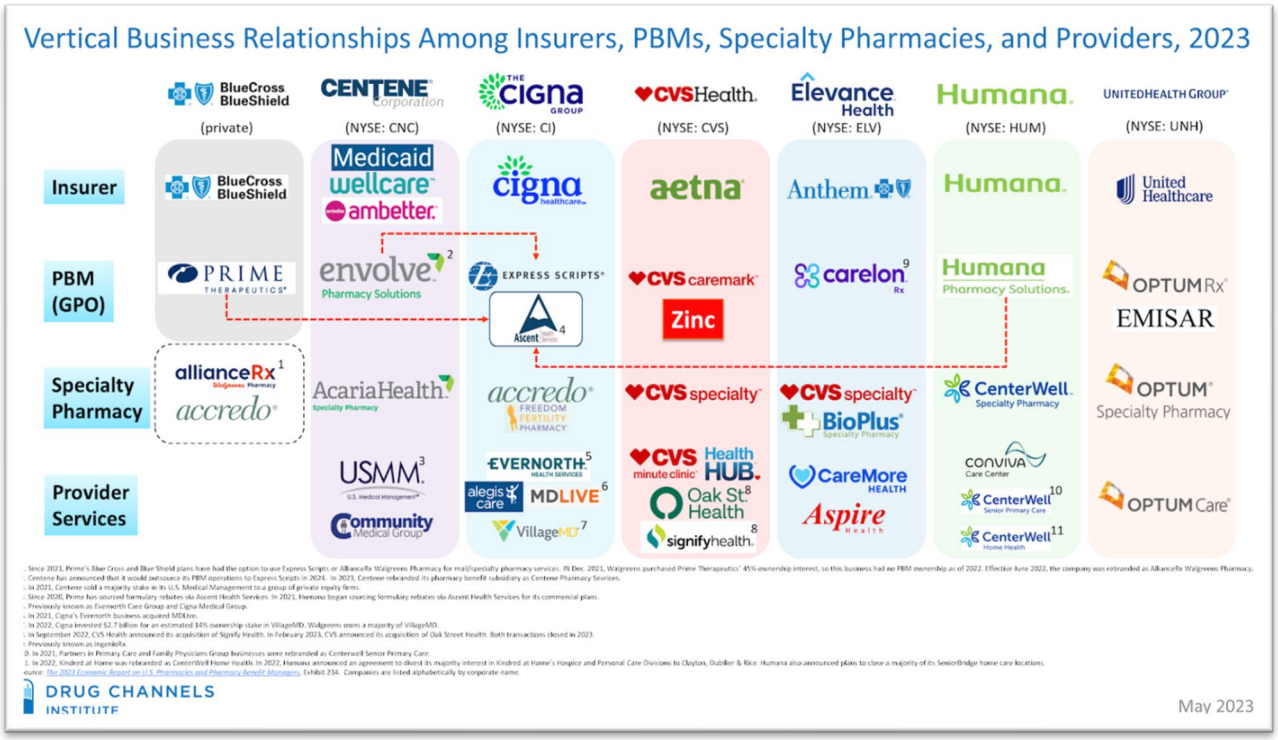
[16] *Supra* note 3.
[17] Nitzan Arad et al., *Realizing the Benefits of Biosimilars: Overcoming Rebate Walls*, DUKE UNIVERSITY MARGOLIS CENTER FOR HEALTH POLICY (March 2022). *See also* Sarah Bhatnagar, *High Drug Prices: Are PBMs the Right Target*, Bipartisan Policy Center (Feb. 02, 2023).
[18] *Id.*
[19] *Supra* note 3. .
[20] *Supra* note 3. *; see also* Press Release, Federal Trade Commission, FTC Launches Inquiry Into Prescription Drug Middlemen Industry (June 7, 2022); *see also* Hannah Rogers, Jennifer Staman, Alexander Pepper, *Pharmacy Benefit Managers: Current Legal Framework*, Congressional Research Service (November 20, 2023).
[21] *Supra* note 3. ; *see also Supra* note 20.
[22] U.S. GOV'T ACCOUNTABILITY OFF., GAO-24-106898, PRESCRIPTION DRUGS: SELECTED STATES' REGULATION OF PHARMACY BENEFIT MANAGERS, 7 (Mar. 2024).
[23] *Id.*
[24] *Id*.
[25] *Pharmacy Benefit Managers*, NAIC *available at* https://content.naic.org/cipr-topics/pharmacy-benefit-managers; *see also* Paige Twenter, *Top PBMs by 2022 market share*, BECKER'S HOSPITAL REVIEW (May 23, 2023)
[26] *Id.*
[27] *Supra* note 20.

Figure 2: Vertical Integration in PBM Markets[28]



III. The Committee's Investigation

In response to mounting concerns over the escalating cost of prescription drugs, then-Ranking Member James Comer initiated an investigation into PBMs on November 17, 2021, with the forum "Reviewing the Role of Pharmacy Benefit Managers in Pharmaceutical Markets."[29] Experts, including pharmacists, physicians, and representatives of PBMs, were able to discuss the role of PBMs in the pharmaceutical market with lawmakers and repeatedly testified to the need for greater transparency in order to determine the full extent of PBMs' tactics and their effects.

In December 2021, the Committee issued a report highlighting initial findings that large PBM consolidation has negatively impacted patient health, increased costs for consumers, forced manufacturers to raise their prices, and created conflicts of interest which distort the market and limit high quality care for patients.[30]

On March 1, 2023, Chairman Comer sent document requests related to formulary design and management, rebates, and fees to CVS Caremark, Express Scripts, Optum Rx, and the three federal agencies that oversee federal health plans: the Centers for Medicare and Medicaid Services (CMS), the Office of Personnel Management (OPM), and the Defense Health Agency

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[28] *Supra* note 2.
[29] Press Release, H. Comm. on Oversight & Accountability, PBM Forum Wrap Up: Greater Transparency, Further Congressional Review Needed to Lower Drug Prices (Nov. 17, 2021).
[30] Staff Report, H. Comm. on Oversight and Reform, *Report: A view from Congress: Role of Pharmacy Benefit Managers in Pharmaceutical Markets*, 117th Cong. (Dec. 10, 2021).

(DHA).[31] Since then, the Committee has received and reviewed more than 140,000 pages of documents. Additionally, the Committee has held two hearings regarding PBMs[32] and marked up and favorably reported H.R. 6283, the Delinking Revenue from Unfair Gouging (DRUG) Act, which would apply to the Federal Employees Health Benefits Act (5 U.S.C. §§ 8901 et seq.).[33]

PBMs' Anticompetitive Behavior

> *"A recent poll by Morning Consult showed that in March 2023…85 percent of Americans are concerned that PBMs are overcharging for prescription medicines and pocketing the difference as profit. In that survey, 88 percent of Democrats and 88 percent of Republicans shared that concern … I think we have a mandate from the American people to investigate.*"[34] **– Rep. Raja Krishnamoorthi (D-Ill.)**

The PBM industry has experienced significant consolidation and vertical integration over the last few decades.[35] In 1995, five PBMs controlled 80 percent of the market; by the 2010s, CVS Caremark, Express Scripts, and Optum Rx dominated 80 percent of the market.[36] CVS Health Corporation, a healthcare company, owns both CVS Caremark, a PBM, CVS Pharmacy, a retail pharmacy chain, and CVS Specialty, a specialty pharmacy. Cigna, a large healthcare company, owns Express Scripts, a PBM, and Express Scripts Pharmacy, a mail-order pharmacy. UnitedHealth Group, another large healthcare company, owns both Optum Rx, a PBM, and an Optum Specialty Pharmacy.

[31] Press Release, H. Comm. on Oversight & Accountability, Comer Launches Investigation into Pharmacy Benefit Managers' Role in Rising Health Care Costs (Mar. 1, 2023).
[32] *The Role of Pharmacy Benefit Managers in Prescription Drug Markets Part I: Self-Interest of Healthcare?*: *Hearing Before H. Comm. on Oversight & Accountability*, 118th Cong. (May 23, 2023); *The Role of Pharmacy Benefit Managers in Prescription Drug Markets Part II: Not What the Doctor Ordered*: *Hearing Before H. Comm. on Oversight & Accountability*, 118th Cong. (Sept. 19, 2023).
[33] Delinking Revenue from Unfair Gouging Act, H.R.6283, 118th Cong. (2023).
[34] *Supra* note 32.
[35] T. Joseph Mattingly II & David Hyman, *Pharmacy Benefit Managers History, Business Practices, Economics, and Policy*, JAMA HEALTH FORUM (Nov. 3, 2023).
[36] Andrew Lautz, *How Pharmacy Benefit Managers Impact Taxpayers and Government Spending*, NATIONAL TAXPAYERS UNION (Jan. 23, 2023).

Figure 3: Vertical Relationships within PBM Markets[37]

[37] *Supra* note 2.

"It is possible to operate a PBM, restrain costs for the employer and taxpayers while still providing the best pharmacy care available. But changes must be made to require greater transparency and allow for greater competition for this to happen."[38] **– Greg Baker, CEO, AffirmedRx**

I. Pharmacy Networks

PBMs administer pharmacy networks, typically comprised of independent community and chain pharmacy providers as well as specialty pharmacies and physician-dispensing facilities associated with medical practices.[39] Establishing these networks is a key function of PBMs, and they utilize this function to "steer" patients to the pharmacies they control.[40] Each of the big three PBMs own their own pharmacies, disincentivizing negotiation, enabling benefitting from higher prices, and hurting their competition by reducing patients' pharmacy choices.[41]

"My wife and I bought the local pharmacy with an SBA loan… What I hoped could be and can be a great opportunity for my community is in peril..." [42] – **Kevin Duane, PharmD, pharmacist and owner of Panama Pharmacy, Jacksonville, Florida**

Anticompetitive practices make it difficult for unaffiliated chain and independent community pharmacies to survive. PBMs reimburse independent and unaffiliated chain pharmacies at low rates and charge retroactive fees.[43] Retroactive fees are often arbitrary and can be levied weeks to months after a prescription is processed.[44] Even though a pharmacy may be in-network, extraneous PBM fees add up, often costing a pharmacy more to fill a prescription than it is reimbursed.[45] Due to the market share of the three largest PBMs, pharmacies are often faced with choosing between accepting fees or not serving patients.

Community and independent pharmacies are struggling to keep up. Dr. Duane testified before the Committee that his pharmacy "cannot negotiate any aspect of [their] contracts with [PBMs] in any meaningful type of fashion."[46] Additionally, Dr. Duane explained:

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[38] *Supra* note 32.
[39] *Supra* note 22.; *see also* Specialty Drug Dispensing for Physician Offices, McKesson, https://www.mckesson.com/specialty/drug-purchasing-and-management/dispensing-services/.
[40] Interim Staff Report, *Pharmacy Benefit Managers: The Powerful Middlemen Inflating Drug Costs and Squeezing Main Street Pharmacies*, U.S. FEDERAL TRADE COMMISSION (July 2024) *available at* https://www.ftc.gov/system/files/ftc_gov/pdf/pharmacy-benefit-managers-staff-report.pdf; *see also Reviewing the Role of Pharmacy Benefit Managers in Pharmaceutical Markets Forum, House Comm. On Oversight and Reform Minority*, 117th Congress. (Nov. 17, 2021).
[41] *Supra* note 2.
[42] Press Release, H. Comm. on Oversight and Accountability, Comer Announces First Hearing on Pharmacy Benefit Managers' Role in Rising Health Care Costs (May 16, 2023).
[43] Stacy Mitchell, *How the FTC Protected the Market Power of Pharmacy Benefit Managers*, ProMarket, (Feb. 19, 2021).
[44] Nat'l Ass'n of Chain Drug Stores, DIR Fees, *available at* https://www.nacds.org/dir-fees/.
[45] *PBM Reform: It's Time for Washington to Protect*, WSPA *available at* https://www.wsparx.org/page/PBM.
[46] *Supra* note 32.

"The outsized role PBMs take in the pharmacy space has caused many problems for our patients and our practice. The three largest PBMs control 80 percent of the market today, which means patients are forced by PBMs into using a certain pharmacy, often one owned and operated by the PBM, or they may be forced to get their drugs through the mail even though they want a pharmacist face-to-face in their community. Patients and their doctors have virtually no say in what drugs are used, since the PBM essentially forces which drugs can be used – not because a drug is better or worse, but because the PBM can make more money from it."[47] **– Kevin Duane, PharmD, pharmacist and owner of Panama Pharmacy, Jacksonville, Florida**

These practices have sometimes violated state law, leading to enforcement actions and legal settlements. In January 2022, CVS Caremark agreed to pay $4.8 million to the Oklahoma Insurance Department for alleged violations of Patient's Right to Pharmacy Choice Act.[48] In March 2023, Ohio Attorney General Dave Yost sued Express Scripts, Prime Therapeutics and five other PBMs for colluding to keep drug prices high and to exclude competing pharmacies from their networks by forcing them to accept drug reimbursement rates "far below what they have to pay for these drugs" and pay "exorbitant 'administrative' fees."[49]

II. Retroactive Fees

"[Independent pharmacies] can be the center of a community. We are more than just providing medication for people… We can help on things that they can't get into right away with their physicians. [Rising PBM fees are] huge. Indescribable amount of chaos. We cannot adequately plan because of the amount of money that is taken back are" [50] **– Kevin Duane, PharmD, pharmacist and owner of Panama Pharmacy, Jacksonville, Florida**

Direct and Indirect Remuneration (DIR) fees are retroactively levied on pharmacies for prescriptions purchased under Medicare Part D benefits. DIR fees were intended in Medicare Part D to ensure accurate reporting and payment for the actual cost of a drug and avoid over-reimbursement by the government.[51] Instead, DIR fees are an avenue for PBMs and plan sponsors to claw back or charge back pharmacies after a reimbursement claim has been

[47] *Supra* note 32.
[48] Oklahoma Ins. Dep't, Press Release, *OID Reaches $4.8 Million Settlement Agreement with CVS Caremark for Alleged Violations of the Patient's Right to Pharmacy Choice Act, Dependent on Federal Court Decision* (Jan. 20, 2022).
[49] News Release, Ohio Attorney General, Yost Sues Express Scripts, Prime Therapeutics and 5 Others, Blaming Exorbitant Drug Prices on Their Collusion (Mar. 27, 2023).
[50] *Supra* note 32.
[51] DIR Fees, Frier Levitt Attorneys at Law, *available at* https://www.frierlevitt.com/what-we-do/pharmacy-law/dir-fees/#:~:text=PBMs%20typically%20utilize%20DIR%20fees,adjustments%2C%E2%80%9D%20or%20similar%20names

submitted.[52] Retroactive fees are being manipulated by PBMs to increase profits and introduce vast uncertainty for pharmacies that are hit with unpredictable fees that result in negative reimbursement rates.[53]

Figure 4: Illustration of DIR Fees' Impact on Pharmacy Business Operations[54]

One way that PBMs penalize competing independent and specialty pharmacies is by basing DIR fees on opaque performance ratings, which are based on retail medication therapy management and chronic disease management.[55] For example, PBM rating systems grant higher performance ratings to pharmacies that frequently dispense generics and "maintenance medications" for chronic conditions such as hypertension or diabetes.[56] As such, specialty pharmacies, like in-house oncology clinics, receive low performance ratings and therefore higher DIR fees.[57] In July 2022, Aids Healthcare Foundation (AHF) sued Express Scripts alleging they manipulated Medicare star ratings to ensure pharmacies get unfairly low scores, allowing

[52] Pharmacy Direct and Indirect Renumeration (DIR) Fees: Recommendations for Reforms to Benefit Patients, Pharmacists, and Government, McKesson, *available at* https://www.mckesson.com/globalassets/mckesson/documents/about-mckesson/public-affairs/reining-in-pharmacy-dir-fees
[53] *Supra* note 51.
[54] *Supra* note 52.
[55] True North Political Solutions, *White Paper: DIR Fees Simply Explained*, PHARMACY TIMES (Oct. 25, 2017).
[56] *Id.*
[57] *Id.*

Express Scripts to "claw back" Medicare benefits from pharmacies. According to AHF, Express Scripts was engaged in 14 different violations across nine states.[58]

> "*According to the government, these [Direct and Indirect Remuneration (DIR)] fees increased by 107,400 percent from 2010 to 2020. This is a travesty. You know what PBM really stands for? It stands for Pretty Big Markups. We've got to stop this."* **– Rep. Raja Krishnamoorthi (D-Ill.)**

In 2017, CMS released a fact sheet about the rise in DIR fees reported in recent years and its impact on net drug costs.[59] According to CMS, higher DIR fees lead to higher out-of-pocket spending.[60] DIR fees do not translate to cost-savings for Medicare beneficiaries, as they are not reflected in the negotiated price that determines patient cost-sharing.[61] Similarly, DIR fees do not save taxpayers money since CMS is reimbursing the drug's negotiated price, rather than the price after DIR fees are applied.[62] Additionally, higher out-of-pocket drug costs increase Medicare plan liability as beneficiaries spend more towards their plan's out-of-pocket maximum.[63] After out-of-pocket spending reaches a certain point ($8,000 in 2024), beneficiaries enter the catastrophic coverage phase.[64] Once a beneficiary falls under catastrophic coverage, Medicare is responsible for all covered drugs for the remainder of that year.[65]

On May 3, 2023, CMS provided guidance for Medicare Part D sponsors on reporting DIR data for contract year 2022.[66] In the guidance, CMS highlighted concerns that risk-sharing payments and adjustments, including all rebates, subsidies, and post-payment incentives, related to supplemental coverage of Part D drugs were not being reported as DIR.[67] It is important that DIR data be reported to CMS accurately, as it determines payment reconciliation for costs incurred by Part D sponsors for Part D drugs, net DIR fees.[68] Under the new guidance, CMS defines DIR broadly as "discounts, chargebacks, rebates, cash discounts, free goods contingent on a purchase agreement, up-front payments, coupons, goods in kind, free or reduced-priced services, grants, legal judgment amounts, settlement amounts from lawsuits or other legal action, and other price concessions or similar benefits."[69] The 2024 DIR reporting guidance for contract year 2023 contained no substantive changes from the previous year's guidance.[70]

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[58] Paige Minemyer, *AIDS Healthcare Foundation Sues Express Scripts over Medicare 'Clawbacks'*, FIERCE HEALTHCARE (Jul. 14, 2022).
[59] Fact sheet, Ctrs. for Medicare & Medicaid Servs., Medicare Part D – Direct and Indirect Remuneration (DIR) (Jan. 19, 2017).
[60] *Id.*
[61] *Id.*); *see also* U. S GOV'T ACCOUNTABILITY OFF., GAO-23-105270, MEDICARE PART D: CMS SHOULD MONITOR EFFECTS OF REBATES ON PLAN FORMULARIES AND BENEFICIARY SPENDING (Sept. 5, 2023).
[62] *Supra* note 59.
[63] *Id.*
[64] *Id.*
[65] *Id.*
[66] Ctrs. for Medicare & Medicaid Servs., Final Medicare Part D DIR Reporting Guidance for 2022 (May 3, 2023).
[67] *Id.*
[68] *Id.*
[69] *Supra* note 66.
[70] *Id.*

In 2022, CMS promulgated a final rule impacting pharmacy price concessions for Medicare Advantage (Part C) and Medicare Prescription Drug Benefit (Part D) effective January 1, 2024.[71] The final rule mandates that all price concessions (including DIR fees) be included in the "negotiated" final price that is paid by patients at the pharmacy counter, rather than being retroactively charged.[72] The rule was intended to provide greater transparency for patients and pharmacies and "lower total beneficiary out-of-pocket costs," according to CMS.[73] However, instead of benefiting pharmacies and patients, the rule has resulted in PBMs withholding pharmacy reimbursement and reducing reimbursement rates below the cost of the medication.[74] The reduced reimbursement is understood to be in response to the PBMs' inability to collect retroactive DIR fees.[75] While the implementation of the rule is still ongoing, the initial impacts indicate that PBMs are simply moving towards replacing DIR fees with reduced reimbursements for competitor pharmacies and not reducing the price of drugs at the pharmacy counter.[76]

While CMS' DIR reporting guidance and final rule were a step towards eliminating unpredictable retroactive fees, these actions do not remove unfair fees entirely, nor increase transparency into PBM fee policies. Rather, DIR fees are instead applied to the point-of-sale price paid by Medicare beneficiaries rather than being assessed on the pharmacy weeks or months after a prescription is filled.[77] As a result, Medicare beneficiaries' out-of-pocket costs increase, and pharmacies are underwater on the cost of dispensing certain drugs. The Department of Health and Human Services (HHS) Inspector General (IG) is currently auditing CMS to determine if Part D sponsors are submitting accurate DIR reporting data to Medicare.[78]

III. Steering Patients to Pharmacies owned by PBMs

> "*PBMs use a variety of methods to steer patients away from unaffiliated pharmacies. They create differential cost-sharing structures and arbitrary lists, such as specialty and aberrant drug lists, among other schemes, to limit independent pharmacies' access to patients."*[79] **– Hugh Chancy, RPh, Owner, Chancy Drugs Pharmacy, Georgia**

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[71] Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency, 87 Fed. Reg. 27,704 (May 9, 2022) (42 C. F. R. § 417, 422, 423).
[72] *Id.*
[73] Maia Anderson, *'This is an Emergency': Trade Group Warns Nearly a Third of all Independent Pharmacies Will Go Extinct Because of a CMS Rule*, FORTUNEWELL (Mar. 30, 2024).
[74] *Report for February 2024 Survey of Independent Pharmacy Owners/*Managers, NCPA, *available at* https://ncpa.org/sites/default/files/2024-02/Feb2024-DIRsurvey.Exec%20Summary.pdf
[75] Letter from Community Oncology Alliance to Hon. Chiquita Brooks-LaSure, Adm'r, Ctrs. for Medicare & Medicaid Servs. (Feb. 21, 2024), *available at* https://assets.mycoa.io/1709818057048_COA_CMS_Letter_ESI-UnreasonableREimbursementTerms_FINAL_Redacted_Sanitized.pdf
[76] *Id.*
[77] *Supra* note 66.
[78] U.S. Dep't of Health & Human Servs. Off. of Inspector Gen., Workplan, Part D Sponsors Reporting of Direct and Indirect Renumerations, *available at* https://oig.hhs.gov/reports-and-publications/workplan/summary/wp-summary-0000249.asp.
[79] *Supra* note 32.

PBMs limit patients' abilities to choose their pharmacies. The three largest PBMs each own retail, mail-order, and specialty pharmacies that are "preferred" in-network under the pharmacy benefit.[80] PBMs steer patients to pharmacies they own by various means, including: (1) preventing patients from receiving 90-day prescriptions at competing pharmacies; (2) abusing data received by the PBM to target patients with highly profitable medications; (3) only covering specialty medications if they are dispensed from a particular pharmacy; and (4) charging patients higher copays at competing pharmacies to incentivize patients to use the PBM owned pharmacy.[81] Anticompetitive behavior harms patients and independent community pharmacies, increasing drug prices for patients, employers, and government payers.[82]

PBM efforts to steer patients have resulted in significant recent litigation including in April 2022, the Minnesota Department of Commerce initiated an enforcement action against CVS Caremark for violations of the Pharmacy Benefit Manager Act, seeking to fine the company $1.25 million. The Department alleged CVS Caremark violated state laws protecting patient choice by requiring patients to fill maintenance medications at CVS retail pharmacies or Caremark-owned mail-order pharmacies.[83] The State of Oklahoma is in active litigation against the Pharmaceutical Care Management Association (PCMA), the trade association for PBMs, attempting to uphold the state's ability to prevent PBMs from, amongst other things, steering patients to PBM-affiliated pharmacies over competing pharmacies.[84] The case is presently being appealed to the Supreme Court. A bipartisan group of 32 Attorneys General have filed an amicus brief urging the Supreme Court to take up the case and overrule the Tenth Circuit's decision that states are unable to regulate PBMs.[85]

According to the Pharmacists Society of the State of New York, PBMs use various tactics, most of which they contractually prohibit competing pharmacies from doing, to entice patients to use PBM-owned pharmacies for long-term maintenance prescriptions.[86] At their mail-order pharmacies, PBMs will offer patients a 90-day prescription for the price of 60 days while prohibiting a local community pharmacy from offering patients the same price.[87] The Committee's investigation found examples of outreach to patients in which the PBM will claim to save the patient 29 percent against the local pharmacy, even though that competing pharmacy's copays are set by the PBM.[88]

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[80] Press Release, Fed. Trade Comm'n, FTC Deepens Inquiry into Prescription Drug Middlemen (May 17, 2023).
[81] *Supra note 32*.; *see also Supra* note 30.; *see also Supra* note 42.
[82] Letter from B. Douglas Hoey, CEO, Nat'l Community Pharmacists Ass'n, to Hon. Lina Khan, Chair, Fed. Trad Comm'n (May 23, 2022).
[83] *State moves to fine CVS/Caremark for patient protection law violations*, NAT'L CMTY PHARMACISTS ASS'N (Apr. 29, 2022).
[84] Press Release, The Office of Minnesota Attorney General, Attorney General Ellison Leads Effort Asking Supreme Court to rule on States' Authority to Regulate Pharmacy Benefit Managers (June 10, 2024).
[85] Brief on Petition for a Writ of Certiorari to the U.S. Ct. of App. for the Tenth Cir., et al. as Amici Curiae Supporting Petitioners, *Pharm. Care Mgmt. Ass'n v. Mulready*, 78 F.4th 1183 (10th Cir. 2023). *available at* https://ncdoj.gov/wp-content/uploads/2024/06/Mulready-v.-PCMA-Amicus-Brief-Certiorari.pdf
[86] *PBM Basics*, Pharmacists Society of the State of New York, Inc., *available at* https://www.pssny.org/page/PBMBasics.
[87] *Id.*
[88] Express Scripts Fifth Production, ESI00012629 (Oct. 27, 2023) (on file with Comm.).

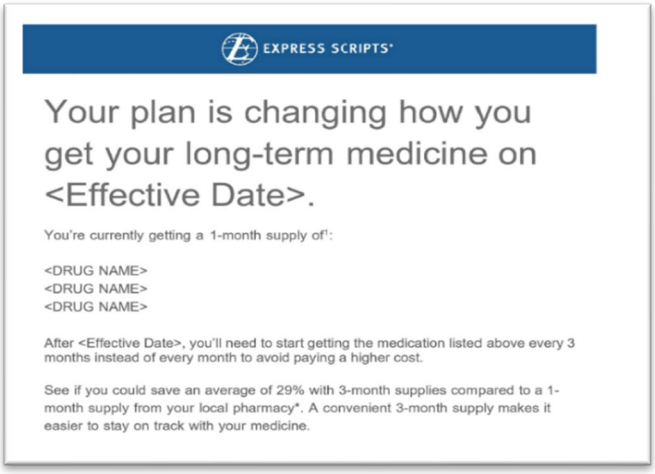
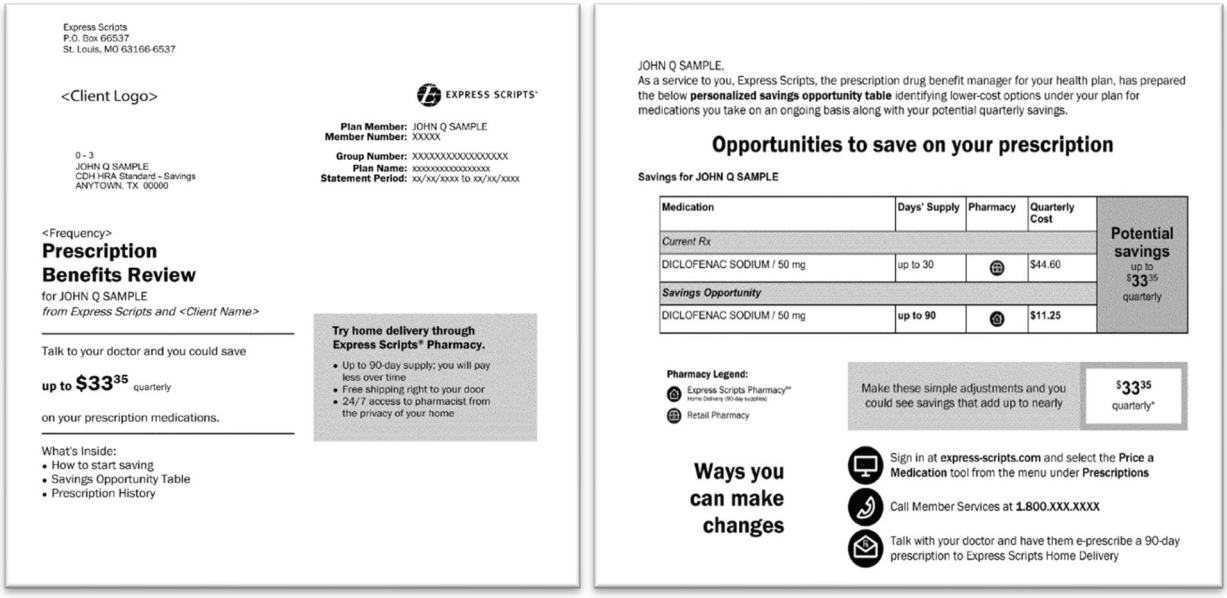


Figure 5: Express Scripts patient outreach for 90-day prescription[89]

Further, the Committee found examples of outreach templates that PBMs use to incentivize patients to use PBM-owned pharmacies. Below is an example of a letter that would go out to a patient urging them to move their prescription to Express Scripts' mail-order pharmacy by providing patients the ability to save money and get more of the medication at once.[90] While this is made to appear to benefit the patient, what it is instead doing in practice is limiting a patient's ability to choose their own pharmacy. Express Scripts can allow a competing brick-and-mortar pharmacy to offer the medication for the same or a lower price and 90-days instead of 30-days, and simply let the patient choose which pharmacy they want to use based on higher quality care or ease of use. But Express Scripts does not do so. Instead, they use their position as middlemen to shift long-term maintenance prescriptions to the pharmacies they own.

[89] *Id.*
[90] Express Scripts Fifth Production, ESI00012638-ESI00012645 (Oct. 27, 2023) (on file with Comm.).

Figure 6: Express Scripts directing patient to Express Scripts Pharmacy[91]

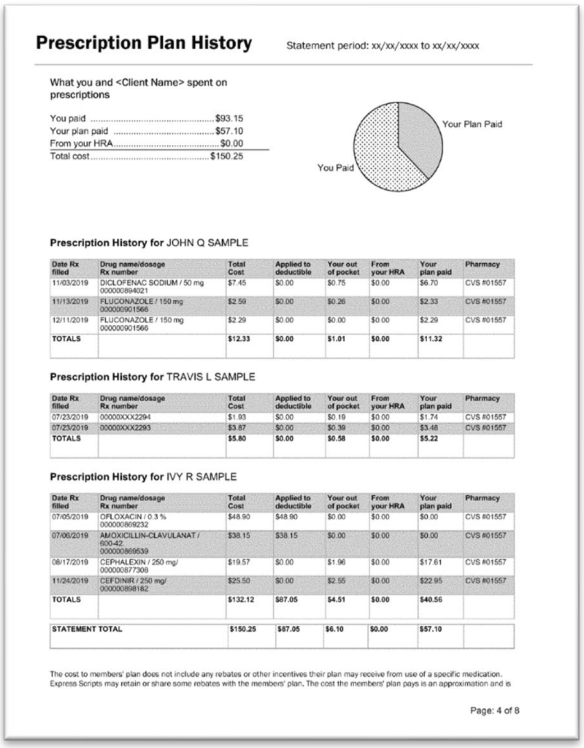


PBMs not only steer patients to mail-order pharmacies for long-term maintenance drugs but they also specifically target patients with higher cost medications. A recent review commissioned by the Washington State Pharmacy Association found that filling prescriptions through mail-order pharmacies in the State of Washington cost payers and patients more, despite being touted as a savings benefit.[92] This analysis found that in Washington, generic prescriptions filled by mail-order cost more than three times higher and branded drugs three to six times higher than if they were filled at traditional pharmacies.[93] Alarmingly, branded mail order drugs cost roughly 35 times higher than those filled by independent pharmacies.[94] An audit of Florida's Medicaid managed care program found that PBM anticompetitive practices that guide patients toward PBM-owned pharmacies charged higher prices on specialty drugs than if they were filled at a competing pharmacy.[95]

Below is another example from Express Scripts illustrating just a small portion of the data the three large PBMs have access to for any patient who uses them to manage their pharmacy benefit:

[91] *Id.*
[92] Jared S. Hopkins, *Mail-order drugs were supposed to keep costs down. It's doing the opposite*., WALL ST. J. (Jun. 25, 2024).
[93] *Id.*
[94] *Id.*
[95] 3 Axis Advisors, *Sunshine in the Black Box of Pharmacy Benefits Management: Florida Medicaid Pharmacy Claims Analysis*, 126 (Jan. 27, 2020).

Figure 7: Express Scripts utilizing patient data to urge the patient to stop using competing pharmacy[96]



Prescription Plan History Statement period: xx/xx/xxxx to xx/xx/xxxx

What you and <Client Name> spent on prescriptions

You paid $93.15
Your plan paid $57.10
From your HRA $0.00
Total cost $150.25

Prescription History for JOHN Q SAMPLE

Date Rx filled	Drug name/dosage Rx number	Total Cost	Applied to deductible	Your out of pocket	From your HRA	Your plan paid	Pharmacy
11/03/2019	DICLOFENAC SODIUM / 50 mg 00000894021	$7.45	$0.00	$0.75	$0.00	$6.70	CVS #01557
11/13/2019	FLUCONAZOLE / 150 mg 00000901566	$2.59	$0.00	$0.26	$0.00	$2.33	CVS #01557
12/11/2019	FLUCONAZOLE / 150 mg 00000901566	$2.29	$0.00	$0.00	$0.00	$2.29	CVS #01557
TOTALS		**$12.33**	**$0.00**	**$1.01**	**$0.00**	**$11.32**	

Prescription History for TRAVIS L SAMPLE

Date Rx filled	Drug name/dosage Rx number	Total Cost	Applied to deductible	Your out of pocket	From your HRA	Your plan paid	Pharmacy
07/23/2019	00000XXX2294	$1.93	$0.00	$0.19	$0.00	$1.74	CVS #01557
07/23/2019	00000XXX2293	$3.87	$0.00	$0.39	$0.00	$3.48	CVS #01557
TOTALS		**$5.80**	**$0.00**	**$0.58**	**$0.00**	**$5.22**	

Prescription History for IVY R SAMPLE

Date Rx filled	Drug name/dosage Rx number	Total Cost	Applied to deductible	Your out of pocket	From your HRA	Your plan paid	Pharmacy
07/05/2019	OFLOXACIN / 0.3 % 00000809232	$48.90	$48.90	$0.00	$0.00	$0.00	CVS #01557
07/06/2019	AMOXICILLIN-CLAVULANAT / 600-42 00000869639	$38.15	$38.15	$0.00	$0.00	$0.00	CVS #01557
08/17/2019	CEPHALEXIN / 250 mg/ 00000877306	$19.57	$0.00	$1.96	$0.00	$17.61	CVS #01557
11/24/2019	CEFDINIR / 250 mg/ 00000898182	$25.50	$0.00	$2.55	$0.00	$22.95	CVS #01557
TOTALS		**$132.12**	**$87.05**	**$4.51**	**$0.00**	**$40.56**	
STATEMENT TOTAL		**$150.25**	**$87.05**	**$6.10**	**$0.00**	**$57.10**	

The cost to members' plan does not include any rebates or other incentives their plan may receive from use of a specific medication. Express Scripts may retain or share some rebates with the members' plan. The cost the members' plan pays is an approximation and is

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Express Scripts not only has the name of a prescription a patient uses but also identifies the costs, which they determine, to the patient. This enables the PBM to undercut the competing pharmacy for maintenance medications or push patients with high-cost medications to the PBM owned pharmacy.

Specialty medications are generally used to treat rare and complex health problems and often require specialized storage and dispensing that is closely supervised by a provider. However, there is no widely accepted definition of a specialty medication. OptumRx policy documents reviewed by the Committee state that specialty pharmacies are necessary for highly complex medications.[97] According to testimony, PBMs "create differential cost-sharing structures and arbitrary lists, such as specialty and aberrant drug lists," to shift certain, generally highly profitable, medications to PBM owned pharmacies.[98]

Further, documents and testimony indicate that PBMs only view the specialty pharmacies they own as necessary for treating patients. When a non-PBM affiliated specialty pharmacy can fill a specialty prescription, PBM coverage tactics shift patients to their affiliated specialty pharmacies, even when it delays or interrupts patient care.[99] In oncology and rheumatology treatment, it is common for providers to prescribe high-cost intravenous drugs that are

[96] *Supra* note 90.
[97] Optum Rx Second Production, ORX-COA-00005477 (May 3, 2023) (on file with Comm.).
[98] *Supra* note 32.
[99] Joyce Frieden, *PBM specialty pharmacy requirement hurting patients, specialists say*, MEDPAGE TODAY (Aug. 23, 2022).

administered under the provider's supervision. In some instances, PBM specialty pharmacy requirements have forced providers to delay treatments by requiring a prescription to be sent to the PBM's specialty pharmacy first before it can be shipped to the provider clinic to be administered.[100] This can result in delays of weeks or more. These delays, combined with the limited formulary mandates, effectively decide which therapy is best for a sick patient and removes decision-making authority from both providers and patients. Medical providers, not PBMs, know what treatments are best for their patients and the best venue in which to receive them.

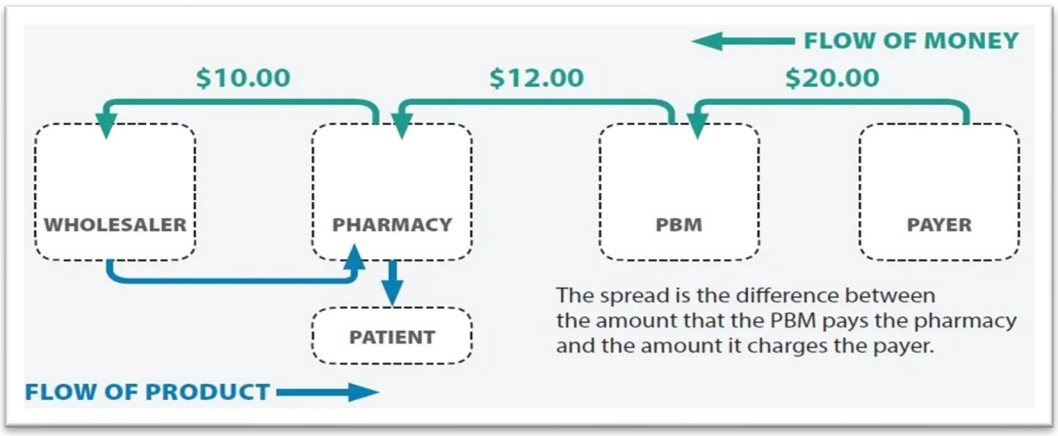
Spread Pricing

> ***Rep. LaTurner:*** *"We have seen examples of PBMs engaging in spread pricing. Where the PBM charges more than what they reimburse the pharmacy and then pocket the difference. In my home of Kansas, accusations of this practice were recently settled for $26.7 million dollars… Do you believe that additional transparency in the price setting of drugs important?"*
>
> ***Mr. JC Scott, CEO, Pharmaceutical Care Management Association:*** *"Yes transparency can be helpful."*[101]

PBMs regularly engage in spread pricing, a practice where the PBM charges payers more than what the PBM reimburses the pharmacy, and the PBM pockets the difference, or "spread."[102] Spread pricing is a common way that PBMs earn revenue.[103] In Figure 8 below, the PBM charges the payer $20 for a prescription but only pays $12 to the pharmacy. The PBM keeps the $8 spread as profit, and often does not disclose the spread to the payer or pharmacy.[104]

[100] *Id.*
[101] *Supra* note 32.
[102] Spread Pricing 101, National Community Pharmacists Association *available at* https://ncpa.org/spread-pricing-101 (last accessed Sept. 1, 2023)
[103] Supra note 36.
[104] Todd Mizeski and Conor R. McCabe, *Proposed Congressional Bill Seeks to Ban Spread Pricing in State Medicaid Plans*, FRIER LEVITT (April 12, 2023).

Figure 8: Spread Pricing Instituted by PBMs[105]



I. Medicaid and Private Health Insurance

> *"Another harmful, anticompetitive tactic employed by PBMs is spread pricing, which refers to the difference between how much a PBM reimburses the pharmacy for a drug and the higher price they turn around and charge the plan for the same prescription. For years, community pharmacists have said that PBMs have been playing spread pricing games, contributing to higher drug costs to the detriment of patients and the taxpayer-funded programs the PBMs are supposed to serve."*[106] – **Hugh Chancy, RPh, Owner, Chancy Drugs Pharmacy, Georgia**

In spread pricing schemes, the payer can include private health insurance plans or, in the case of Medicaid, the government.[107] Most state Medicaid programs function as managed care programs which pay a monthly rate per enrolled member to contracted managed care organizations (MCOs).[108] The MCOs then reimburse the provider for health services under the terms of a Medicaid contract.[109] MCOs often contract with PBMs to manage prescription drug

[105] Ed Silverman, *Spread Pricing: From Largely Unknown to Much Scrutinized and Criticized*, MANAGED CARE (Sept. 2019) *available at* https://lsc-pagepro.mydigitalpublication.com/publication/?i=613323&article_id=3460622&view=articleBrowser.
[106] *Supra* note 32.
[107] *Supra* note 102.
[108] Hannah Maniates, *Why did they do it that way? Understanding Managed Care*, Nat'l Assoc. of Medical Dirs. (Jan. 22, 2024).
[109] *Id.*

benefits.[110] Spread pricing occurs when "a PBM charges an MCO more for a drug than the amount a PBM pays a pharmacy," and the PBM pockets the difference.[111]

PBMs frequently tout the savings they provide for payers and patients through negotiation, drug utilization programs, and drug discounts. However, there are numerous instances where state auditors have found significant spread pricing schemes that increase costs for payers and patients.[112] Multiple states have subsequently audited their Medicaid programs due to concerns about spread pricing amid high Medicaid drug costs.[113] In 2018, the Ohio Attorney General found that Centene Corp., while managing Ohio's Department of Medicaid prescription drug program, engaged in spread pricing and cost the state program nearly $225 million.[114] Ohio brought a lawsuit against Centene, who ultimately agreed to pay $88.3 million to the state.[115] Since that lawsuit, Centene has paid nearly $1 billion in 18 states over spread pricing schemes.[116] Centene had long contracted with CVS Caremark as its PBM and recently moved to Express Scripts.[117] In another audit, the HHS IG found that PBMs in the District of Columbia improperly kept $23.3 million in spread pricing from 2016-2019.[118] In November 2022, Express Scripts agreed to pay $3.2 million to settle claims that they overcharged Massachusetts' workers' compensation insurance system for prescription drugs.[119]

Due to its cost to taxpayers, several states have taken steps to prohibit spread pricing in Medicaid managed care programs and congressional lawmakers have introduced multiple bills that would prohibit spread pricing.[120] The Congressional Budget Office (CBO) estimates that eliminating spread pricing in Medicaid managed care organizations, as outlined in the Lower

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[110] *Medicaid MCO PBM Pricing,* U.S. Dep't of Health and Human Services OIG a*vailable at* https://oig.hhs.gov/reports-and-publications/workplan/summary/wp-summary-0000434.asp#:~:text=Managed%20care%20organizations%20(MCOs)%20contract,drug%20benefits%20on%20their%20behalf

[111] Catherine Candisky, *State Report: Pharmacy Middlemen Reap Millions from Tax-funded Medicaid*, THE COLUMBUS DISPATCH (2018) *available at* https://stories.usatodaynetwork.com/sideeffects/state-report-pharmacy-middlemen-reap-millions-from-tax-funded-medicaid/; s*ee also* *Supra* note 110.

[112] Eric Pachman & Antonio Ciaccia, *The cancerous design of the U.S. drug pricing system*, 46Brooklyn (Jul. 2018); *see also* U. S. DEP'T OF HEALTH & HUMAN SERVS. OFF. OF INSPECTOR GEN., THE DISTRICT OF COLUMBIA HAS TAKEN SIGNIFICANT STEPS TO ENSURE ACCOUNTABILITY OVER AMOUNTS MANAGED CARE ORGANIZATIONS PAID TO PHARMACY BENEFIT MANAGERS, A-03-20-00200 (Mar. 16, 2023).

[113] U.S. DEP'T. OF HEALTH & HUMAN SERVICES OFF. OF INSPECTOR GEN., A-03-20-00200, THE DISTRICT OF COLUMBIA HAS TAKEN SIGNIFICANT STEPS TO ENSURE ACCOUNTABILITY OVER AMOUNTS MANAGED CARE ORGANIZATIONS PAID TO PHARMACY BENEFIT MANAGERS (March 2023).

[114] News Release, Ohio Attorney General's Office, Centene Agrees to Pay a Record $88.3 Million to Settle Ohio PBM Case Brought by AG Yost (June 14, 2021); *see also* Supra note 36.

[115] *Id.*

[116] James Drew, *Centene PBM Settlement with South Carolina raises total payout to $964.8M*, ST. LOUIS BUS. J. (Jan. 4, 2024).

[117] Raghav Mahobe & Leroy Leo, *Centene to Cut Costs with New Pharmacy Benefit Manager, Shares Jump*, Reuters (Oct. 25, 2022).

[118] *Supra* note 113.

[119] Brendan Pierson, *Express Scripts to Pay $3.2 Mln to Settle Massachusetts Overcharge Claims*, REUTERS (Nov. 7, 2022).

[120] Erin Slifer and Alyssa Llamas, *Bipartisan Congressional Support for PBM Reform Grows*, THE COMMONWEALTH FUND (June 21, 2023).

Costs, More Transparency Act of 2023,[121] would reduce federal spending by $1.1 billion over ten years.[122]

II. Impacts on Pharmacies

Problems with spread pricing also manifest in pharmacy networks where PBMs can require patients to use PBM-owned or affiliated "preferred" pharmacies with more favorable reimbursement contracts.[123] Due to PBMs' role as middlemen reimbursing competing pharmacies for dispensing drugs, PBMs can reimburse pharmacies they own more than they reimburse competing pharmacies, such as community and independent pharmacies.[124] In a healthy market this would typically result in the competing pharmacies simply contracting with other PBMs, they are unable to do so because of the consolidation.[125] Therefore, community and independent pharmacies are left with no choice but to contract with PBMs, otherwise, they could not serve their customers and remain in business.[126] The contracts between PBMs and independent and community pharmacies are opaque and often designed to hurt a competing pharmacy's business, sometimes leading to business closure.[127]

Express Scripts' contracts beginning in 2024 instituted indefinite reimbursement rates for Medicare Part D participants, meaning that there is no contractual guarantee for consistent reimbursements for a drug.[128] For example, Express Scripts' average reimbursement on branded specialty drugs for cancer treatments to independent community oncologists is less than the cost of acquiring the drug, by an average of between 22 and 26 percent less than average wholesale price.[129] As a result, pharmacies are absorbing up to 11.5 percent of a drug's cost to dispense high-cost, life-saving treatment to patients.[130] Independent pharmacies are taking a loss to dispense medications to save patient's lives. They have no way to know what the reimbursement rates will be on a given day for a given medication, and they have no accountability measures to determine if their reimbursement rates are the same as competing pharmacies or pharmacies owned by the PBMs. Neither these pharmacies, nor their patients, know what the PBM is charging their clients on these medications.

Between 2010 and 2018, roughly 6 percent of independent pharmacies closed in the United States.[131] Furthermore, the Rural Policy Research Institute "found that reimbursements [to pharmacies] under the cost of [a drug's] acquisition led to the closure of 1,231 independent pharmacies in rural areas between 2003 and 2018. As a result, 630 rural communities

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[121] H.R.5378 - 118th Congress (2023-2024): Lower Costs, More Transparency Act (2023).
[122] CONG. BUDGET OFF., ANSWERS TO QUESTIONS FOR THE RECORD FOLLOWING A HEARING ON HEALTH CARE SPENDING (Mar. 22, 2024), *available at* https://www.cbo.gov/publication/60133.
[123] Supra note 80; *see also* *Supra* note 86; PBM Abuses, Nat'l Cmty. Pharmacists Ass'n, *available at* https://ncpa.org/sites/default/files/2020-12/pbm-business-practices-one-pagers.pdf.
[124] *Supra* note 86.
[125] *Id.*
[126] *Id.*
[127] Arthur Allen, *What to know about the drug price fight in those TV ads*, NPR (July 7, 2023).
[128] *Supra* note 75.
[129] Express Scripts as Primary Plan Name – 2024, Average Script – Branded Specialty Drugs (Documents on file with the Comm.).
[130] *Id.*
[131] *Supra* note 123.

nationwide that had at least one retail pharmacy in 2003 had zero retail pharmacies in 2018."[132] In urban areas, 1 in 8 pharmacies closed between 2009 and 2015 due to "lower-than-cost reimbursements in the Medicaid and Medicare programs, disproportionately affecting independent pharmacies and low-income neighborhoods."[133] When independent pharmacies close, patients are forced to travel further or pay more to receive their medications.

Rebates and Fees

> "*When PBMs pursue varying rebate agreements with plan sponsors, coverage of generics is delayed and patients suffer as a result. These delays in coverage restrict patient access to lower-cost generics and expose patients to unnecessarily high cost-sharing, even though lower-cost alternatives are available*."[134] – Craig Burton, Executive Director, Biosimilars Council

Drug rebates are partial refunds, or "after-the-fact payments, usually calculated as a percentage of a drug's list price" paid by the drug manufacturers to PBMs.[135] CVS Caremark reports on its formularies that it "may receive rebates, discounts, and service fees from pharmaceutical manufacturers for certain listed products."[136] Rebates for prescription medications were first provided safe harbor in 1987 when Congress amended the Anti-Kickback Statute and directed the Secretary of HHS to immunize certain practices from prosecution and create guardrails to prevent abuse.[137] Thereafter, the Secretary of HHS delegated this authority to the HHS IG, who promulgated rules delineating the safe harbors and appropriate guardrails.[138] After significant litigation and confusion in the 1990s, the HHS IG revised the rule to what it remains today.[139] The system these regulations have created allow retrospective rebates to be conditioned on a PBM manipulating the market to shift market share to one medication over another, even if those medications are less expensive.[140] PBMs have argued that these rebates are vital to driving down the cost of prescription drugs,[141] however spending on prescription drugs has increased nearly every year since.[142]

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[132] *Id.*
[133] *Id.*
[134] *Supra* note 32.
[135] *Supra* note 17.
[136] *See e.g.*, CVS Caremark First Production, CCM00000023 (March 31, 2023) (on file with Comm.).
[137] Medicare and Medicaid Patient and Program Protection Act of 1987, Pub. L. 100-93, 101 Stat. 680 (1987).
[138] 57 FR 3330, Federal Register, *available at* https://www.federalregister.gov/citation/57-FR-3330.
[139] 42 C.F.R. 1001.952(h)(4), Code of Federal Regulations (July 09, 2024), *available at* https://www.ecfr.gov/current/title-42/chapter-V/subchapter-B/part-1001/subpart-C/section-1001.952
[140] Thomas R. Barker & Ross Margulies, *The History of Rebates in the Drug Supply Chain and HHS' Proposed Rule to Change Safe Harbor Protection for Manufacturer Rebates*, Foley Hoag LLP (Apr. 2019).
[141] *Prescription Drug Rebates*, PCMA *available at* https://www.pcmanet.org/prescription-drug-rebates.
[142] *Prescription Drug Expenditure in the United States From 1960 to 2022,* Statista, *available at* https://www.statista.com/statistics/184914/prescription-drug-expenditures-in-the-us-since-1960

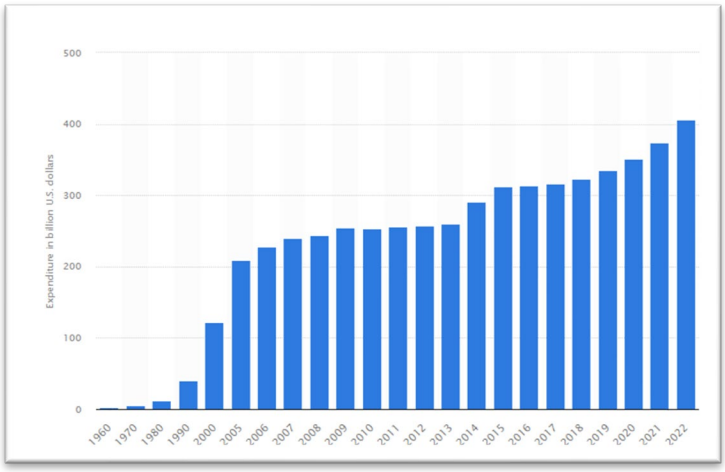

Figure 9: Prescription Drug Expenditure in the United States from 1960-2022[143]

The largest PBMs have significantly more leverage when negotiating rebates compared to smaller PBMs and should be able to command higher rebates.[144] PBM rebate retention rates vary by company and contract. The result should be greater savings for patients who receive benefits from these PBMs. However, this does not appear to be the case. The image below shows how much it costs to purchase a 30-day supply of a generic chemotherapy drug, Imatinib, from Cost Plus Drugs versus CVS. Purchasing this drug from Cost Plus Drugs instead of CVS saves a patient or health insurance company hundreds of thousands of dollars each year.

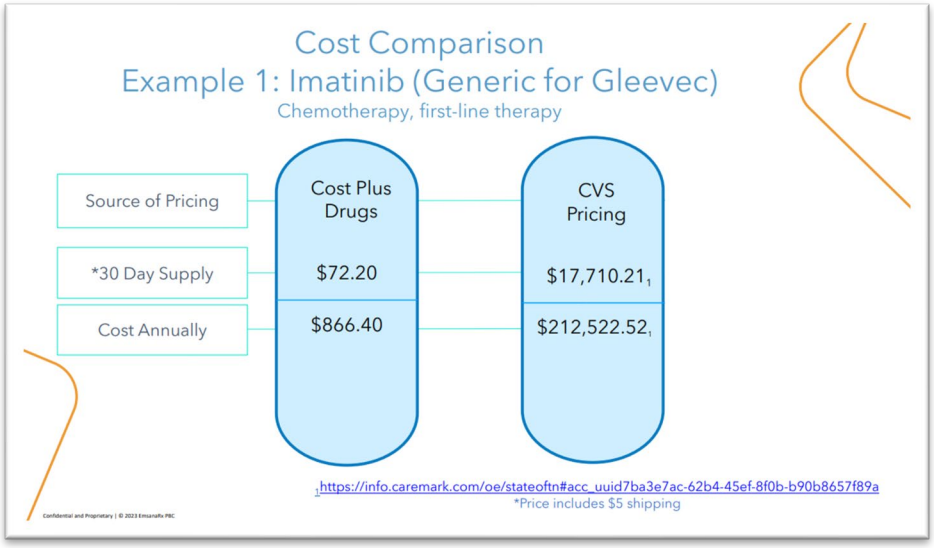

Figure 10: Cost Comparison between Cost Plus Drugs and CVS Pricing for Imatinib[145]

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[143] *Id.*

[144] S. FIN. COMM., STAFF REPORT, INSULIN: EXAMINING THE FACTORS DRIVING THE RISING COST OF A CENTURY OLD DRUG (Jan. 14, 2021).

[145] Greg Baker, *Written Testimony: Role That Pharmacy Benefit Managers (PBMs) Play in the Pharmaceutical Market* (May 23, 2023) *available at* https://oversight.house.gov/wp-content/uploads/2023/05/AffirmedRx-Testimony-to-the-House-Committee-on-Oversight-and-Accountability-May-2023.pdf

In 2020, a University of Southern California study found a direct correlation between rebate increases and manufacturer price increases: a $1 increase in rebates corresponds with a $1.17 increase in drug list price, "suggest[ing] that rebates do play a role in increasing list prices."[146] During a September 2023 Committee hearing, Representative Grothman (R-Wis.) discussed the role of rebates on insulin affordability with Lori Reilly, Chief Operating Officer, Pharmaceutical Research and Manufacturers of America:[147]

> ***Rep. Grothman:*** *Insulin has been a growing concern for Americans. How have PBM practices such as rebate negotiations impact the affordability of insulin for patients with diabetes?*
>
> ***Ms. Reilly:*** *The net price of insulin has actually decreased… But most patients haven't felt that, again, because PBMs insist on charging patients a full list price of the medicine and not the negotiated rate. The typical insulin has a rebate of about 84 percent, which is 84 percent lower than what patients are being asked to pay. The PBMs have not had an interest in putting lower priced insulin on the market.*

An alternative PBM market has emerged that provides a more transparent and cost-saving alternative to traditional PBM business model. Like a traditional PBM, transparent PBMs provide employers, plan sponsors, and insurers with access to prescription drug benefits for their clients. However, transparent PBMs have clear pass-through business models which provide more direct, clear contracts; frequent opportunities for the client to audit the PBM; fair copays; almost no limitations on client's access to PBM data; and 100 percent pass-through of rebates.[148] Instead of relying on rebates and mark-ups, many Transparent PBMs' derive their revenue from flat administrative fees, removing the conflicts of interest that can drive up the costs of prescriptions.[149] As a result, transparent PBMs are very effective at negotiating rebates and discounts with drug companies that result in reduced out-of-pocket costs for patients. For example, Transparency Rx, a coalition of Transparent PBMs, provides clients with 163 percent savings on high blood pressure and heart medications, 184 percent savings on medications for Type 2 diabetes, and 195 percent savings on statin drugs for cholesterol, compared to traditional PBMs.[150] With transparent contract terms, access to information, and the ability to audit the PBM, payers can verify that they are not paying hidden fees and are actually receiving the PBMs' promised cost-savings.[151]

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[146] *Supra* note 17.
[147] *Supra* note 32.
[148] Rx Preferred Benefits, Pharmacy Benefits Management, *available at* https://rxpreferred.com/solutions/pbm-services; *see also* Alliance of Community Health Plans, A Unique Approach: Transparent PBMs (Apr. 5, 2019), *available at* https://achp.org/wp-content/uploads/PBM-Infographic_4.5.19.pdf
[149] *Id.*
[150] Transparency Rx, Transparency Bridges Gaps, *available at* https://transparency-rx.com
[151] *Supra* note 148.

I. Formulary Manipulation and Abuse

> "*Lack of transparency and the complexity of rebates and fees can make it difficult for plan sponsors to assess whether they are fully benefiting from all price concessions that PBMs negotiate on their behalf*."[152] **– Lori Reilly, Chief Operating Officer, Pharmaceutical Research and Manufacturers of America**

PBMs are responsible for developing formularies, which are lists of drugs that are covered under a health insurance plan.[153] Formularies are typically divided into four tiers, with Tier 1 including generic drugs and having the lowest copay, and Tier 4 including unique or specialty drugs (e.g., chemotherapy) with the highest out-of-pocket cost.[154] Since these tiers differ in their cost-sharing amounts, beneficiaries are encouraged to use drugs on the lower tiers when possible.[155] Drug manufacturers have a clear financial incentive to secure access on a plan sponsor's formulary: being included on a formulary, especially in a lower tier, means that more people will have access to the manufacturers' drugs at lower costs.[156] For health conditions and diseases, like diabetes, that can be treated by several similar drugs, it is even more important for a manufacturer to be covered on a formulary.[157]

The Committee found evidence that while each PBM conducts an extensive review of the safety and clinical efficacy of a medication when designing its formularies, each PBM places strong considerations on the financials of a medication when determining what tier to place the medication. For clarity, these financials do not automatically prioritize medications that are lower costs for plans or patients, but instead prioritize the financial benefit a PBM can obtain by placing the medication in a more desirable tier.

Optum Rx designs its formularies by starting with its National Pharmacy & Therapeutics Committee (P&T), which consists of physicians and pharmacists, not employed by Optum Rx, who "evaluate existing and emerging drugs based on scientific evidence, and review and appraise those drugs in an unbiased and evidenced-based way. A drug's cost plays no role in the P&T Committee's clinical review, only becoming relevant after the P&T Committee has identified drugs in a particular therapeutic class that are clinically effective and should be covered."[158] According to a P&T Committee charter, drugs are selected and sorted on the Optum Rx formulary based on "economic considerations" only after safety, efficacy, and therapeutic need have been established."[159]

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[152] *Supra* note 32.
[153] *Supra* note 144.
[154] Understanding Drug Tiers, PATIENT ADVOCATE FOUNDATION, https://www.patientadvocate.org/explore-our-resources/understanding-health-insurance/understanding-drug-tiers/.
[155] *Supra* note 59.
[156] *Supra* note 144.
[157] *Id.*
[158] Letter from Michael D. Bopp, Partner, Gibson, Dunn & Crutcher LLP, to James Comer, Chairman, H. Comm. on Oversight & Accountability (March 15, 2023).
[159] Optum Rx Second Production, ORX-COA-00005226-ORX-COA-00005235 (May 3, 2023) (on file with Comm.).

After the P&T Committee has met and provided, Optum Rx turns to the Formulary Management Committee and Business Implementation Committee.[160] The Formulary Management Committee is described as an internal leadership group that "makes recommendations on the placement of an FDA-approved prescription drug to an assigned tier" and whether any exclusion programs, and utilization management programs such as prior authorization, quantity limits, and step therapies, that have been recommended by the P&T Committee should be applied.[161] The Formulary Management Committee's recommendations include considerations of "clinical, economic, and pharmacoeconomic evidence on a heterogeneous population, including information from the Optum Rx P&T Committee and supporting financial analyses."[162] Whereas the P&T Committee meetings are transparent and open to the public,[163] the Formulary Management Committee is not, despite its role in considering "financial effect…to set final formulary tiering."[164] After the Formulary Management Committee recommendations are made, the decisions are sent to the Business Implementation Committee and implemented into plan policies.[165]

Express Scripts works with payers to design formularies and gives its clients the option to use one of Express Script's standard formularies or create a custom formulary.[166] Its most popular formulary, the Express Scripts National Preferred Formulary, is used by clients that cover 21 million people. Clients covering an additional 4 million lives utilize one of Express Scripts' other standard formulary options.

Express Scripts uses a process to develop formularies that incorporates three Committees: the Therapeutic Assessment Committee, the National P&T Committee, and the Value Assessment Committee.[167] The process starts with the Therapeutic Assessment Committee, consisting of "clinical pharmacists and physicians who are employed by Express Scripts," which reviews scientific literature and data[168] on new medications and then makes a formulary placement recommendation to the P&T Committee.[169] The P&T committee, comprised of "practicing physicians and pharmacists not employed by Express Scripts," reviews formulary placement for all new and old medications.[170] Thereafter these recommendations go to the Value Assessment Committee, consisting of "Express Scripts' employees from formulary management, product management, finance, and clinical account management."[171] The Value

[160] Optum Rx Second Production, ORX-COA-00002078- ORX-COA-00002087 (May 3, 2023) (on file with Comm.).
[161] Optum Rx Second Production, ORX-COA-00005268- ORX-COA-00005276 (May 3, 2023) (on file with Comm.).
[162] *Id.*
[163] Optum Rx Second Production, ORX-COA-00005321 (May 3, 2023) (on file with Comm.).
[164] Optum Rx Second Production, ORX-COA-00005323 (May 3, 2023) (on file with Comm.).
[165] *Supra* note 160.
[166] Letter from Christopher J. Armstrong, Partner, Holland & Knight, to James Comer, Chairman, H. Comm. on Oversight & Accountability (Mts arch 16, 2023).
[167] Express Scripts First Production, ESI00000001-ESI00000005 (April. 6, 2023) (on file with Comm.).
[168] "The drug evaluation documents include, at a minimum: a summary of the pharmacology, safety, efficacy, dosage, mode of administration, and the relative place in therapy of the medication under review compared to other pharmacologic alternatives." *Id.*
[169] *Id.*
[170] *Id.*
[171] *Id.*

Assessment Committee considers the "value of drugs by evaluating the net cost, market share, and drug utilization trends of clinically similar medications," and has the authority to designate a medication as "include" or "exclude" from all formularies, not on the basis of whether it benefits patients, but the economics of the medication.[172] While the P&T Committee can ignore a recommendation by the Value Assessment Committee for inclusion or exclusion, the Committee did not receive documents illustrating that the P&T does so.[173] Instead, evidence suggests that decisions were often made based on the economics of a medication, rather than its benefit to patients or affordability.[174]

CVS Caremark develops and reviews formularies in a similar manner to Optum Rx and Express Scripts. The Trade Relations Group first submits formulary recommendations to the Formulary Review Committee, who in turn submits template formularies to the P&T Committee.[175] All CVS Caremark template formularies are reviewed and approved on a quarterly basis.[176] Additionally, 11 percent of CVS Caremark's clients choose to use a custom formulary.[177]

The Formulary Review Committee is an internal CVS Caremark committee responsible for evaluating business factors that can affect a formulary, such as utilization trends, the potential impact of generic drugs or drugs slated to become available over the counter, brand and generic pipeline, line of business, plan sponsor cost, applicable manufacturer agreement, and the potential impact on members.[178] For example, "when an A-rated generic becomes available, it is typically considered preferred and…encouraged."[179] The Formulary Review Committee takes these factors and uses them to make business recommendations to the P&T Committee, and the P&T Committee must approve all recommendations before they can be included on a formulary.[180]

The P&T Committee is an advisory body independent of CVS Caremark and is comprised of nineteen physicians and three pharmacists; the twenty-two members are not employees of CVS Caremark.[181] The P&T Committee is "supported by the CVS Caremark Clinical Formulary Department," which houses clinical pharmacists who prepare drug monographs and therapeutic class reviews based on a clinical literature review.[182] The P&T Committee bases its decisions on "scientific evidence, standards of practice, peer-reviewed

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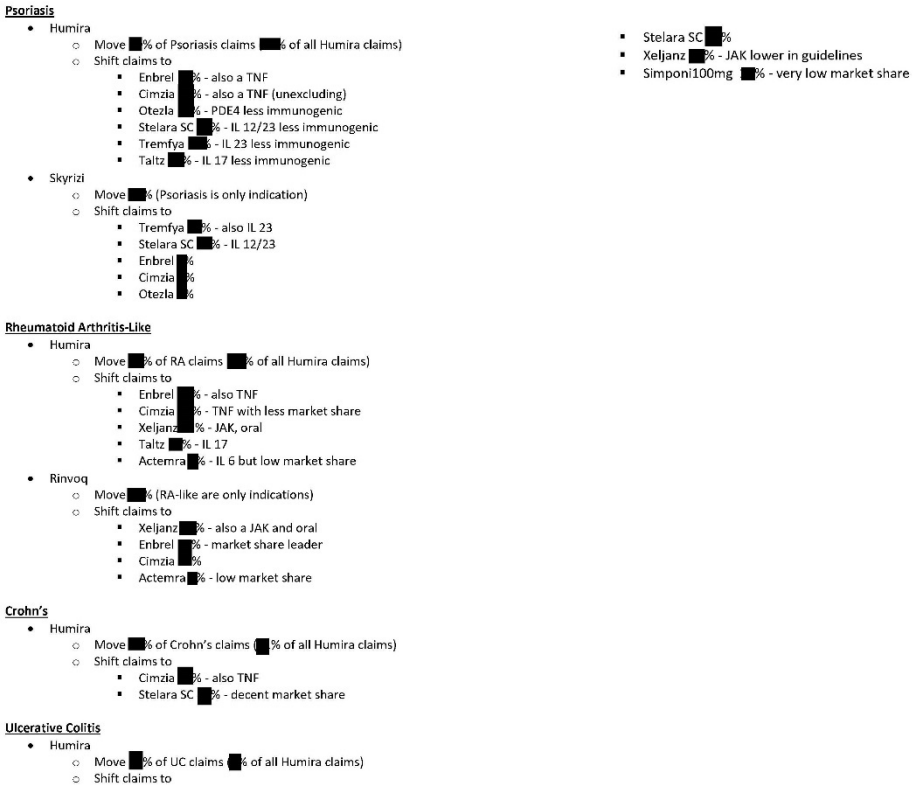
[172] *Id.*
[173] *Id.*
[174] Express Scripts First Production, ESI00000266 (April. 6, 2023) (on file with Comm.).; – Januvia (peptidase-4 inhibitor), test strips, insulin, ESI00000271 Multiple Sclerosis (Aubagio, Tecfidera, Gilenya, Mayzent
[175] Letter from Nicholas L. McQuaid, Partner, Latham & Watkins, to James Comer, Chairman, H. Comm. on Oversight & Accountability (July 14, 2023).
[176] *Id.*
[177] Letter from Nicholas L. McQuaid, Partner, Latham & Watkins, to James Comer, Chairman, H. Comm. on Oversight & Accountability (May 10, 2024).
[178] CVS Caremark Seventh Production, CCM00024472 (Dec. 29, 2023) (on file with Comm.).
[179] CVS Caremark Seventh Production, CCM00024473 (Dec. 29, 2023) (on file with Comm.).
[180] *Supra* note 178.
[181] *Supra* note 178.; *see also* CVS Caremark Seventh Production, CCM00024470-CCM00024471 (Dec. 29, 2023) (on file with Comm.).
[182] CVS Caremark Seventh Production, CCM00024471 (Dec. 29, 2023) (on file with Comm.).

medical literature, accepted clinical practice guidelines, and other appropriate information."[183] CVS Caremark works to make sure that the P&T Committee does not have access to or consider information regarding CVS Caremark's "rebates, negotiated discounts, or net costs."[184]

PBMs also maintain exclusion lists, which are drugs that are not included on formularies.[185] For example, in 2021, Express Scripts excluded approximately 400 drugs from its formularies.[186] When a drug is excluded from a formulary, it will not be covered by the insurer.[187] This forces patients to either switch to another drug, potentially affecting health outcomes, or pay out-of-pocket, which is often unsustainable.[188]

One example of PBM market manipulation was evident in documents reviewed by the committee which indicate that Express Scripts was discussing how to shift patients from medications going off patent exclusivity to other high-cost medications:

Figure 11: Express Scripts internal document indicating how they would shift claims to more lucrative medications[189]



[183] *Id.*
[184] *Id.*
[185] *Supra* note 144.
[186] *Supra* note 144.
[187] *Id.*
[188] *Id.*
[189] Express Scripts Eighth Production, ESI00012723-00012724 (June. 14, 2024) (on file with Comm.).

PBMs often claim that the threat of exclusion or the benefit of being a "preferred" product typically allows them to extract greater rebates from manufacturers.[190] While this may be the case, the Committee found that PBMs often choose higher cost medications for their formularies costing patients more at the counter, employers more to subsidize their prescription drug plans, and taxpayers more for federal health care programs. In reviewing standard formularies for 2020, 2021, and 2022, from the three largest PBMs, the Committee found 300 examples, which can be found in the Appendix to the report, of the three largest PBMs preferring medications that cost at least $500 per claim more than the medication they excluded on their formulary. While some of these decisions likely have valid clinical reasons, the sheer quantity and dramatic increase in costs highlight the priority of PBMs.

In total, the Committee identified more than 1000 examples of medications that, according to Medicare Part D data, would have been less expensive had the excluded medication been given preference or simply able to compete on a level playing field.

II. Rebates Effects on Biosimilars and Competition

> *"There is significant evidence from the [Office of the Inspector General], [Federal Trade Commission], [Government Accountability Office], of a number of different practices that PBMs utilize that make it harder for companies to reduce the list price of their medicines…* The Wall Street Journal *noted just this past week that [PBMs] often overcharge. So I believe there is a pattern of behavior that has been well documented that demonstrates the large challenges that exist with PBMs that is not to the benefit of patients but to the detriment."* **– Lori Reilly, Chief Operating Officer, Pharmaceutical Research and Manufacturers of America**

Drug rebate payments are a PBM negotiation tool used to promote utilization of expensive brand drugs.[191] Rebates paid to PBMs are typically a percentage of a drug's list price, so PBMs have an incentive to select more expensive drugs for formulary status.[192] A January 2023 report released by the Association for Accessible Medicines (AAM) revealed that PBMs block patient access to lower-cost generic drugs in favor of higher priced brand drugs with high rebates.[193] PBMs also have a financial incentive to promote the use of expensive medications and encourage drug list-price increases in order to increase their profits. [194] Drug manufacturers are increasing drug list prices to satisfy PBMs' demands for higher rebates. [195] New generic

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[190] *PBM Tools Will Save Health Plan Sponsors and Consumers More than $1 Trillion on Prescription Drug Costs*, PCMA, *available at* https://www.pcmanet.org/pbm-tools.
[191] Deirdre MacBean, *How high prescription drug rebates can derail pharmacy benefit plans*, HEALTHPARTNERS *available at* https://www.healthpartners.com/plan/blog/prescription-drug-rebates-and-pbms (last accessed: May 16, 2023).
[192] Joanna Shepherd, *Pharmacy Benefit Managers, Rebates, and Drug Prices: Conflicts of Interest in the Market for Prescription Drugs,* YALE LAW & POLICY REVIEW, Vol. 38 (Jan. 1, 2019).
[193] *Study Finds Middlemen Increasingly Block Patient Access to New Generics*, ASS'N FOR ACCESSIBLE MEDICINES (Jan. 23, 2023) *available at* https://accessiblemeds.org/resources/press-releases/middlemen-block-patient-access-new-generics.
[194] *Supra* note 192.
[195] *Id.*

drugs are experiencing historically slow adoption by patients directly resulting from PBM coverage decisions to prefer higher priced drugs with high rebates over lower list price drugs. [196] During the Committee's second hearing on PBM practices, Representative Gary Palmer (R-Ala.) discussed the negative impact of PBM rebates on the availability of prescription drugs with Craig Burton, Executive Director of the Biosimilars Council.[197]

> ***Rep. Palmer:*** *So, what you are saying is rebates have a negative impact on patients?*
>
> ***Mr. Burton:*** *Yes, sir.*
>
> ***Rep. Palmer:*** *So, what you are saying to the Committee is that this price setting could impact the availability of certain generic drugs… This is a confusing game that is being played. What I don't want to get lost in all this is that the patient is not the number one concern here.*
>
> ***Mr. Burton:*** *I think that's right… There seems to be an assumption that a general brand drug will just stay on the market. That isn't the case.*

Biologics can be used to treat a myriad of illnesses, such as psoriasis, diabetes, and cancer.[198] They are also some of the costliest prescriptions dispensed in the United States.[199] Only two percent of Americans use biologics, yet they account for approximately 40 percent of prescription drug spending.[200] A less expensive alternative to biologics are biosimilars, a type of biologic medicine that "is highly similar to a biologic medicine already approved by the FDA" and which "have no clinically meaningful differences from the [biologic]."[201] They are analogous to generic drugs: a biosimilar is to a biologic what a generic drug is to a brand name drug.

A consequence of rebates and exclusion lists is that they create a barrier to market entry for biosimilars.[202] Biosimilars are often excluded from a formulary or are listed on higher tiers of the formulary, which makes them more expensive for plans and patients.[203] For example, Amgen, a biotechnology company, recently launched Amjevita, the first non-interchangeable biosimilar of Humira.[204] The company launched both a high-list, high-rebate version of the drug and a low-list, low-rebate version of the drug. Most PBMs and plan sponsors have opted for the

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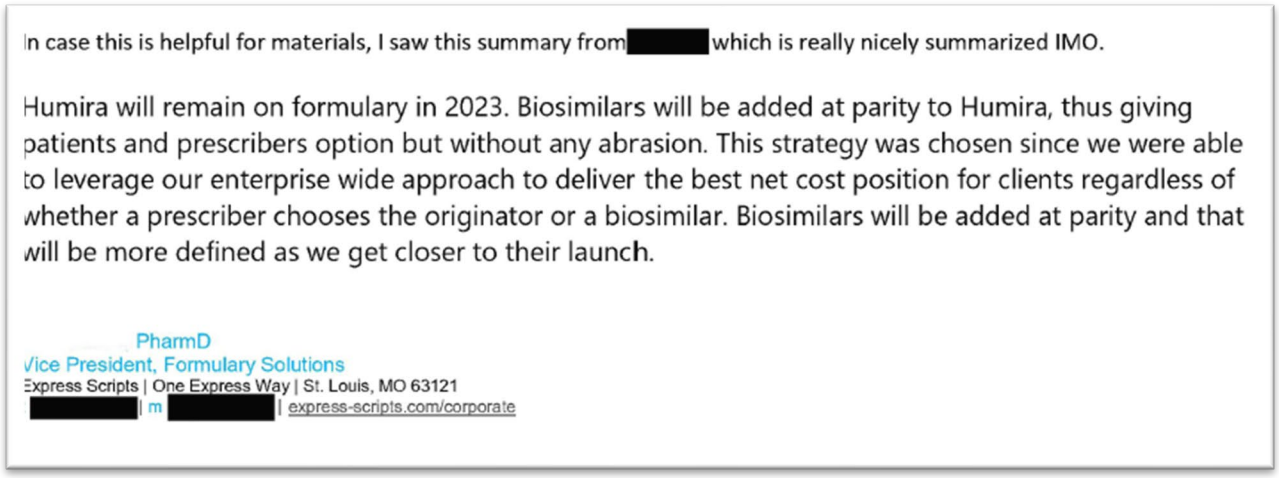
[196] *Supra* note 193.
[197] *Supra* note 32.
[198] *Overview for Health Care Professionals*, U.S. FOOD & DRUG. ADMIN. (last updated Dec. 13, 2022) *available at* https://www.fda.gov/drugs/biosimilars/overview-health-care-professionals.
[199] Biosimilars Handbook, BIOSIMILARS COUNCIL *available at* https://www.biosimilarshandbook.org/patient-learning-track.
[200] *Id.*
[201] Biosimilar Basics for Patients, U.S. Food & Drug Admin. (last updated Aug. 10, 2023).
[202] *Supra* note 17.
[203] Laura Joszt, *Margaret Rehayem: Rebates Remain Influential and a Barrier to Biosimilar Adoption for Employers*, AJMC (Apr. 28, 2023).
[204] Leigh Ann Anderson, *Is Amjevita Interchangeable with Humira?,* DRUGS.com (last updated Apr. 30, 2024).

high-list, high-rebate version.[205] The adoption of higher priced versions of drugs will garner higher rebates for PBMs while patients end up paying more out-of-pocket and taxpayers pay more in government run programs such as Medicare and TRICARE.[206]

This practice is not reserved for taxpayer funded health care programs. In emails reviewed by the Committee, staff at Express Scripts highlighted that their account teams should not discuss Humira with their clients "due to rebate impact with Abbvie."[207] These emails also expose that even though PBMs have the market power to negotiate when a biosimilar comes on the market, their negotiations do "not translat[e] to savings or value worth moving against the innovator."[208] In fact, for plan year 2023, as biosimilars to Humira come to market, Express Scripts used its market power to offer biosimilars at the same price as Humira.[209]

Figure 12: Email from Express Scripts VP for Formulary highlighting that biosimilars would be offered at the same price as Humira[210]



In case this is helpful for materials, I saw this summary from [redacted] which is really nicely summarized IMO.

Humira will remain on formulary in 2023. Biosimilars will be added at parity to Humira, thus giving patients and prescribers option but without any abrasion. This strategy was chosen since we were able to leverage our enterprise wide approach to deliver the best net cost position for clients regardless of whether a prescriber chooses the originator or a biosimilar. Biosimilars will be added at parity and that will be more defined as we get closer to their launch.

[redacted] PharmD
Vice President, Formulary Solutions
Express Scripts | One Express Way | St. Louis, MO 63121
[redacted] | m [redacted] | express-scripts.com/corporate

These comments raise questions as to why they are unable to extract savings from manufacturers when PBMs exert control over the market. In this case, Express Scripts used its market power to keep all net prices the same, therefore exacting a higher rebate while keeping list prices, and therefore the patient's copay, higher.

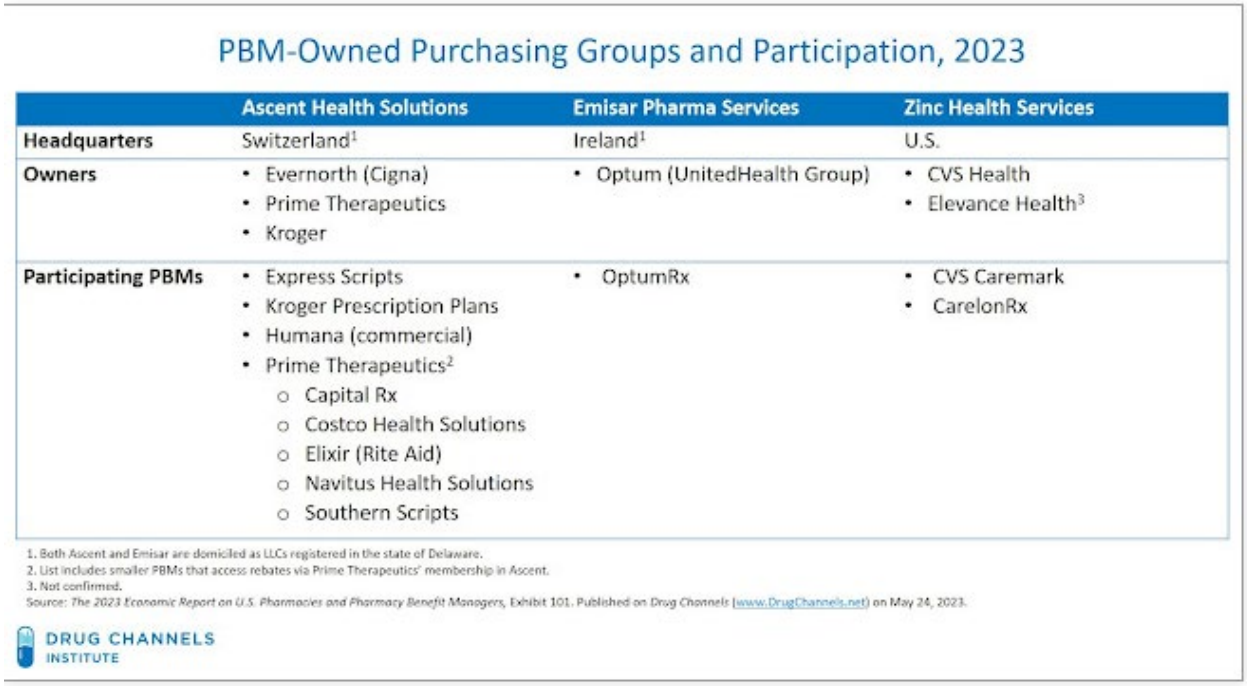
III. PBMs' creation of foreign business entities to hide rebates and fees

In the past five years the three largest PBMs have created group purchasing organizations (GPOs) and moved to centralize negotiation with pharmaceutical manufacturers for rebates and

[205] Adam J. Fein, *The Warped Incentives Behind Amgen's Humira Biosimilar Pricing – And What We Can Learn from Semglee and Repatha,* DRUG CHANNELS (Feb. 7, 2023).
[206] *Id.*
[207] Express Scripts Eight Production, ESI00012756 (June. 14, 2024) (on file with Comm.).
[208] Express Scripts Eight Production, ESI00012766 (June. 14, 2024) (on file with Comm.).
[209] Express Scripts Eight Production, ESI00013648 (June. 14, 2024) (on file with Comm.).
[210] *Id.*

fees.[211] These organizations are not only providing negotiation services for these three PBMs but also for many smaller PBMs as well.[212] On its face this seems like a move which would enable the PBMs to better leverage their and other PBM's negotiating powers to obtain steeper drug discounts.[213] However, two of the three GPOs were formed in foreign countries known for their lack of financial transparency and low tax rates. Express Scripts created the GPO Ascent Health Services (Ascent), based in Switzerland and Optum Rx created Emisar Pharma Services (Emisar), based in Ireland.[214]

Figure 13: PBM-owned Group Purchasing Organizations and PBM Participation[215]



PBM-Owned Purchasing Groups and Participation, 2023

	Ascent Health Solutions	Emisar Pharma Services	Zinc Health Services
Headquarters	Switzerland[1]	Ireland[1]	U.S.
Owners	• Evernorth (Cigna) • Prime Therapeutics • Kroger	• Optum (UnitedHealth Group)	• CVS Health • Elevance Health[3]

Participating PBMs	• Express Scripts
	• Kroger Prescription Plans
	• Humana (commercial)
	• Prime Therapeutics[2]
	  ○ Capital Rx
	  ○ Costco Health Solutions
	  ○ Elixir (Rite Aid)
	  ○ Navitus Health Solutions
	  ○ Southern Scripts
		• OptumRx	• CVS Caremark
			• CarelonRx

1. Both Ascent and Emisar are domiciled as LLCs registered in the state of Delaware.
2. List includes smaller PBMs that access rebates via Prime Therapeutics' membership in Ascent.
3. Not confirmed.

Source: *The 2023 Economic Report on U.S. Pharmacies and Pharmacy Benefit Managers*, Exhibit 101. Published on Drug Channels (www.DrugChannels.net) on May 24, 2023.

DRUG CHANNELS INSTITUTE

Why have these PBMs created GPOs based abroad, when they could easily have created them in the United States? According to reports, Express Scripts' motivations for basing Ascent in Switzerland was likely for "[t]ax efficiency" and to "[l]everage GPO safe harbor rules to avoid rebate reform and enable Express Scripts to collect GPO admin fees."[216] Similarly, experts believe that Optum Rx's decision to base Emisar in Ireland was because they stood "to lose a lot if they got regulated on rebates…[c]reating another organization that's offshore, they can protect their interests."[217] It appears that the PBMs created these entities with the sole intent to limit transparency and avoid regulations on rebates.

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[211] Adam J. Fein, *Five (or Maybe Six?) Reasons that the Largest PBMS Operate Group Purchasing Organizations*, DRUG CHANNELS (May 24, 2023).
[212] *Id.*
[213] *Id.*
[214] *Id.*
[215] *Id.*
[216] Adam J. Fein, *Drug Channels News Roundup, May 2019: Express Scripts' New GPO, More on Amazon/PillPack, a BS Update, and Vegas Video*, DRUG CHANNELS (May 30, 2019).
[217] Deborah Abrams Kaplan, *PBMs are Creating GPOs, and Stirring Debate as to Why*, MHE Publication (June 12, 2022).

These are not the only foreign entities PBMs use to avoid scrutiny. In 2021, Cigna created Quallent Pharmaceuticals, a wholly owned subsidiary based in the Cayman Islands,[218] which "sources select pharmaceuticals from U.S. Food and Drug Administration (FDA)-approved pharmaceutical manufacturers."[219] Last year, CVS Health created Cordavis, a wholly owned subsidiary based in Dublin, Ireland[220], which is being used to "commercialize and/or co-produce biosimilar products…for the U.S. pharmaceutical market."[221] The location of these subsidiaries raise significant questions about the purpose of their creation, in particular whether their foreign domicile is intended to prevent transparency and enable PBMs to retain hidden rebates and keep patient costs high.

PBMs' Impact on Patient Care

> *"Unfortunately, the PBM preferred drug is often not the best drug for a patient but the most profitable drug for the PBM… Treatment delays, denials, and fueling drug costs is the PBM hell my patients and I live in every day. The top PBMs have such leverage that they do what they want."*[222] **– Dr. Miriam Atkins, Oncologist, Augusta Oncology**

PBMs' anticompetitive behaviors have significant implications for Americans' health because of the financial incentives to force patients into more expensive medications. New-to-market generic drugs are experiencing historically slow adoption by patients directly resulting from PBM coverage decisions.[223] The delays are driven by PBM's choice to prefer higher priced drugs with high rebates over lower list price generic drugs.[224] Dr. Miriam Atkins, a medical oncologist in Augusta, Georgia, testified before the Committee in May 2023, stating that she must challenge PBMs "to get [her] patients [the] evidence-based, lifesaving treatment they need."[225]

> ***Chairman Comer:*** *Dr. Atkins, do you think a patient is more likely to take a cancer drug if a drug is $72 or $17,000?*
>
> ***Dr. Atkins:*** *$72 for sure.*

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[218] Adam J. Fein, *What's Behind CVS Health's Novel Vertical Integration Strategy for Humira Biosimilars* (Sept 06, 2023); *see also* https://www.quallentpharmaceuticals.com/ ("60 Nexus Way, P.O. Box 30997, Grand Cayman Ky1-1204, Cayman Islands")
[219] *About Us,* Quallent Pharmaceuticals *available at* https://www.quallentpharmaceuticals.com/about-us.
[220] *Who We Are*, *About Us, Meet Our Team,* Cordavis, *available at* https://www.cordavis.com
[221] *Supra* note 216. ; *see also CVS Health Launches Cordavis,* PR Newswire *available at* https://www.prnewswire.com/news-releases/cvs-health-launches-cordavis-301908281.html
[222] *Supra* note 32.
[223] *Supra* note 193.
[224] *Supra* note 193.
[225] *Supra* note 32. (statement of Dr. Miriam Atkins, AO Multispecialty Clinic).

Chairman Comer: *So would you agree that insane prices on vital medication like this are killing people?*

Dr. Atkins: *Yes.*[226]

PBM practices not only impact patients' pocketbooks, but also their health. PBMs use tactics like prior authorization and fail first requirements, also known as step therapy, which can prevent or delay patients from accessing the medicines they need.[227] According to the American Medical Association (AMA) a prior authorization is a requirement by a PBM that a physician get approval from the PBM for the prescription they prescribed.[228] AMA states that prior authorizations "can lead to negative clinical outcomes."[229] Fail first policies require patients to try and fail on a medicine preferred by their insurer and PBM before the originally prescribed medicine is covered.[230] PBMs justify these methods to "control costs and enhance safety by ensuring that patients do not use more expensive treatments when less expensive but equally effective therapies are available."[231]

As part of the Committee's investigation, Caremark, Express Scripts, and OptumRx cumulatively produced thousands of pages of formularies and narrative letters explaining how each PBM crafts its formularies. Within these PBM's formularies they specifically delineate certain tiers or certain medications for prior authorization. Fail first is generally not as clearly identifiable in a formulary but can be found by looking at the lists of medications used to treat a specific disease. When there is only one medication on the lowest tier, with other competing brand name medications on higher tiers, it is designed for a patient to use the medication on the lowest tier until they fail, then they can be approved to use medications on higher tiers. The Committee found countless examples in each formulary of medications that have been designated for prior authorization or that appear to be designated as fail first medications.

Apply prior authorization or fail first policies to certain medications can harm patients by restricting necessary care unless the patient can pay for the prescription out of pocket.[232] Additionally, lengthy delays for prior authorizations can cause suffering or even death as patients wait for PBMs to approve life-saving medications their doctors prescribe.[233] PBMs enact these policies to manipulate the market share of certain medications to get higher rebates from pharmaceutical manufacturers at the expense of patients. Patient health should not be compromised for PBM profits.

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[226] *Supra* note 32.
[227] Katie Koziara, *New data show insurers and PBMs increase barriers to care*, PhRMA (Dec. 2, 2021),
[228] Sara Berg, *What Doctors Wish Patients Knew About Prior Authorization*, AMA (Sep. 11, 2023).
[229] Sara Berg, *What Doctors Wish Patients Knew About Prior Authorization*, AMA (Sep. 11, 2023).
[230] *Supra* note 227.
[231] Geoffrey Joyce, et al, *Medicare Part D Plans Greatly Increased Utilization Restrictions on Prescription Drugs, 2011-20*, HealthAffairs (Mar. 2024).
[232] *Id.*
[233] Aaron Tallent, *Oncologists Say Prior Authorization is Causing Delays in Care*, OBR ONCOLOGY (Mar. 25, 2022); *What is Prior Authorization*, CIGNA (2021); Kevin B. O'Reilly, *1 in 3 doctors has seen prior auth lead to serious adverse event*, AMA (Mar. 29, 2023).

One positive the Committee identified while reviewing PBM care initiatives was that PBMs protect patients' health and safety by checking for medication interactions and identifying when patients may be taking a medication in an inappropriate manner. As middlemen, PBMs have access to all patient data and are therefore able to identify when a patient gets multiple of the same medication in a short time period, thus enabling them to identify potential misuse of a medication for both the patient and their physician. PBMs are also able to identify how medications may interact with one another in a way that could injure a patient. This is not an uncommon occurrence as many patients, particularly elderly patients, receive care from multiple different physicians and pharmacies.

Figure 14: Identifying potential concerns with a patient's prescriptions[234]

Prescription History

Date of Service	Drug Description	Strength	Quantity	Days Supply
10 08 22	CLONIDINE HCL	0.3 MG	270	90
10 05 22	FARXIGA	10 MG	30	30
09 29 22	AMLODIPINE BESYLATE	10 MG	90	90
09 14 22	METOPROLOL TARTRATE	100 MG	180	90
08 29 22	FLUTICASONE PROPIONATE	50 MCG	48	90
08 21 22	SPIRONOLACTONE	50 MG	90	90
08 18 22	LOSARTAN POTASSIUM	100 MG	90	90
08 11 22	LOSARTAN POTASSIUM	100 MG	30	30
08 02 22	METFORMIN HCL	500 MG	180	90
08 02 22	CLONIDINE HCL	0.3 MG	270	90
08 01 22	SPIRONOLACTONE	50 MG	30	30

Impacts on Federal and State Health Care Programs

In addition to their effects on patients' health, PBMs' anticompetitive practices directly affect American taxpayers. As Mr. Greg Baker, CEO of AffirmedRx, testified before the Committee, "PBMs are not constrained by any obligation to be transparent on their pricing or methodology… this problem is also costing taxpayers significantly since some of the biggest health plans in the country are run by local and state entities."[235]

I. Federal Employee Health Benefits (FEHB)

FEHB is the largest employer-sponsored group health insurance program in the United States, covering more than 8 million federal employees, retirees, and family members.[236] FEHB

[234] Express Scripts Seventh Production, ESI00012672 (Feb. 14, 2024) (on file with Comm.).
[235] *Supra* note 32.
[236] FEHB Handbook, , U.S. Office of Personnel Management (last visited July 11, 2024), *available at* https://www.opm.gov/healthcare-insurance/healthcare/reference-materials/fehb-

enrollees typically share the cost of their health insurance with the federal government as the employer; the government's portion of premiums paid is set by law, and the enrollee is responsible for paying the difference.[237] The government's contribution can be paid out of agency appropriations or other funds available for the payment of salaries.[238]

A March 2024 report by the Office of Personnel Management (OPM) IG found that a FEHB plan, the American Postal Workers Union Health Plan, was overcharged nearly $45 million by Express Scripts, who had been contracted by the Health Plan to provide pharmacy benefits for enrollees from contract year 2016 through 2021.[239] This overcharge was due to Express Scripts not passing through all discounts, credits, and rebates that were required by the contract.[240] Under the contract's PBM Transparency Standards, Express Scripts was required and failed to send pass-through transparent drug pricing from retail pharmacy claims, remit several drug purchasing discounts from drugs filled by Express Scripts' own mail order pharmacy warehouses and specialty pharmacies, return retail pharmacy claim transaction fees that it was credited, share drug manufacturer rebates, and share a portion of FEHB's drug manufacturer rebates with FEHB and the health plan.[241] Specifically, a large portion of the rebates collected by Express Scripts and its rebate aggregator, Ascent, were not passed through "due to lower rebate percentages agreed to internally between [Express Scripts] and Ascent, thereby allowing Ascent to keep the portion of rebates that [the OPM IG is] questioning."[242]

This instance was not the only time that Express Scripts has been found to overcharge an FEHB plan. In February 2023, the OPM IG audited Group Health Incorporated's FEHB pharmacy operations for contract years 2015 through 2019.[243] The IG found that FEHB was overcharged approximately $15 million because Express Scripts did not pass through all the discounts, credits, rebates, and administrative fees that were required in Express Scripts' contract.[244]

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handbook/#:~:text=It%20is%20the%20largest%20employer,family%20members%2C%20and%20former%20spouses

[237] Cost of Insurance, U.S. Office of Personnel Management(last visited July 11, 2024), *available at* https://www.opm.gov/healthcare-insurance/healthcare/reference-materials/reference/cost-of-insurance/.

[238] *Id*.

[239] U.S. OFF. OF PERSONNEL MGMT. OFF. OF INSPECTOR GEN., OFF. OF AUDITS, REPORT NO. 2022-SAG-029, FINAL AUDIT REPORT: AUDIT OF THE AMERICAN POSTAL WORKERS UNION HEALTH PLAN'S PHARMACY OPERATIONS AS ADMINISTERED BY EXPRESS SCRIPTS, INC. FOR CONTRACT YEARS 2016-2021 (Mar. 29, 2024).

[240] *Id*.

[241] *Id*.

[242] *Id*.; *see also* Terence Park, Dae Y. Lee, *OIG Audit of Federal Employee Pharmacy Benefits Plan Reveals Express Scripts Retained $44.9 Million in Overpayments and Unreported Rebates*, FRIER LEVIT ATTORNEY AT LAW (May 15, 2024).

[243] U.S. OFF. OF PERSONNEL MGMT. OFF. OF INSPECTOR GEN., OFF. OF AUDITS, REPORT NO. 1H-08-00-21-015, FINAL AUDIT REPORT: AUDIT OF GROUP HEALTH INCORPORATED'S FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM PHARMACY OPERATIONS AS ADMINISTERED BY EXPRESS SCRIPTS, INC. FOR CONTRACT YEARS 2015 THROUGH 2019 (Feb. 16, 2023).

[244] *Id*.

II. Medicare

Unlike Medicare Parts A and B, which are administered by Medicare, Medicare Parts C (commonly called Medicare Advantage) and D are administered by private health insurance companies.[245] Medicare Part D provides prescription drug benefits to enrollees,[246] while Medicare Part C is an alternative to Medicare Parts A and B which frequently includes Part D prescription benefit coverage.[247] According to GAO, Part D plan sponsors used PBMs to provide 74 percent of drug benefit management services in 2016.[248] As more vertical integration has occurred, it is likely that even more than 74 percent of plan sponsors use PBMs to manage their prescription drug benefit.

CVS reported that Medicare Part D plans are required to cover at least two drugs per therapeutic class and "substantially all" drugs in these six categories: anticonvulsants, antidepressants, antineoplastics, antiretrovirals, antipsychotics, and immunosuppressants.[249] Mandating coverage in these six areas can lead to differences in pricing between government plans and commercial plans because it "reduces the incentives for manufacturers to offer meaningful discounts…because manufacturers know plan sponsors must cover their drugs in these classes.[250] Caremark alleges that coverage mandates lead to higher costs for CMS and Part D enrollees compared to other types of plans.[251]

PBMs have also been accused of overcharging the federal government with regard to Medicare. In May 2017, the Department of Justice filed a lawsuit against UnitedHealth Group, which owns Optum Rx, alleging the company overcharged the government by more than $1 billion through its Medicare Advantage plans by submitting invalid diagnosis data. The case is still ongoing. [252] In December 2019, CVS and it's Omnicare business were sued by the Department of Justice over alleged fraudulent billing of Medicare and other government programs for outdated prescriptions for disabled and elderly individuals.[253] In September 2023, Cigna Group, Express Scripts' parent company, agreed to pay $172,294 to resolve allegations that it violated the False Claims Act by submitting and failing to withdraw inaccurate and

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[245] *Center for Medicare Advocacy*, Part D/ Prescription Drug Benefits *available at* https://medicareadvocacy.org/medicare-info/medicare-part-d/; *Understanding Medicare Advantage Plans*, MEDICARE *available at* https://www.medicare.gov/Pubs/pdf/12026-Understanding-Medicare-Advantage-Plans.pdf
[246] *Id*.
[247] *Supra* note 245.
[248] U.S. GOV'T ACCOUNTABILITY OFF., GAO-19-498, MEDICARE PART D: USE OF PHARMACY BENEFIT MANAGERS AND EFFORTS TO MANAGE DRUG EXPENDITURES AND UTILIZATION (Jul 15, 2019).
[249] Letter from Nicholas L. McQuaid, Partner, Latham & Watkins, to James Comer, Chairman, H. Comm. on Oversight & Accountability (Aug. 28, 2023).
[250] *Id.*
[251] *Id.*
[252] United States of America et al v. Unitedhealth Group incorporated et al, no. 1:2022CV00481 - document 138 (D.D.C. 2022), Justia Law, https://law.justia.com/cases/federal/district-courts/district-of-columbia/dcdce/1:2022cv00481/240495/138/ (last visited May 21, 2024).
[253] Rebecca Pifer, *CVS Long-Term Care Pharmacy Sued by DOJ Over Fraudulent Prescribing Practices*, HEALTHCARE DIVE (Dec. 17, 2019).

untruthful diagnosis codes for its Medicare Advantage Plan enrollees to increase Cigna Group's payments from Medicare.[254]

In the Appendix to this report, the Committee identified more than 300 examples of the three largest PBMs preferring medications that cost at least $500 per claim more than the alternative medication they excluded on their formulary. When this information is applied to the Medicare program, the Committee estimates that these decisions cost taxpayers billions per year.

III. Medicaid

Medicaid is frequently delivered through a Managed Care Organization (MCO).[255] PBMs usually serve as third party administrators to an MCO, which contracts with a state's Medicaid program to manage its prescription drug benefits.[256]

Over the years, PBMs have repeatedly been found to overcharge Medicaid. In September 2014, CVS agreed to pay $6 million to settle allegations that it knowingly failed to reimburse Medicaid for prescription drug costs.[257] Furthermore, in 2017 alone, PBMs and their pharmacies made as much as $4.2 billion by improperly engaging in spread pricing and charging the Medicaid program more than they were reimbursing pharmacies.[258]

As previously mentioned in this report, although PBMs frequently tout the savings they provide for payers and patients, there are numerous instances where state auditors have found significant spread pricing schemes that increase costs for payers and patients.[259] PBMs have been caught overcharging Medicaid programs in Ohio, Kentucky, Illinois, and Arkansas by more than $415 million.[260]

Subsequently, multiple states have audited their Medicaid programs because of concerns about spread pricing amid high Medicaid drug costs and brought lawsuits against the PBMS, alleging that the PBM overcharged the state's Medicaid program.[261] In 2018, the Ohio Attorney General investigated Centene Corp. and found that it engaged in spread pricing while managing Ohio's Department of Medicaid prescription drug program and cost the state program nearly $225 million.[262] Ohio sued Centene, who ultimately agreed to pay $88.3 million to the state.[263]

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[254] United States ex rel. Cutler v. Cigna Corp., et al., No. 3:21-cv-00748 (M.D. Tenn.) United States Department of Justice (2023) *available at* https://www.justice.gov/opa/pr/cigna-group-pay-172-million-resolve-false-claims-act-allegations (last visited May 14, 2024)
[255] Elizabeth Hinton & Jada Raphael, *10 Things to Know About Medicaid Managed Care*, KFF (May 1, 2024).
[256] *Supra* note 249.
[257] Jonathan Stempel, *CVS' Caremark Unit Settles U.S. False Claims Allegations*, REUTERS (Sep. 26, 2014)
[258] Robert Langreth, David Ingold, Jackie Gu, *The Secret Drug Pricing System Middlemen Use to Rake in Millions*, BLOOMBERG (Sep. 11, 2018).
[259] *See e.g. Supra* note 112.); *see also Id.*
[260] *Supra* note 111; *see also* Lisa Gillespie, *Pharmacy Middlemen Overcharged Medicaid $123.5 Million, State Says*, LOUISVILLE PUBLIC MEDIA (Feb. 23, 2019); *see also* Samantha Liss, *Centene Reaches $72M Settlement with Illinois, Arkansas for Alleged Medicaid Overcharges*, HEALTHCARE DIVE (Oct. 1, 2021).
[261] *Supra* note 113.
[262] *Supra* note 114.; *see also* Supra note 36.
[263] *Supra* note 114.

Since that lawsuit, Centene has paid nearly $1 billion in 18 states over spread pricing schemes.[264] Centene had long contracted with Caremark as its PBM and recently moved to Express Scripts.[265] In another audit, the HHS IG found that PBMs in the District of Columbia improperly kept $23.3 million in spread pricing from 2016-2019.[266] In November 2022, Express Scripts agreed to pay $3.2 million to settle claims that they overcharged Massachusetts' workers' compensation insurance system for prescription drugs.[267]

Due to its cost to taxpayers, several states have taken steps to prohibit spread pricing in Medicaid managed care programs and congressional lawmakers have introduced multiple bills that would prohibit spread pricing.[268] The CBO estimates that eliminating spread pricing in Medicaid managed care organizations, as outlined in the Lower Costs, More Transparency Act of 2023,[269] would reduce federal spending by $1.1 billion over ten years.[270]

IV. TRICARE

In 2019, a suit was filed against Express Scripts after a whistleblower alleged the company defrauded the federal government and vendors out of billions of dollars through the delivery of unnecessary prescription drugs to military personnel.[271] In October 2022, it was announced that TRICARE beneficiaries would lose access to approximately 15,000 independent pharmacies due to contract changes between Express Scripts and the Defense Health Agency.[272] Consequently, U.S. service members and veterans have encountered difficulties trying to access their prescriptions in a timely manner and at their preferred pharmacies.[273]

At the Committee's first PBM hearing in May 2023, multiple Congressmen expressed their concerns about TRICARE to Kevin Duane, PharmD, a pharmacist and owner of an independent pharmacy in Jacksonville, Florida, home to multiple military facilities and thousands of TRICARE beneficiaries.[274] In dropping independent pharmacies, TRICARE beneficiaries are encountering significant hurdles when trying to access their prescriptions. Representative Andy Biggs (R-Ariz.) and Dr. Duane discussed the impact of PBM pharmacy networks on our nation's service men and women:[275]

> ***Rep. Biggs:*** *Have PBMs made it more difficult for veterans and service members to access prescription drugs in a timely manner?*

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[264] *Supra* note 116.
[265] *Supra* note 117.
[266] *Supra* note 113.
[267] *Supra* note 119.
[268] *Supra* note 120.
[269] *Supra* note 121.
[270] *Supra* note 122.
[271] *Around the nation: Lawsuit Alleges PBM's 'Refill Pill Mill' Defrauded Government*, ADVISORY BOARD (Jun. 23, 2022); *PBM Faces Suit Over Alleged 'Refill Pill Mill' Scheme*, NAT'L CMTY PHARMACISTS ASS'N (Jun. 29, 2022).
[272] *TRICARE changes force 15,000 pharmacies out of network*, The American Legion (Oct. 27, 2022).
[273] Jake Stofan, *INVESTIGATES: Veterans forced to wait for hours in long lines at NAS Jax pharmacy,* Action News Jax (May 23, 2023).
[274] *Jacksonville Florida Military Bases*, Military.com *available at* https://www.military.com/base-guide/jacksonville-florida-military-bases.
[275] *Supra* note 32.

Dr. Duane: *Absolutely.*

Representative Pat Fallon (R-Tex.) engaged with Greg Baker, CEO of AffirmedRx, to discuss the impact of Express Scripts' decision to reduce pharmacy benefits for TRICARE members:[276]

> ***Rep. Fallon:*** *In the Fall of 2022, Express Scripts announced they would be reducing prescription reimbursements for 10 million TRICARE members. Additionally, 15,000 primarily rural and independent pharmacies were then dropped from the TRICARE network. That is particularly concerning to me since I represent 10 rural counties… How does this impact access and competition? It was reported that Express Scripts removed rural staples like Walmart, Kroger, and Sams Club in favor of CVS, of course a pharmacy that is owned by one of the other Big Three. Do you find it harder to compete in the market?*
>
> ***Mr. Baker:*** *We absolutely do.*
>
> ***Rep. Fallon:*** *If we are removing competition from TRICARE networks, how does that improve service and lower costs?*
>
> ***Mr. Baker:*** *It does not do either of those things.*

Impacts of Recent Policy Proposals

I. Anti-kickback Rebate Rule

Medicare Part D rebates were shielded in the 1990s from the federal anti-kickback statutes under safe harbor protections because they were thought to be passed through to Medicare patients and lower out-of-pocket costs.[277] At the conclusion of Trump Administration, CMS finalized a rule curbing the use of rebates in Medicare Part D to pass along manufacturer rebates to patients.[278] However, patient out-of-pocket costs typically do not reflect rebates that are paid directly from drug manufacturers to PBMs and instead reflect coinsurance and copays based on the often inflated list price of the drug.[279] Instead, this rule provided safe harbor

[276] *Id.*
[277] Jeff Lagasse, *Updated: Trump-era rebate rule for Medicare Part D on hold until 2023*, HEALTHCARE FINANCE (Feb. 1, 2021).
[278] Removal of Safe Harbor Protection for Rebates Involving Prescription Pharmaceuticals and Creation of New Safe Harbor Protection for Certain Point-of-Sale Reductions in Price on Prescription Pharmaceuticals and Certain Pharmacy Benefit Manager Service Fees, 85 Fed. Reg. 76,666 (Nov. 30, 2020) (to be codified at 42 C.F.R. pt. 1001).
[279] 85 Fed. Reg. 76,666 (Nov. 30, 2020) (to be codified at 42 C.F.R. pt. 1001).

provisions for rebates applied to drugs as they are dispensed at the pharmacy counter, thereby encouraging drug manufacturers, PBMs, and plan sponsors to lower drug costs for patients.[280]

Additionally, the rule would have increased PBM transparency by allowing safe harbor provisions for PBM service fees only under the conditions that PBMs report their compensation via written agreements with drug manufacturers, conduct services in compliance with state and federal law, be paid fair market value compensation for PBM services, and submit annual written disclosures to drug manufacturers that are made available to HHS.[281] The implementation of this rule was delayed to January 1, 2032, by a provision within the Inflation Reduction Act of 2022 (IRA).[282] The rebate rule, while promising for lowering out-of-pocket drug costs, must be implemented carefully to ensure that the benefits of manufacturer discounts do not accumulate to PBMs and are instead passed through to patients.

II. Medicare Price Negotiation

The passage of the IRA permitted CMS to negotiate the prices of certain prescription drugs covered under Medicare Part D.[283] Only those drugs that have been in the marketplace for several years without competition are eligible for negotiations.[284] In August 2023, the first ten drugs selected for negotiation were announced, including drugs frequently used to treat common health conditions such as diabetes, heart failure, and blood clots.[285] Several manufacturers of these medications, including AstraZeneca, Bristol Myers Squibb, Janssen Biotech, and Merck have filed lawsuits against HHS to stop the negotiation process.[286] As of July 2024, there are approximately 10 outstanding lawsuits which challenge CMS' ability to negotiate drug prices: 1 in Texas, 1 in Illinois, 1 in Ohio, 1 in Connecticut, 1 in D.C., 1 in Delaware, and 4 in New Jersey.[287] The lawsuits allege various constitutional violations, including an argument that price negotiation amounts to an illegal taking of a product without just compensation because "it allows Medicare to obtain manufacturers' patented drugs without paying fair market value under the threat of serious penalties."[288]

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[280] 85 Fed. Reg. 76,666 (Nov. 30, 2020) (to be codified at 42 C.F.R. pt. 1001).
[281] *Supra* note 278.
[282] Margaux J. Hall et al., *Congress paves the way for drug pricing reforms with passage of the Inflation Reduction Act of 2022*, ROPES & GRAY (Aug. 12, 2022).
[283] Press Release, U.S. Dept. of Health and Human Services, HHS Selects the First Drugs for Medicare Drug Price Negotiation (Aug. 29, 2023).
[284] Tami Luhby, *Drugmakers want to stop Medicare from negotiating prices. Here's what you should know*, CNN (June 16, 2023).
[285] Press Release, The White House, FACT SHEET: Biden-Harris Administration Announces First Ten Drugs Selected for Medicare Price Negotiation (Aug. 29, 2023).
[286] Joseph Choi, *5 things to know about the first 10 drugs chosen for Medicare negotiation*, THE HILL (Aug. 29, 2023).
[287] O'Neill Institute for National and Global Health Law, Georgetown University Law Center, Health Care Litigation Tracker: Inflation Reduction Act, *available at* https://litigationtracker.law.georgetown.edu/issues/inflation-reduction-act/ (last visited Jul. 10, 2024).
[288] *Supra* note 286;*see also Supra* note 284.

The Administration's action threatens to negatively impact patients by increasing launch prices for new medications.[289] In August 2022, the CBO determined that "the inflation-rebate and negotiation provisions would increase the launch prices for drugs that are not yet on the market relative to what such prices would be otherwise."[290] Additionally, analysts suggest that pharmaceutical companies will attempt to counter limits on future price increases by launching new drugs at higher prices and raising prices on existing drugs under the guise of inflation.[291] Unfortunately, ZS Associates, a consulting firm with a focus on global healthcare, predicts that higher launch prices will most harshly affect treatments for cancer and other rare diseases because the IRA could restrict price increases.[292]

There are also concerns that government price setting will chill research and development (R&D) and reduce patient access as pharmaceutical companies shift R&D from drugs that are most necessary to those not beholden by U.S. price controls.[293] Additionally, price caps may discourage venture capital investment in pharmaceutical development as future pay-off will decrease.[294] In August 2022, the Association for Accessible Medicines (AAM) and the Biosimilars Council expressed disappointment with the IRA, stating it "replace[d] competition – the only proven way to provide patients relief from high brand drug prices – with a flawed framework for government price setting that will chill the development of, and reduce patient access to, lower-cost generic and biosimilar medicines."[295] Research conducted at the University of Chicago found that price controls would increase healthcare spending by $50.8 billion over 20 years, culminating in 135 fewer drugs, which in turn would result in "a loss of 331.5 million life years in the U.S., 31 times as large as the 10.7 million life years lost from COVID-19 in the U.S. to date."[296] Already, 22 drugs and 36 research programs have been discontinued by manufacturers since the passage of the IRA.[297]

Furthermore, the Biden Administration has failed to demonstrate that Americans will not experience challenges accessing treatments and long wait-times. The Chamber of Commerce argues that patients in countries with similar price control policies have access to fewer treatments and must wait longer to get those treatments and contends that the Administration has

[289] Jared S. Hopkins, *A New U.S. Law Aims to Reduce Drug Prices. But First, It Might Raise Them.,* THE WALL STREET JOURNAL (Jan. 14, 2023).
[290] Press Release, Energy and Commerce Committee, House Ways and Means Committee, and Senate Finance Committee, Democrats' Drug Price-Setting Scheme Dismantles Medicare's Promise, Undermines Seniors' Health (Aug. 29, 2023) (citing Letter from Phillip L. Swagel, Dir., Congressional Budget Off., to Hon. Jason Smith, Ranking Member, H. Comm. on the Budget (Aug. 4, 2022).
[291] *Id*. (citing to Jared S. Hopkins, *A New U.S. Law Aims to Reduce Drug Prices. But First, It Might Raise Them.,* THE WALL STREET JOURNAL (Jan. 14, 2023).
[292] *Supra* note 289.
[293] Brooke Masters, *The world will need to stop piggybacking on US pharma*, FINANCIAL TIMES (Sept. 1, 2023).
[294] *Id.*
[295] Press Release, Association for Accessible Medicines, AAM Statement on Senate Passage of Inflation Reduction Act (Aug. 7, 2022).
[296] *Supra* note 290.; Christina Smith, *The Inflation Reduction Act Will Raise Drug Costs and Reduce Cures*, Citizens Against Government Waste (Aug. 5, 2022).
[297] Life Sciences Investment Tracker, incubate *available at* https://lifesciencetracker.com.

failed to conduct research or analysis on the impact on access that America's seniors will face due to the IRA.[298]

[298] Press Release, U.S. Chamber of Commerce, U.S. Chamber: Biden Administration Rushes to Implement Drug Price Control Scheme, Failing to Examine the Negative Side Effects for Seniors (Aug. 28, 2023),

Legislative Reforms

Amid the complex concerns with PBMs' anticompetitive tactics that drive up healthcare costs for Americans, federal and state governments are advancing policy solutions to increase transparency and prohibit unfair business practices.

I. Federal reforms

Both chambers of Congress have proposed reforms in the 118th Congress that tackle problems discussed in this report with the current nature of the PBM market. These proposals include stopping retroactive DIR fees, setting reimbursement and rate floors, delinking PBM compensation from the price of a medication, standardizing performance measures for pharmacies, eliminating narrow definitions of specialty drugs that turn patients away from preferred pharmacy towards that of the PBM, stopping compulsory mail-order for patients, and expanding in-network pharmacy coverage. Bipartisan legislative proposals in the House of Representatives and Senate are at various stages of the legislative process and share the same goal of improving transparency in the PBM market to save taxpayers and patients money.

Proposed legislation in the 118th Congress includes:

- *Delinking Revenue from Unfair Gouging (DRUG) Act (H.R. 6283)* creates certain requirements for PBMs that contract with a carrier offering health benefits plans offered under the FEHB program, including de-linking policies and prohibitions on spread pricing and patient steering. Earlier this year, the House Committee on Oversight and Accountability favorably reported the DRUG Act with bipartisan support.[299]

- *Lower Costs, More Transparency Act (H.R. 5378)* passed the House of Representatives on December 11, 2023, with overwhelming bipartisan support.[300] This legislation requires a variety of transparent pricing disclosures from medical providers, as well as mandating that PBMs semiannually report to health plan sponsors information including spending, rebates, and fees associated with covered plan drugs. If this bill becomes law, PBM contracts will be required to allow health plan fiduciaries to audit certain claims and cost information to improve transparency. For PBM arrangements under Medicaid, pass-through pricing models are required and spread pricing is prohibited.[301] According to CBO, H.R. 5378 would produce net savings of $715 million and generate $4.3 billion in revenue by 2033.[302]

- *Pharmacy Benefit Manager Transparency Act of 2023 (S. 127)* prohibits PBMs from engaging in certain practices when managing the prescription drug benefits under a

[299] *Supra* note 33.
[300] *Supra* note 121.
[301] *Id.*
[302] Cong. Budget Off., Cost Estimate – Estimated Direct Spending and Revenue Effects of H.R. 5378, the Lower Costs, More Transparency Act (Dec. 8, 2023), *available at* https://www.cbo.gov/system/files/2023-12/hr5378-DS-and-Revs_12-2023.pdf.

health insurance plan, including charging the plan a different amount than the PBM reimburses the pharmacy. The bill also prohibits PBMs from arbitrarily, unfairly, or deceptively (1) clawing back reimbursement payments, or (2) increasing fees or lowering reimbursements to pharmacies to offset changes to federally funded health plans. S. 127 was reported out of the Senate Committee on Commerce, Science, and Transportation in March 2023.[303]

- *Medicare PBM Accountability Act (H.R. 5385)* amends Title XVIII of the Social Security Act (Medicare Program) to establish PBM extensive reporting requirements with respect to prescription drug plans and Medicare Advantage Prescription Drug (MA-PD) plans under Medicare Part D. H.R. 5385 was reported favorably by the House Energy and Commerce Committee in December 2023.[304]

- *PBM Reporting Transparency Act (S. 2493)* requires the Medicare Payment Advisory Commission (MedPAC) to submit two reports to Congress on arrangements with pharmacy benefit managers with respect to prescription drug plans and MA–PD plans.[305] The first report requires (1) a description of trends, including high-level averages and totals for each of the types of information submitted; (2) an analysis of any differences in agreements and their effects on plan enrollee out-of-pocket spending and average pharmacy reimbursement, and any other impacts; and (3) any recommendations the Commission determines appropriate. The second report must describe any changes with respect to the information in the first report over time, together with any other recommendations deemed appropriate by MedPAC.

- *Protecting Patients Against PBM Abuses Act (H.R. 2880)* establishes requirements for Medicare pharmacy benefit managers (PBMs) with respect to remuneration, payments, and fees. Specifically, it restricts PBMs that are under contract with plans under the Medicare prescription drug benefit or Medicare Advantage from (1) receiving income for their services other than flat dollar amount service fees; (2) basing any service fees on the prices of covered drugs or any associated discounts, rebates, or other remuneration; (3) charging plan sponsors for ingredient costs or dispensing fees in amounts that are different than what is reimbursed to the pharmacy; or (4) reimbursing network pharmacies for less than that what is reimbursed to PBM-affiliated pharmacies. Such PBMs must also report on the difference between certain costs for drugs on the plan's formulary and those that are not on the formulary but are therapeutically equivalent. PBMs must also report certain information regarding rebates and fees they receive from drug manufacturers. CMS must publish this and other information that is currently reported by PBMs online. H.R. 2880 was reported favorably by the House Committee on Energy and Commerce in December 2023.[306]

[303] S.127 - 118th Congress (2023-2024): Pharmacy Benefit Manager Transparency Act of 2023 (2023).
[304] H.R.5385 - 118th Congress (2023-2024): Medicare PBM Accountability Act (2023).
[305] S.2493 - 118th Congress (2023-2024): PBM Reporting Transparency Act (2023).
[306] H.R.2880 - 118th Congress (2023-2024): Protecting Patients Against PBM Abuses Act (2023).

- *Pharmacy Benefit Manager Sunshine and Accountability Act (H.R. 2816)* expands and otherwise modifies reporting requirements for PBMs. Current law requires PBMs contracting with plans under the Medicare prescription drug benefit or plans that are offered on state health insurance exchanges to report certain information regarding rebates, fees, and other related information. The bill applies these requirements to PBMs that contract with private health insurers, and it expands these requirements to include more specific information relating to prices and fees, such as rebates that the PBM receives from drug manufacturers that are not passed through to other entities and the highest and lowest rebate percentages the PBM receives among all its contracts. The bill also requires HHS to annually post the information reported by PBMs on its website.[307]

- *Pharmacy Benefits Manager Accountability Act (H.R. 2679)* establishes reporting requirements for PBMs. The bill's requirements include PBMs reporting annually to plan sponsors certain information about the amount of prescription drug copayment assistance funded by drug manufacturers, a list of covered drugs billed under the plan during the reporting period, and the total gross and net spending by the health plan on prescription drugs during the reporting period. In addition, PBMs must submit specified elements of the report (e.g., the total gross spending on prescription drugs) to the Government Accountability Office (GAO). With this information, GAO must report on the pharmacy networks of plans or PBMs, including whether such networks under common ownership (i.e., vertical integration) with the plans or PBMs are designed to encourage plan enrollees to use network pharmacies over other pharmacies.[308]

II. State reforms

Congress may also draw legislative solutions from the success of state-level PBM reforms, as states also act to remedy the anticompetitive nature of the PBM market. States are the primary regulator of private health insurance and all 50 states have enacted some level of PBM reform since 2017.[309]

The most commonly enacted PBM provision, passed in 44 states, prohibits PBMs from instituting contracts with pharmacies that prevent a pharmacy or pharmacist from disclosing accurate pricing information to patients.[310] The next most common legislative provision, passed in 30 states, limits the amount a patient is required to pay for their medication through manufacturer rebates or coupons and requires a patient pay the lesser of published costs for a particular drug.[311] Other state-level PBM reforms include:[312]

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[307] H.R.2816 - 118th Congress (2023-2024): Pharmacy Benefit Manager Sunshine and Accountability Act (2023).
[308] H.R.2679 - 118th Congress (2023-2024): Pharmacy Benefits Manager Accountability Act (2023).
[309] Nat'l Acad. for State Health Policy, *State Pharmacy Benefit Manager Legislation* (last updated Nov. 7, 2023), *available at* https://nashp.org/state-tracker/state-pharmacy-benefit-manager-legislation/
[310] *Id.*
[311] *Supra* note 309.
[312] *Id.*

- Requiring PBM licensure/registration
- Requiring PBMs to report rebate or other information to the state
- Establishing Maximum Allowable Costs (MAC) list requirements
- Prohibiting discrimination against 340B-covered entities
- Prohibiting claw backs/retroactive denials
- Establishing reimbursement requirements
- Preventing or prohibiting spread pricing
- Creating regulations for the state or a contracted party's audit of a PBM
- Creating regulations for a PBM's audit of a pharmacy
- Requiring PBMs to share rebate or other information to health plans
- Requiring a PBM to have a fiduciary duty to insurers
- Banning patient steering

GAO recently released a report highlighting five states' laws regulating PBM drug pricing and pharmacy payments. Most importantly, the GAO study identified that states enacting these types of reforms are most successful when regulators have "broad state regulatory authority" and "robust enforcement powers" to rely on, in addition to legislative authority.[313] In this report, notable state-level reform areas enacted in Arkansas, California, Louisiana, Maine, and New York include: [314]

- *Fiduciary or other "duty of care" requirements*: Fiduciary duty to act in the best interest of the health plan or other entity to which the duty is owed and act in "good faith" or "fair dealing."

- *Drug pricing and pharmacy reimbursement*: Limiting PBMs' use of manufacturer rebates and their ability to pay pharmacies less than they charge health plans (i.e., engage in spread pricing).

- *Transparency*: Requiring PBMs to be licensed by and/or registered and report certain information such as drug pricing, fees, and amounts of rebates received and retained.

- *Pharmacy network and access requirements*: Prohibiting discrimination against unaffiliated pharmacies and limiting patient co-pays charged by PBMs.

As these laws go into effect, greater transparency and increased competition in the healthcare market is expected to lead to pass-through cost savings for payers and patients. Texas has unique insight into the true "cost" of PBMs because its Department of Insurance requires PBMs to file annual reports on rebates, fees, and other payments.[315] In 2023, PBMs operating in Texas reported receiving $2.2 billion in manufacturer rebates, of which $91 million were retained as revenue, $2.07 billion were passed on to issuers (payers), which PBMs often own,

[313] *Supra* note 22.
[314] *Id.* .
[315] Adam J. Fein, *Texas Shows Us Where PBMs' Rebates Go*, DRUG CHANNELS INST. (Aug. 9, 2022).

and only $15 million were passed through to enrollees (patients).[316] This type of reporting for just one state's PBM revenues is an example of how better transparency measures can hold companies accountable for what they are charging payers and patients.

[316] TEX. DEP'T OF INSURANCE, 2023 PRESCRIPTION DRUG COST TRANSPARENCY REVIEW: PHARMACY BENEFIT MANAGERS (last updated May 31, 2024), *available at* https://www.tdi.texas.gov/reports/life/2023-pharmacy-benefit-managers.html

Conclusion

PBMs function as middlemen in the pharmaceutical market, situated between health insurers, drug manufacturers, and pharmacies. Their primary responsibilities include negotiating prescription drug prices with drug manufacturers and pharmacies on behalf of payers, the creation and maintenance of formularies and pharmacy networks, reimbursing pharmacies for dispensing prescriptions, and the operation of the electronic systems that process prescription drug claims at retail pharmacies.

With these roles, PBMs are ideally positioned to influence the price of prescription drugs. They should be able to decrease the cost of prescription drugs and improve Americans' health, but that has not occurred. Instead, the opposite has happened: the cost of prescription drugs has increased every year since 2005, patients have fewer choices for which pharmacies they want to use, and physicians are forced to prescribe specific PBM preferred medications which are often more expensive.

The Committee has found PBMs' anticompetitive tactics, implemented by PBMs to protect their profit margins, are often the driving force behind these decisions. Because a PBM's compensation is determined by which business model their clients choose, PBMs are incentivized to implement practices such as spread pricing and steering patients to PBM-owned pharmacies. The largest PBMs have also developed a business model where they can force drug manufacturers to pay high rebates for the manufacturer's drug to be placed in a favorable formulary tier while excluding competing, lower-priced prescriptions such as generics or biosimilars. Other tactics, such as prior authorizations and fail first, harm Americans by delaying or preventing their access to life-saving medications. These tools allow PBMs to slow the market uptake of cheaper generics and biosimilar alternatives to brand-name drugs which serves to keep the cost of prescription drugs high.

As governments have begun to examine PBMs closely and increase transparency in the marketplace, Caremark, Optum Rx, and Express Scripts have begun to create foreign corporate entities to obscure their operations and prevent them from being subject to proposed transparency reforms in the United States.

The Committee's findings indicate that the present role of PBMs in prescription drug markets is failing and requires change. Congress and states must implement legislative reforms to increase the transparency of the PBM market and ensure patients are placed at the center of our health care system, rather than PBMs' profits.

No SB306 Fact Sheet (1) (1).pdf
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NO SB306 FACT SHEET

SB306 will negatively affect injured workers by preventing access to care, increase overall healthcare costs, and enrich Pharmacy Benefit Managers. SB306 is radical - no state in the country uses acquisition costs in WC Fee Guides. Impossibly low reimbursements will be mandated by Statute, removing the flexibility and power of the Workers Compensation Commission to make changes as needed. Maryland has reduced work comp rates by 37% and CEIC has returned $105M to shareholders in two years. This bill should include a fair and reasonable reimbursement for pharmacies, eliminate predatory practices of PBMs and protect injured workers, rather than furthering the interests of insurance companies.

LACK OF ACCESS TO CARE/PATIENT CHOICE

253,201	Marylanders Affected
29,308	Marylanders Are at a HIGH RISK of Denials, Delays in Prescription Treatment
329	Independent Pharmacies Won't be Able to Dispense for Comp
ZERO	States Use the "Acquisition Index" for Workers Comp
36	States Use AWP
#1	Represent the Highest Number of Injured Workers in MD, Who Are **POLICE OFFICERS**

INCREASE COSTS TO WORKERS COMP SYSTEM

$23M	In Delayed Care Related Expenses, Indirect Costs
50%	Increase Rx Costs Due to PBM Practices
$3.5M	Spend by PDAB with Zero Costs Savings to MD
18%	Increase in Prescription Costs Expected Due to PBM Control
986%	Mark-up on Cancer Drugs by PBMs - PBM Pricing Could Double as it has in the Past
7,736%	PBMs Marked-up Tadalafil, Primary Purpose is Pulmonary Hypertension Medication

GIVES PBMS ANTI-COMPETITIVE TRADE PRACTICES, MORE POWER

$7.3B	FTC Claims PBMs Pocketed This Amount in Drug Costs
$334B	Rebates and Legal "Kick-Backs" from the Middlemen to Insurance Carriers
39	States Attorneys General Pursuing PBM Litigation to Curb Abuses
2,275	Pharmacy Closures = Anti-Competetive Trade Practices
3	Pharmacy Deserts = Baltimore, Hartford Co. & Howard Co.

SAVE MARYLAND WORKERS, NOT INSURANCE COMPANIES

MD WORKERS COMP INSURANCE IS HEALTHY

19.4%	Chesapeake Employers Insurance(CEIC) Market Share in MD (largest)
10.8%	Harford Insurance Market Share in MD (2nd largest)
$105M	CEIC Excess Revenue 2023-2024
37%	Decrease in Workers Compensation Rates, According to CEIC
33rd	Lowest- MD's Workers Compensation Rates Ranking Against Other States

CLOSURES

2,600	Rite Aid Closures Starting 2021
4,150	Walgreen's Closures Starting 2019
744	CVS Closures Announced in 2021
30%	of Maryland Pharmacy Closures in Baltimore
20%	of Maryland Pharmacy Closures in Montgomery County
2,275	Pharmacy Closures in 2024 Nationally

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optum-pharmacy-resource-guide-2024 (2).pdf
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Position: FWA

Pharmacy Resource Guide

Workers' Compensation

February 2024

Optum

We are pleased to share this Pharmacy Resource Guide. Inside you will find a state-by-state guide to the pharmacy fee schedule and jurisdictional maps highlighting key workers' compensation laws and regulations. From a statistical perspective, we have provided the top 10 therapeutic classes, top 25 medications as a percentage of total spend, total number of prescriptions and percentage of generic spend. Also included is a helpful brand-generic index of commonly prescribed workers' compensation medications.

Questions about our program may be directed to your account manager or clinical liaison.

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2024 Pharmacy state fee schedule detail

Alaska

BR AWP +$5.00 GR AWP +$10.00 ■

- Lesser of FS, fee to general public, or negotiated fee.
- Reimbursement shall use the original manufacturers AWP.
- Reimbursement shall be limited to “medical necessity” and at the lowest generic NDC.

Alabama

BR AWP +5% +$10.75 GR AWP +5% +$13.97 ■

- Lesser of FS or provider’s U&C.
- Bills shall include original underlying NDC and NDC of repackaged/relabeled product. Reimbursement is lesser of original AWP and repackaged/relabeled AWP. DF payable only to pharmacies.

Arkansas

BR AWP +$5.13 GR AWP +$5.13 ■

- Lesser of FS, provider’s U&C, or MCO/PPO contract price.
- No DF to physicians. OTCs billed by physicians reimbursed at provider’s charge or up to 20% above cost of item. Dispensing practitioners must obtain permit (from state) and demonstrate need prior to dispensing approval.

Arizona

BR AWP -15% +$7.00 GR AWP -25% +$7.00 ■

- Reimbursement is based on actual medication dispensed. Medicines dispensed by either pharmacy or physician subject to FS. FS caps on some topical medications.
- Bills for physician dispensed/repackaged medications shall include NDC of medication dispensed and original manufacturer NDC. Reimbursement based on NDC of underlying medication product.
- Reimbursement based on AWP of underlying medicine product and bills shall include NDC for each ingredient used.
- Max reimbursement for topical compounds = lessor of $200 for a 30-day supply (prorated) or reimbursement in FS for compounds.

California

BR AWP -17% +$7.25 GR AWP -17% +$7.25 ■

- FS set at 100% of current Medi-Cal fee schedule. Lesser of AWP - 17% / MAC or FUL or U&C plus a DF
- If NDC of dispensed medication not in Medi-Cal but NDC of underlying medication is, use NDC of underlying medication. If NDC from original labeler not in Medi-Cal, max fee is 83% of AWP of lowest priced therapeutically equivalent medication plus relevant DF. Requires prior approval of carrier.
- Billed using NDC of each ingredient. If no NDC, ingredient not reimbursable. Reimbursement for physician dispensed compounds not to exceed 300% of documented paid costs, or $20 above. Requires prior approval of carrier.

Colorado

BR AWP +$4.00 GR AWP +$4.00 ■

- If AWP ceases, substitute WAC + 20%.
- For repackaged medications use AWP and NDC of underlying medication. Opioids, scheduled controlled substances, and benzodiazepines shall only be provided through a pharmacy.
- Rates for prescription strength topical compounds categorized according to four state-specific Z codes. Fees represent maximum reimbursable amount. All compound ingredients must be listed by quantity used.
- Certain topicals without a prescription (excluding patches) are limited to a maximum of $30.60 for a 30-day supply. Certain patches without a prescription are limited to a maximum of $71.40 for a 30-day supply.

Connecticut

BR AWP +$5.00 GR AWP +$8.00 ■

- Reimbursement lesser of NDC for underlying medication from manufacturer or therapeutic equivalent medication product from manufacturer NDC. If information pertaining to original manufacturer is not provided or is unknown, payer may select NDC and associated AWP for reimbursement. OTC dispensed in practitioners offices is limited to acquisition cost + 30%.

Delaware

BR AWP -31.9% +$3.29 DF GR AWP -38% +$4.10 DF ■

- Lesser of provider’s U&C, negotiated contract amount or FS.
- Reimbursement based on AWP for underlying medication product as identified by its NDC, from original labeler. Physicians dispensing from office do not receive DF. No practitioner, unless properly licensed, shall dispense a controlled substance beyond a medically necessary 72-hour supply.
- Billed listing each ingredient and separately calculating charge using NDC; single compounding fee of $10 per prescription.

BR = Brand Rate (% of AWP) + Dispense Fee

GR = Generic Rate (% of AWP) + Dispense Fee

Reimbursement Description | Compounded Medications

Physician Dispensed/Repackaged | Topical Medications

Jurisdictional Generic Medication Mandates

- Substitution mandated
- Substitution mandated except where prescriber notate DAW, DNS or similar
- Substitution mandated except where written statement of medical necessity, prior authorization or other requirement provided/met
- Substitution not specifically mandated for workers’ comp

Abbreviations

AWP = Average Wholesale Price DAW = Dispense as Written DF = Dispensing Fee DFEC = Division of Federal Employees’ Compensation DNS = Do Not Substitute DOI = Date of Injury EAC = Estimated Acquisition Cost FS = Fee Schedule FUL = Federal Upper Limit IW = Injured Worker MAC = Maximum Allowable Cost NDC = National Drug Code OTC = Over the Counter POS = Point of Sale SMN = Statement of Medical Necessity U&C = Usual and Customary WAC = Wholesale Acquisition Cost

Florida

BR AWP +$4.18 GR AWP +$4.18 ■

- Reimbursement at FS except where employer/carrier or entity "acting on behalf of" employer/carrier directly contracts with provider seeking lower reimbursement.
- AWP for repackaged/relabeled medications dispensed by "dispensing practitioner" shall be AWP of original manufacturer/underlying medication +12.5% + $8.00 DF. Must include original NDC. Physician dispensed drugs must be authorized and medically necessary.
- Permitted when prescribed formulation not commercially available and reimbursement shall be AWP of each ingredient + $4.18 DF. Requires prior approval of carrier.

Georgia

BR AWP +$4.74 GR AWP +$7.11 ■

- Reimbursement based on current published manufacturer's AWP of product on date of dispensing.
- Bills must include NDC of original manufacturer/ distributor's stock package.
- Must be billed by the compounding pharmacy Reimbursement shall be the sum of AWP for each ingredient -50% plus a single compound fee of $20. Reimbursement limited to compounds containing three or fewer active ingredients.

Hawaii

BR AWP +40% GR AWP +40% ■

- Repackaged medications reimbursed at fee schedule based on original manufacturer NDC.
- Reimbursed at fee schedule based upon gram weight of each underlying ingredient. AWP shall be that set by the original manufacturer.

Idaho

BR AWP +$5.00 GR AWP +$8.00 ■

- Reimbursement is lesser of FS, billed charge, or charge agreed to pursuant to contract.
- Reimbursement based on AWP of original manufacturer. Physicians not reimbursed a DF or compounding fee.
- Reimbursed at sum of AWP of each individual medication, plus a $5 DF and $2 compounding fee. Ingredients of compounds require NDC of original manufacturer.

Kansas

BR AWP -10% +$3.00 GR AWP -15% +$5.00 ■

- Lesser of FS or provider's U&C.
- Reimbursed at fee schedule based on original manufacturer's NDC and require prior approval of carrier.
- Reimbursed at fee schedule based on original manufacturer's NDC and requires prior approval of carrier.

Kentucky

BR AWP -10% +$5.00 GR AWP* -15% +5.00 ■

*Of lowest priced therapeutically equivalent in stock

- Reimbursement at lower amount permitted if agreed.
- Reimbursement based on AWP of original NDC. DF only payable to licensed pharmacist. Doctors are restricted to dispensing only a 48-hour supply of any CII or CIII medication containing hydrocodone from their office.
- AWP of the compound medication is to be determined using the NDC of the original product from the manufacturer. A single $20 compounding fee shall be reimbursed.

Louisiana

BR AWP +10% +$10.99 GR AWP +40% +$10.99 ■

- DF is based on current state Medicaid DF.
- Physicians may only dispense controlled substances or medications of concern if registered as a dispensing physician and only up to a single 48-hour supply.
- Paid at FS formula for generics and bill must indicate "COMPOUND Rx" on form.
- Treatment Guidelines address usage of topical medications.

Massachusetts

BR See description +$10.02 GR See description +$10.02 ■

- Single-source drug(s) reimbursed at lowest of MMAC, AAC or U&C charge plus the DF. Multi-source drug(s) reimbursed at lowest of FUL, MMAC, AAC or U&C charge plus the DF.
- Permitted only when necessary for immediate and proper treatment until possible for patient to have prescription filled by a pharmacy.
- Additional DF based upon type of compound dispensed.

BR = Brand Rate (% of AWP) + Dispense Fee

GR = Generic Rate (% of AWP) + Dispense Fee

Reimbursement Description | Compounded Medications

Physician Dispensed/Repackaged | Topical Medications

Jurisdictional Generic Medication Mandates

- ■ Substitution mandated
- ■ Substitution mandated except where prescriber notate DAW, DNS or similar
- ■ Substitution mandated except where written statement of medical necessity, prior authorization or other requirement provided/met
- ■ Substitution not specifically mandated for workers' comp

Abbreviations

AWP = Average Wholesale Price DAW = Dispense as Written DF = Dispensing Fee DFEC = Division of Federal Employees' Compensation DNS = Do Not Substitute DOI = Date of Injury EAC = Estimated Acquisition Cost FS = Fee Schedule FUL = Federal Upper Limit IW = Injured Worker MAC = Maximum Allowable Cost NDC = National Drug Code OTC = Over the Counter POS = Point of Sale SMN = Statement of Medical Necessity U&C = Usual and Customary WAC = Wholesale Acquisition Cost

Michigan

BR AWP -10% +$3.50 GR -10% AWP +$5.50 ■

- Lesser of MAR in FS or provider's U&C charge.
- Billed and reimbursed based on original manufacturer's NDC.
- Reimbursement for "custom" compounds limited to max of $600 (charges exceeding subject to review). Topical compounds billed using specific amount of each ingredient and original manufacturer's NDC. Reimbursed at max of AWP -10% of original manufacturer's NDC, pro-rated for each ingredient, plus a specific DF. Ingredients without NDCs not reimbursed. Additional "medical necessity" requirements on custom and topical compounds. Non-compound topicals addressed separately.

Minnesota

BR AWP -12% +$3.65* GR AWP -12% +$3.65* ■

*Electronic. Paper for both BR and GR is AWP + $5.14

- FS is bifurcated depending on paper billing and electronic or "real-time" billing and payment (as required) and includes MAC for GR.
- Permitted if not for profit, or if for profit, physician must file with the appropriate licensing board and receive approval.

Mississippi

BR AWP +$5.00 GR -5% AWP +$5.00 ■

- Unless contract, reimbursement is lesser of provider's total billed charge or FS.
- Reimbursed using NDC from underlying medication product from original labeler. DF not payable to doctors.
- Bills shall include listing of each individual ingredient NDC. Reimbursement sum of AWPs of each underlying NDC medication product + $5.00 DF. Topicals limited to a max of $300 per 120 grams per month quantity (without prior authorization).
- Private label topicals limited to $30 for a 30-day supply prorated. Patches limited to $70 for a 30-day supply prorated.

Montana

BR AWP -10% +$3.00 GR -25% AWP +$3.00 ■

- Lesser of FS or provider's U&C.
- Practice limited to certain exceptions.

North Carolina

BR AWP -5% GR AWP -5% ■

- Lesser of FS or an agreement between the provider/payer.
- Original manufacturer's NDC required on bills for repackaged and doctor dispensed medications. Reimbursement for doctor dispensed medications shall not exceed fee schedule based on AWP of the original NDC. No outpatient provider (other than pharmacies) may receive reimbursement for any CII through CV medications over an initial 5-day supply commencing on the employee's initial treatment.

North Dakota

BR $4.00 DF GR $5.00 DF ■

- Based on a markup above WAC, except compounds.
- Reimburses compounds at AWP - 72%, plus a single item compounding fee based on level of effort (LOE). Additional restrictions on topical pain preparations.

New Mexico

BR AWP -10% +$5.00 GR AWP -10% +$5.00 ■

- Lesser of FS, U&C, or contract.
- Reimbursement at AWP - 10% with no DF. Initial physician dispense not greater than 10 days for new prescriptions. Provider dispensed medications shall not exceed cost of generic equivalent.
- Reimbursed at ingredient level, plus single DF. Bills must include original NDC. Ingredients with no NDC not reimbursable.

Nevada

BR AWP +$12.96 GR AWP +$12.96 ■

- Lesser of FS, U&C, or contracted rate.
- May dispense initial supply (15 days) of CII or CIII. Include original NDC on bills. May not charge or seek reimbursement for OTC.
- Reimbursement based upon agreement and includes quantity prior to dispense. All compound bills shall list individual ingredients and NDC. Ingredients lacking an NDC shall not be reimbursed.

BR = Brand Rate (% of AWP) + Dispense Fee

GR = Generic Rate (% of AWP) + Dispense Fee

Reimbursement Description | Compounded Medications

Physician Dispensed/Repackaged | Topical Medications

Jurisdictional Generic Medication Mandates

- ■ Substitution mandated
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New York

BR AWP -12% +$4.00 GR AWP -20% +$5.00 ■

FS or lower contracted rate.

Physician dispensing limited to 72 hours with exceptions. Repackaged medications reimbursed based on AWP for underlying medication.

Reimbursed at ingredient level. Payment based on sum of allowable fee for each ingredient, plus a single DF of $6 per compound. Ingredients with no NDC not reimbursable. Requires prior approval of carrier.

Ohio

BR AWP -15% +$3.50 GR AWP -15% +$3.50

Lesser of U&C or FS.

Medications supplied to IW in physician's office not considered outpatient medication and not reimbursed by BWC. Repackaged brand medications, product cost component shall be calculated using AWP of original labeler (repackaged generics not addressed). Only pharmacy providers eligible for DF.

Billed and reimbursed based on ingredient NDCs (no reimbursement for ingredients without NDC). Max product cost component reimbursement for any one compounded Rx is $400, different DF for sterile/non-sterile compounds.

Oklahoma

BR AWP -10% +$5.00 GR AWP -10% +$5.00 ■

Lesser of FS or provider's U&C for same or similar service.

Physician dispensed (non-repackaged) lesser of AWP - 10% or payer's contracted rate. Repackaged medications reimbursed at lesser of AWP for original NDC - 10% or AWP of lowest cost therapeutic equivalent medication - 10%.

Shall be billed by compounding pharmacy and at the ingredient level. Reimbursement shall be sum of allowable fee for each ingredient, plus a single $5 DF. Ingredients without NDC not reimbursed.

Oregon

BR AWP -16.5% +$2.00 GR AWP -16.5% +$2.00 ■

Lesser of FS, provider's U&C, or contract.

Compensability of physician dispensing limited to initial 10-day supply except in emergency.

Must be billed by ingredient, listing each ingredient's NDC (ingredients w/o NDC not reimbursable). Max fee = AWP-16.5% for each ingredient + a single $10 compounding fee.

Pennsylvania

BR AWP +10% GR AWP +10% ■

If provider's actual charge less than FS, pay actual charge.

Reimbursement shall be at FS based on original manufacturer's NDC, which must be submitted on bill. If original NDC is not submitted, reimbursement shall be FS of the least expensive clinically-equivalent medication. Outpatient providers (other than licensed pharmacies) may not seek reimbursement for Schedule II medication in excess of an initial seven-day supply commencing on "initial treatment" for specific WC claim. Should an IW require a "medical procedure," one additional 15-day supply permitted, commencing on date of procedure. Providers may not seek reimbursement for any other prescription medications in excess of an initial 30-day supply, commencing on "initial treatment" by a provider for specific WC claim and may not seek reimbursement for an OTC medication.

Rhode Island

BR AWP -10% GR AWP -10% ■

Physicians cannot bill for dispense, only to administer medications (injectables) in office.

Compounds containing repackaged medications shall be reimbursed using NDC of the underlying medication. Compounds shall be billed by separating the ingredients by NDC and corresponding quantity.

Reimbursement for topical compounds shall not exceed $500 for a 30-day supply.

BR = Brand Rate (% of AWP) + Dispense Fee

GR = Generic Rate (% of AWP) + Dispense Fee

Reimbursement Description
Physician Dispensed/Repackaged
Compounded Medications
Topical Medications

Jurisdictional Generic Medication Mandates

■ Substitution mandated

■ Substitution mandated except where prescriber notate DAW, DNS or similar

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South Carolina

BR AWP + $5.00 GR AWP +$5.00 ■

Lessor of FS or provider's U&C.

Practitioner dispensed OTCs require preauthorization before dispensing. Repackaged drugs required to be billed with original manufacturer's NDC and reimbursed according to it.

All medications must be reasonable and necessary. Payment for compounded prescription drugs shall be the sum of the AWP by gram weight for each ingredient + a single $5 DF.

Reimbursement for prescription strength topicals limited to a max of $240 for 30-day supply (prorated) not to exceed a 90-day supply. Reimbursement for non-prescription strength patches limited to $70 for 30-day supply (prorated).

Tennessee

BR AWP + $5.10 GR AWP +$5.10 ■

Lesser of FS, provider's U&C, or contracted rate.

Reimbursement based on published manufacturer's AWP of product/ingredient, calculated on a per-unit basis, on date of dispense. If original manufacturer's NDC not provided on bill, reimbursement based on AWP of lowest priced therapeutically equivalent medication. Physician should not receive a DF.

Compounding fee not to exceed $25 per compound and may be charged by any entity other than physician. All compound bills shall include NDC of original manufacturer.

Texas

BR AWP + 9% +$4.00 GR AWP +25% +$4.00

Reimbursement at compliant contracted rate (a direct contract with provider or through a registered pharmacy network) or lesser of FS or billed amount.

Physician dispensing only permitted to meet immediate needs or in rural area.

Calculate each ingredient separately (AWP in FS) plus a $15 compounding fee per prescription. Bills shall include each medication included in the compound. Requires prior approval of carrier.

Vermont

BR AWP + $3.15 GR AWP +$3.15 ■

Lesser of FS or actual charge.

Washington

BR AWP -10% +$4.50 GR AWP -50% +$4.50 ■

L&I (state fund) does not pay for medication dispensed in physician's office and policy is to not pay for repackaged medications.

Reimbursement allows cost of ingredients, plus a $4.50 professional fee and a $4 compounding time fee. Must be billed with NDC for each ingredient.

Wisconsin

BR AWP +$3.00 GR AWP +$3.00 ■

DF only payable to pharmacist. Reimbursed at exisiting pharmacy fee schedule.

Wyoming

BR AWP -10% +$5.00 GR AWP -10% +$5.00 ■

Lesser of FS or provider's U&C.

Physicians billing for compounds must provide pharmacy invoice and pay at 130% of supplier's/manufacturer's invoice price. Repackaged medication reimbursed using AWP of lowest cost therapeutic equivalent.

Compounding pharmacies that bill are compensated per FS, per line item if ingredient determined coverable. Pharmacists/third-party billers must submit itemization for all ingredients and quantities used in compounding process. Prescriptions for compound creams must list all medications included.

Federal services

BR AWP -15% +$4.00 *DFEC* **AWP -10% +4.00** *Non-DFEC*

GR AWP -40% +$4.00 *DFEC* **AWP -25% +4.00** *Non-DFEC*

Lesser of FS or U&C charge amount

For OWCP programs, all medications dispensed from physician's office and submitted with codes J3490, J8499, J8999, and J9999 require accompanying original NDC. For FECA/Black Lung any doctor dispensed Rx submitted using CPT code 99070 require accompanying original NDC.

Compounds shall be billed at ingredient level, including NDCs. Reimbursement for compounds with three or less ingredients shall be AWP - 50% of each NDC. Reimbursement for compounds with four or more ingredients shall be AWP - 70% of each NDC.

BR = Brand Rate (% of AWP) + Dispense Fee

GR = Generic Rate (% of AWP) + Dispense Fee

Reimbursement Description | Compounded Medications

Physician Dispensed/Repackaged | Topical Medications

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No fee schedule

District of Columbia

Paid at U&C.

Iowa ■

Must be reasonable .

Illinois ■

Insurer pays all necessary and reasonable costs.

Medications dispensed outside of licensed pharmacy are AWP + $4.18 and repackaged medications use AWP of underlying medication as identified by NDC from original labeler.

Indiana ■

Reimbursement for repackaged medications dispensed (other than retail/mail pharmacy) use AWP of original manufacturer. If NDC not determined, max reimbursement is lowest cost generic for prescribed/dispensed medication.

Doctors dispensing medications from their office(s) are only entitled to receive reimbursement for medications dispensed during the first seven days from DOI.

Maryland ■

For medications or products lacking FS, carriers can assign a relative value to product/service. May be based on nationally recognized/published relative values or values assigned for similar products/services.

Maine ■

Paid at U&C.

Missouri

Paid at U&C.

Nebraska ■

Paid actual charge billed unless payor has evidence exceeds regular charge for service in similar cases.

New Hampshire ■

Pay reasonable value.

New Jersey ■

Paid at U&C.

Physician dispensing limited to only seven-day supply unless more than 10 miles from nearest pharmacy. Additional limit on charges.

South Dakota ■

Not to exceed U&C.

Utah ■

A reasonable fee.

Physician dispensing permitted only in very limited situations.

Virginia ■

Disputes use prevailing community rate.

Physician dispensing only permitted with certain specified limits (i.e., samples, emergency, not available) unless properly licensed by the Board of Pharmacy.

West Virginia ■

No Controlling Rx FS – Providers bill their U&C.

Legend medicatons dispensed by a physician will not be reimbursed except in emergency.

BR = Brand Rate (% of AWP) + Dispense Fee

GR = Generic Rate (% of AWP) + Dispense Fee

Reimbursement Description

Physician Dispensed/Repackaged

Compounded Medications

Topical Medications

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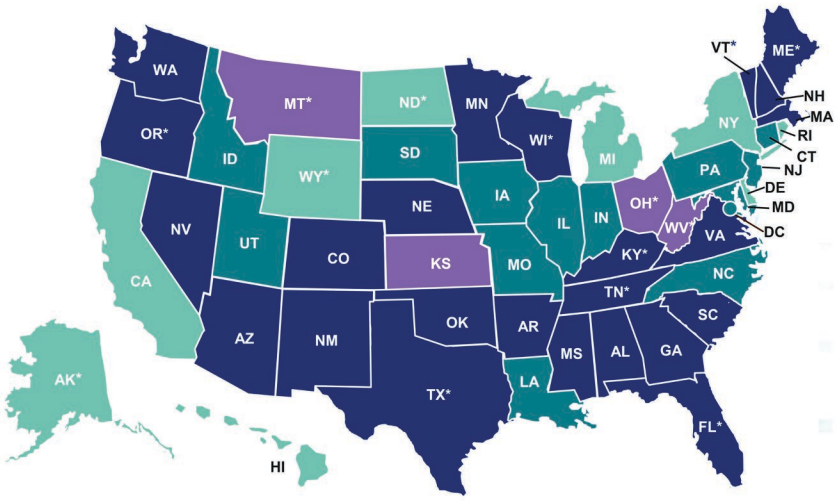
Maps of jurisdictional laws and regulations

Generic medication mandates

Mandating generic substitution is a regulatory tool to reduce pharmacy costs in the workers' compensation system. Mandates vary by state. In some states, the injured person can pay the difference for a brand medication over its generic version. Other states require the use of generics only, or require prior authorization/statement of medical necessity to use brand medications.

DAW = Dispense as Written

DNS = Do Not Substitute.



- Substitution mandated except where written statement of medical necessity, prior authorization or other requirement provided/met
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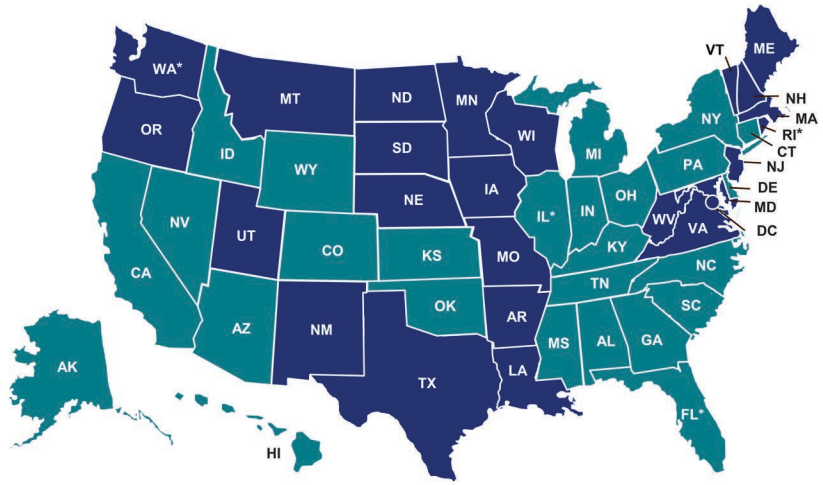
Data reflects published state statutes/regulations on generic dispensing. *Indicates injured person can pay difference between brand and generic when brand dispensed without prior authorization. Current as of February 2024.

NDC for repackaged medications

In response to the increased use of repackaged medications, some states require the original NDC when billing for any repackaged medication. Other states require both the original NDC and the repackaged NDC. Understanding the billing requirements of repackaged medications can provide cost savings for payers.

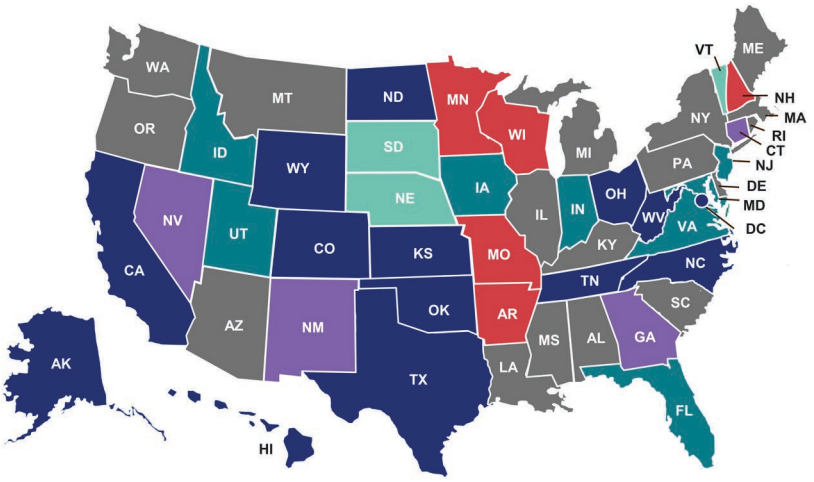


- Mandates use of original NDC for billing and/or reimbursement
- No mandate for use of original NDC for billing/reimbursement

Additional regulatory/statutory factors and qualifications may apply. Data reflects published statutes/regulations/case law on usage of underlying NDC for repackaged medications. Current as of February 2024.

Durable medical equipment fee schedule

Fee schedule policies for durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) vary by state. The majority of states reimburse based on a Medicare factor or a Maximum Allowable Reimbursement formula. While most states have established fee schedules for DMEPOS, not all items are covered by a fee schedule in all jurisdictions. Knowing state reimbursement formulas and fee schedules ensures cost-effective care.

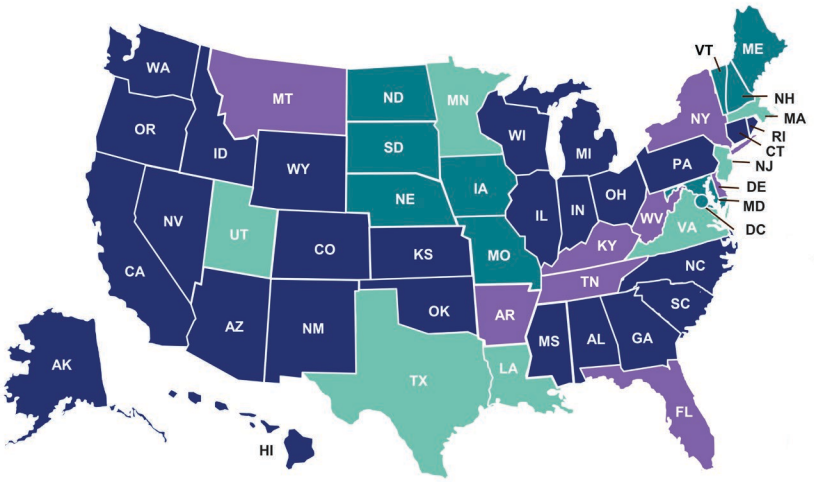


- State-established MAR
- Medicare allowable (may be +/- percentage markup)
- Not regulated or addressed/no specific Fee Schedule established
- Provider cost and/or invoice amount + markup
- U&C or reasonable amount
- Provider billed charge (may be +/- percentage markup)

FS = Fee Schedule, MAR = Maximum Allowable Reimbursement, U&C = Usual & Customary Charge. Note: Categories represent interpretation of state requirements. Some states use tiered/multiple levels of reimbursement. Data reflects published State Fee Schedules. Current as of February 2024.

Physician dispensing restrictions

Most states regulate physician dispensing to control costs. A few states restrict physician dispensing to an initial treatment or an initial days' supply, while others have established billing requirements and caps on reimbursement. Knowing jurisdictional requirements helps control costs and drive injured persons to use in-network pharmacies.

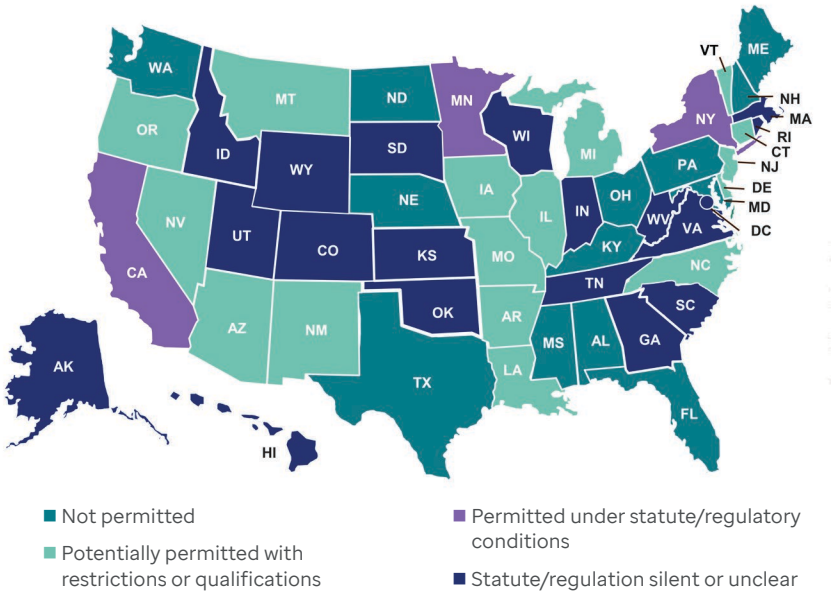


- Legal restrictions on physician dispensing (Practice Act)
- No clear legal or workers' compensation limits on physician dispensing and/or repackaging
- Legal restrictions (Practice Act) in addition to workers' comp controls
- Workers' comp statutes/regulations limit physician dispensing and/or repackaging (restrictions on dispensing, billing and/or reimbursement)

Note – States such as AR, DE, FL, KY, NY, and TN have overlapping workers' compensation and state Practice Act controls Data reflects published state statutes/regulations/case law on Physician Dispensing/Repackaging. Current as of February 2024.

Pharmacy direction of care

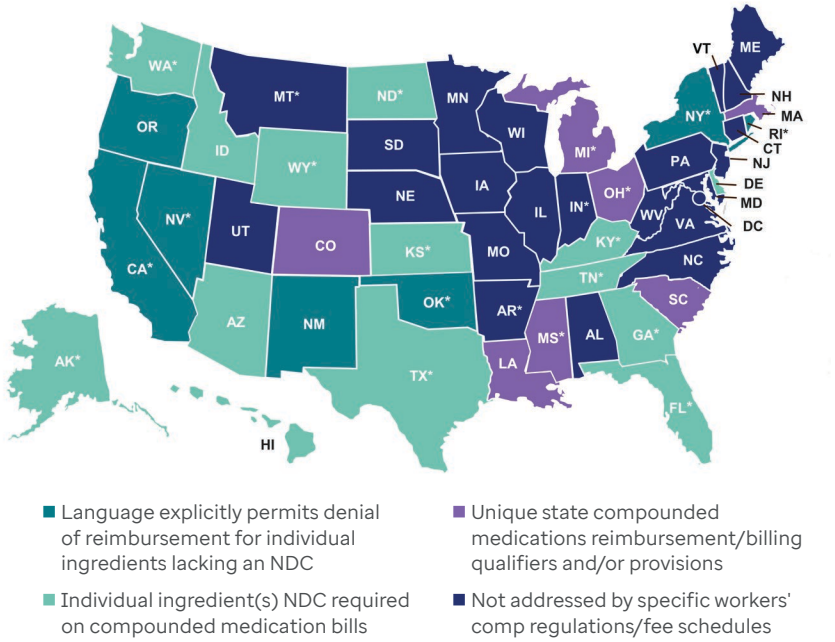
Directing injured persons to a specific pharmacy provider or pharmacy network is not as standard as steering them to a physician or medical network. A limited number of states permit full direction of care for pharmacy. However, the majority of states require navigating regulation, statute, and case law. California, Minnesota, and New York currently permit a payer or employer to utilize a pharmacy provider/network for delivery of care while other states, such as Alabama and Texas, specifically prohibit direction of care for pharmacy services.



Categories set according to statute/regulation/case law relating to direction of care for pharmacy benefit/medical provider networks. Does not reflect dispensing physicians. Current as of February 2024.

Compounded medications

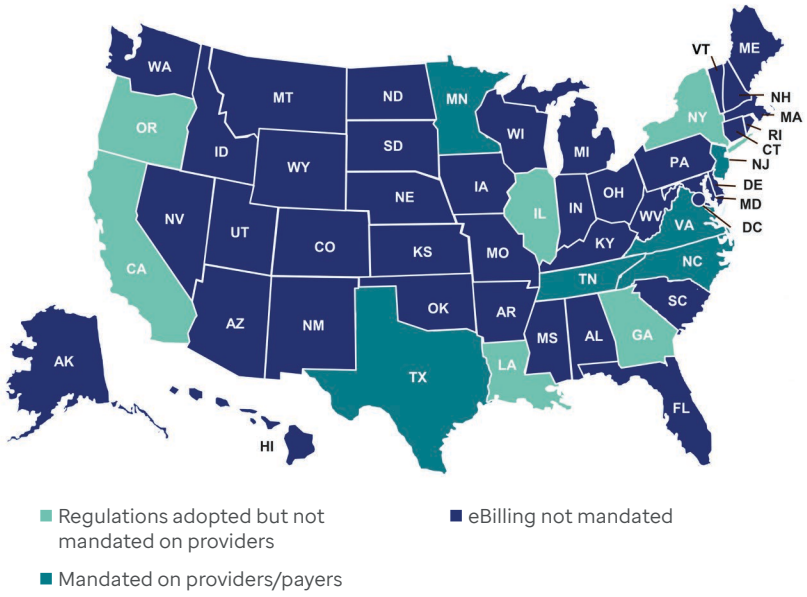
The use of compounded medications increases treatment costs. To address these costs, states adopted fee schedules, billing requirements, and prior authorization constraints. Policy requirements vary by state; however, a majority of states require either prior authorization on compounded medications prior to dispense or require bills to include the NDC of all compounded ingredients. Some states prohibit reimbursement on ingredients that lack an NDC or are considered inactive ingredients.



Additional state regulatory/statutory billing and payment requirements which may include prior authorization. Data reflects published statutes/regulations/fee schedules related to workers' compensation compounded medication billing/reimbursement. Current as of February 2024.

eBilling regulations

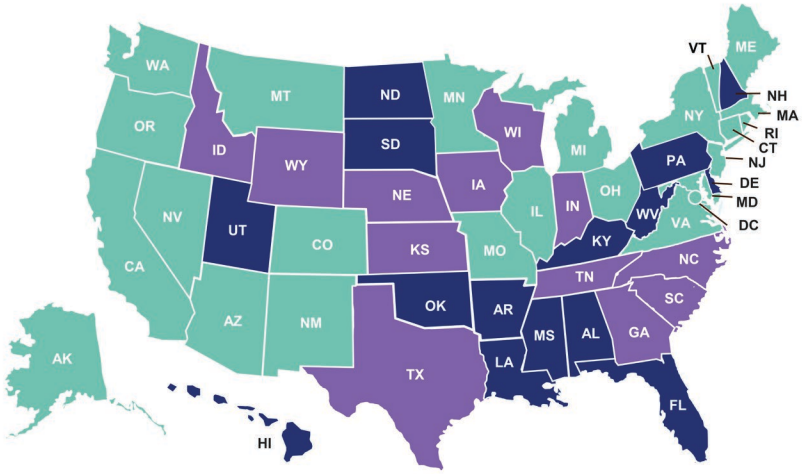
Currently the majority of states have yet to address eBilling. However, states adopting eBilling regulatory frameworks have considered input from their stakeholders and incorporated national standards. Some states are mandating eBilling for both providers and payers and some permit the usage of "agreed upon formats" when they are compliant with the state adopted formats.



Map reflects eBilling mandates inclusive of all workers' compensation medical and pharmacy services. Data reflects published statutes/regulations requiring eBilling or published implementation guides with an eBilling effective date. Current as of February 2024.

Medical marijuana

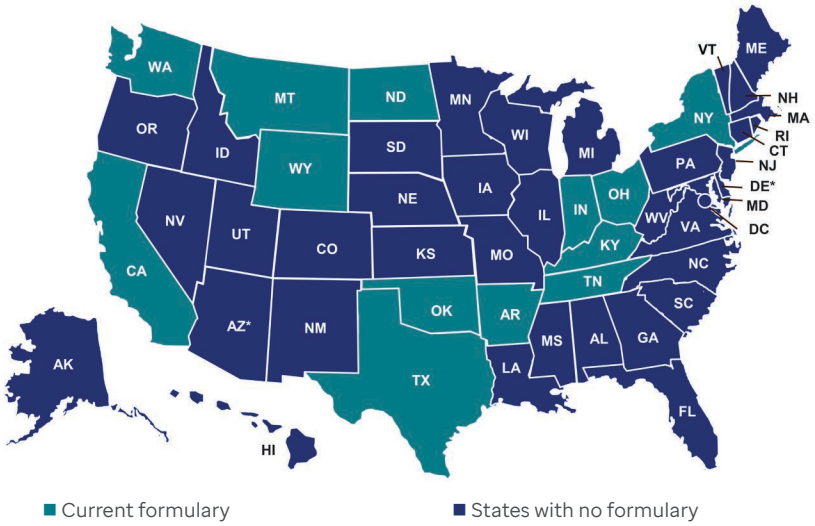
Many states have approved the use of medical marijuana for specific conditions. Currently only New Mexico outlines usage and reimbursement for medical marijuana in their workers' compensation fee schedule. Several states such as California, Illinois, New Jersey, New York, and Minnesota may include medical marijuana treatment due to recent legislative and regulatory actions. Based on these rapid changes, management of chronic pain with medical marijuana needs to be addressed in workers' compensation claims.



Source: ProCon.org. Current as of February 2024.

Workers' comp medication formularies

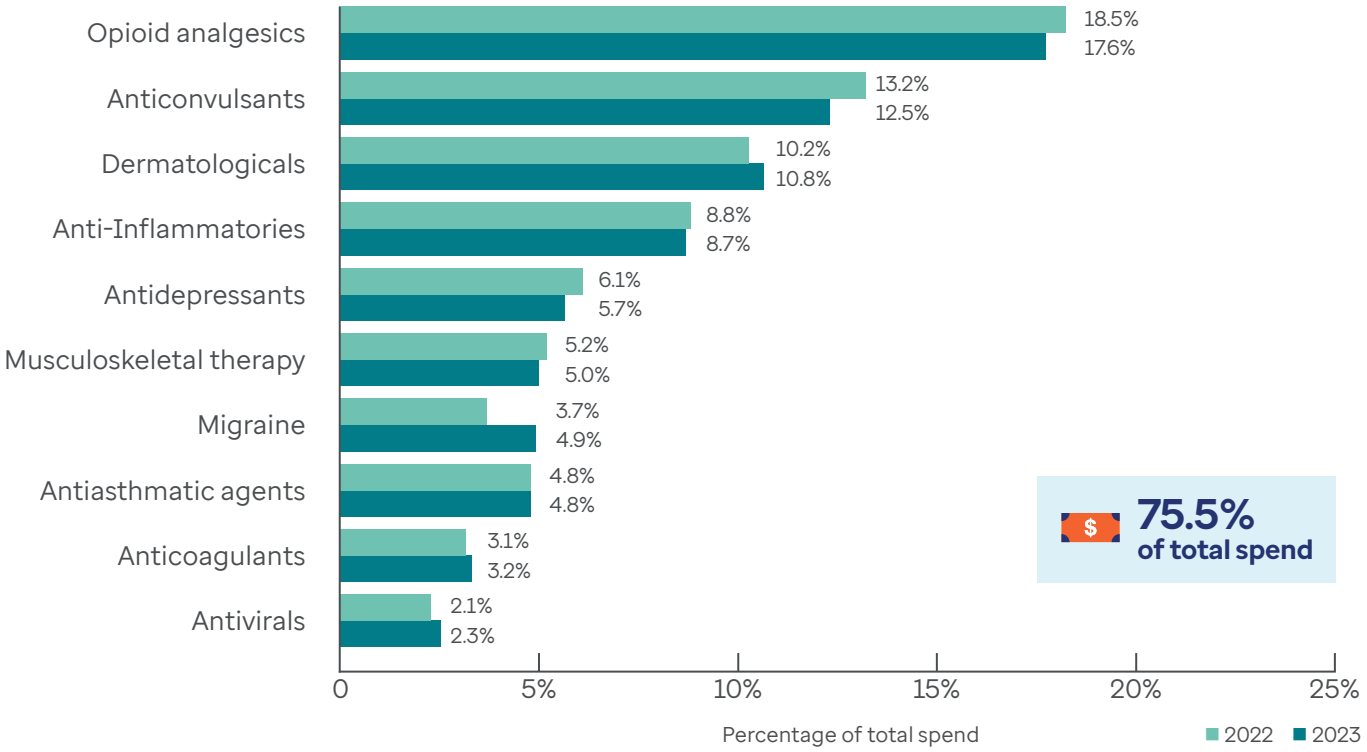
States are using mandated workers' compensation formularies to control medication utilization and cost. The formularies range from incorporation of commercially available formularies such as ODG or ACOEM to state-specific formularies maintained by the state workers' compensation agencies. Regulation requirements, formulary structure, and format vary among jurisdictions.



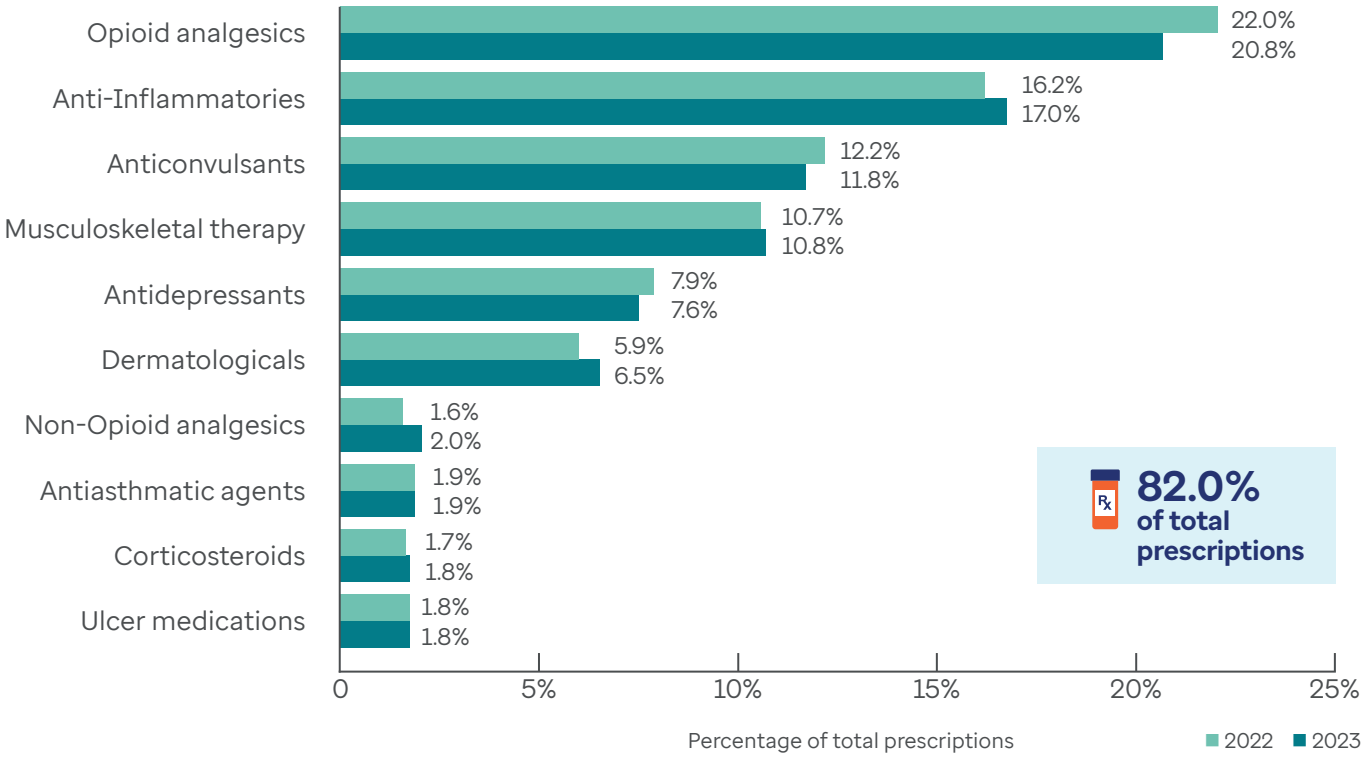
Arizona technically adopted the ODG formulary along with their medical treatment guidelines; however, preauthorization is not required. Delaware also adopted a "preferred drug list" or PDL. Current as of February 2024.

Top 10 therapeutic classes

Top ten therapeutic classes ranked by total spend



Top ten therapeutic classes ranked by number of prescriptions



Top 25 medications

Top 25 medications ranked as a percentage of total spend, including AWP changes

2023 Rank	2022 Rank	Total spend	Common brand name	Generic name	Therapeutic class	Brand and generic AWP	Brand only AWP
1	1	6.10%	Lyrica capsule	pregabalin	Anticonvulsants	0.7%	7.9%
2	2	4.30%	Oxycontin tablet	oxycodone ER	Analgesics - Opioid	5.1%	3.7%
3	3	3.60%	Percocet tablet	oxycodone-acetaminophen	Analgesics - Opioid	5.8%	3.3%
4	4	2.80%	Lidoderm patch	lidocaine	Dermatologicals	-7.6%	-33.0%
5	6	2.70%	Celebrex capsule	celecoxib	Analgesics - Anti-Inflammatory	-1.1%	7.3%
6	5	2.60%	Cymbalta capsule	duloxetine	Antidepressants	-0.1%	3.2%
7	7	1.90%	Neurontin tablet	gabapentin	Anticonvulsants	0.6%	8.8%
8	10	1.90%	Eliquis tablet	apixaban	Anticoagulants	6.0%	6.0%
9	9	1.90%	Mobic tablet	meloxicam	Analgesics - Anti-Inflammatory	0.6%	
10	8	1.80%	Neurontin capsule	gabapentin	Anticonvulsants	5.0%	8.1%
11	11	1.50%	Nucynta tablet	tapentadol	Analgesics - Opioid	9.3%	9.3%
12	12	1.30%	Norco tablet	hydrocodone-acetaminophen	Analgesics - Opioid	1.1%	
13	20	1.30%	Nurtec tablet	rimegepant	Migraine Products	3.6%	3.6%
14	14	1.20%	Nucynta ER tablet	tapentadol ER	Analgesics - Opioid	7.4%	7.4%
15	15	1.10%	Xarelto tablet	rivaroxaban	Anticoagulants	4.9%	4.9%
16	13	1.10%	Pennsaid solution	diclofenac	Dermatologicals	6.5%	-0.7%
17	17	1.00%	Flexeril tablet	cyclobenzaprine	Musculoskeletal Therapy Agents	2.3%	1.8%
18	32	1.00%	Terocin patch	lidocaine-menthol	Dermatologicals	3.6%	3.6%
19	18	1.00%	Belbuca patch	buprenorphine	Analgesics - Opioid	5.4%	5.4%
20	16	1.00%	Lioresal* tablet	baclofen	Musculoskeletal Therapy Agents	-1.0%	
21	23	0.90%	Solaraze gel	diclofenac	Dermatologicals	-7.1%	
22	30	0.90%	Ubrelvy tablet	ubrogepant	Migraine Products	5.1%	5.1%
23	24	0.80%	Zofran tablet	ondansetron	Antiemetics	2.2%	
24	33	0.80%	Trelegy inhaler	fluticasone-umeclidinium-vilanterol	Antiasthmatic And Bronchodilator Agents	3.0%	3.0%
25	19	0.80%	Flector patch	diclofenac	Dermatologicals	1.4%	5.0%

*Brand medication not available
ER = extended-release

Top 25 medications ranked as a percentage of total number of prescriptions, including AWP changes

2023 Rank	2022 Rank	Total Rx	Common brand name	Generic name	Therapeutic class	Brand and generic AWP	Brand only AWP
1	1	6.80%	Norco tablet	hydrocodone-acetaminophen	Analgesics - Opioid	1.1%	
2	3	5.00%	Motrin, Advil tablet	ibuprofen	Analgesics - Anti-Inflammatory	-0.7%	10.7%
3	2	4.90%	Neurontin capsule	gabapentin	Anticonvulsants	5.0%	8.1%
4	4	4.30%	Flexeril tablet	cyclobenzaprine	Musculoskeletal Therapy Agents	2.3%	1.8%
5	5	4.10%	Mobic tablet	meloxicam	Analgesics - Anti-Inflammatory	0.6%	
6	6	3.50%	Percocet tablet	oxycodone-acetaminophen	Analgesics - Opioid	5.8%	3.3%
7	7	3.20%	Lyrica capsule	pregabalin	Anticonvulsants	0.7%	7.9%
8	8	2.80%	Ultram tablet	tramadol	Analgesics - Opioid	0.8%	
9	9	2.60%	Roxicodone tablet	oxycodone	Analgesics - Opioid	0.8%	-11.2%
10	11	2.50%	Celebrex capsule	celecoxib	Analgesics - Anti-Inflammatory	-1.1%	7.3%
11	10	2.30%	Cymbalta capsule	duloxetine	Antidepressants	-0.1%	3.2%
12	12	2.30%	Naprosyn tablet	naproxen	Analgesics - Anti-Inflammatory	0.3%	1.3%
13	16	2.30%	Lidoderm patch	lidocaine	Dermatologicals	-7.6%	-33.0%
14	15	2.20%	Zanaflex tablet	tizanidine	Musculoskeletal Therapy Agents	-0.3%	1.7%
15	14	2.20%	Voltaren gel	diclofenac sodium	Dermatologicals	12.8%	-11.5%
16	13	2.10%	Neurontin tablet	gabapentin	Anticonvulsants	0.6%	8.8%
17	17	1.90%	Robaxin tablet	methocarbamol	Musculoskeletal Therapy Agents	9.9%	
18	18	1.30%	Lioresal* tablet	baclofen	Musculoskeletal Therapy Agents	-1.0%	
19	23	1.20%	Tylenol tablet	acetaminophen	Analgesics - Non-Opioid	-0.1%	2.1%
20	20	1.20%	Voltaren tablet	diclofenac	Analgesics - Anti-Inflammatory	0.4%	
21	19	1.20%	Elavil* tablet	amitriptyline	Antidepressants	-2.3%	
22	22	1.10%	Medrol pak	methylprednisolone	Corticosteroids	0.3%	0.0%
23	21	0.90%	Oxycontin tablet	oxycodone ER	Analgesics - Opioid	5.1%	3.7%
24	24	0.80%	Desyrel* tablet	trazodone	Antidepressants	-0.6%	
25	25	0.70%	MS Contin tablet	morphine sulfate	Analgesics - Opioid	-3.2%	-3.5%

*Brand medication not available
ER = extended-release

Top 25 medications ranked as a percentage of generic spend, including generic utilization

2023 Rank	2022 Rank	Total generic spend	Common brand name	Generic name	Therapeutic class	Total generic Rx	Generic utilization
1	1	9.90%	Lyrica capsule	pregabalin	Anticonvulsants	3.3%	94.9%
2	3	4.50%	Celebrex capsule	celecoxib	Analgesics - Anti-Inflammatory	2.7%	97.4%
3	2	4.40%	Cymbalta capsule	duloxetine	Antidepressants	2.5%	97.3%
4	4	4.00%	Lidoderm patch	lidocaine	Dermatologicals	2.1%	85.3%
5	6	3.50%	Mobic tablet	meloxicam	Analgesics - Anti-Inflammatory	4.5%	100.0%
6	7	3.20%	Percocet tablet	oxycodone-acetaminophen	Analgesics - Opioid	3.7%	96.8%
7	5	3.10%	Neurontin tablet	gabapentin	Anticonvulsants	2.3%	98.9%
8	8	2.90%	Neurontin capsule	gabapentin	Anticonvulsants	5.4%	99.4%
9	9	2.50%	Norco tablet	hydrocodone-acetaminophen	Analgesics - Opioid	7.5%	100.0%
10	11	1.90%	Flexeril tablet	cyclobenzaprine	Musculoskeletal Therapy Agents	4.7%	100.0%
11	10	1.80%	Lioresal* tablet	baclofen	Musculoskeletal Therapy Agents	1.4%	100.0%
12	12	1.80%	Pennsaid solution	diclofenac	Dermatologicals	0.1%	94.4%
13	14	1.70%	Solaraze gel	diclofenac	Dermatologicals	0.2%	100.0%
14	15	1.50%	Zofran tablet	ondansetron	Antiemetics	0.4%	100.0%
15	18	1.40%	Voltaren gel	diclofenac sodium	Dermatologicals	2.4%	97.9%
16	16	1.30%	Zanaflex tablet	tizanidine	Musculoskeletal Therapy Agents	2.4%	99.8%
17	13	1.30%	Flector patch	diclofenac	Dermatologicals	0.2%	83.2%
18	17	1.30%	Roxicodone tablet	oxycodone	Analgesics - Opioid	2.8%	99.6%
19	19	1.20%	Motrin, Advil tablet	ibuprofen	Analgesics - Anti-Inflammatory	5.4%	98.9%
20	28	1.10%	Zofran tablet ODT	ondansetron ODT	Antiemetics	0.3%	100.0%
21	25	1.00%	Truvada tablet	emtricitabine-tenofovir	Antivirals	0.1%	98.6%
22	24	1.00%	Cataflam tablet	diclofenac potassium	Analgesics - Anti-Inflammatory	0.2%	99.9%
23	27	1.00%	Prilosec capsule	omeprazole	Ulcer Drugs	0.8%	100.0%
24	21	1.00%	Abilify tablet	aripiprazole	Antipsychotics/Antimanic Agents	0.2%	96.9%
25	22	1.00%	Lidocaine ointment	lidocaine	Dermatologicals	0.2%	100.0%

*Brand medication not available
ER = extended-release
ODT = orally disintegrating tablet

Brand-Generic index

Brand	Generic	Therapeutic class	Pharmaceutical uses†
Abilify®	aripiprazole	Antipsychotic	Schizophrenia/Bipolar disorder/Depression
Aciphex®	rabeprazole	Ulcer medication	Ulcers/GERD
Adderall®	amphetamine/ dextroamphetamine	Stimulant	Attention deficit hyperactivity disorder
Advair Diskus®	fluticasone/salmeterol	Antiasthmatic	Asthma/COPD
Advil®	ibuprofen	NSAID	Pain/Inflammation
Advil® Dual Action	ibuprofen/acetaminophen	Non-Opioid analgesic	Minor aches and pain
Aimovig®	erenumab-aooe	Migraine product	Migraine
Airsupra™	albuterol/budesonide	Antiasthmatic	Asthma
Ajovy®	fremanezumab-vfrm	Migraine product	Migraine
Altace®	ramipril	Antihypertensive	High blood pressure/Heart failure
Ambien CR®	zolpidem extended-release	Hypnotic	Insomnia
Ambien®	zolpidem	Hypnotic	Insomnia
Amitiza®	lubiprostone	Gastrointestinal agent	Constipation/Opioid-Induced constipation
Amrix®	cyclobenzaprine extended-release	Skeletal muscle relaxant	Muscle spasm
Anaprox® DS	naproxen sodium	NSAID	Pain/Inflammation
Androgel®	testosterone	Androgen	Testosterone deficiency
Antivert®	meclizine	Antiemetic	Nausea/Vomiting
Apadaz®	benzhydrocodone/acetaminophen	Opioid analgesic	Pain
Aricept®	donepezil	Neurological agent	Alzheimer's Disease
Arthrotec®	diclofenac/misoprostol	NSAID	Pain/Inflammation
Atarax®	hydroxyzine	Antianxiety agent	Anxiety/Itching
Ativan®	lorazepam	Antianxiety agent	Anxiety/Insomnia
Augmentin®	amoxicillin/clavulanate potassium	Antibiotic	Bacterial infections
Avinza®	morphine extended-release	Opioid analgesic	Pain
Bactrim® DS	sulfamethoxazole/trimethoprim	Antibiotic	Bacterial infections
Bactroban®	mupirocin	Antiinfective - Topical	Skin infections
Bengay®	menthol	Dermatological - Topical	Muscle pain
Brixadi®	buprenorphine	Opioid analgesic	Opioid dependence
BuSpar®	buspirone	Antianxiety agent	Anxiety
Butrans®	buprenorphine	Opioid analgesic	Pain
Bystolic®	nebivolol	Antihypertensive	High blood pressure
Cambia®	diclofenac potassium	Migraine product	Migraine
Cataflam®	diclofenac potassium	NSAID	Pain/Inflammation
Catapres®	clonidine	Antihypertensive	High blood pressure
Celebrex®	celecoxib	NSAID	Pain/Inflammation
Celexa®	citalopram	Antidepressant	Depression
Cialis®	tadalafil	Misc. cardiovascular	Erectile dysfunction/Enlarged prostate
Cipro®	ciprofloxacin	Antibiotic	Bacterial Infections
Cleocin®	clindamycin	Antibiotic	Bacterial infections
Clinoril®	sulindac	NSAID	Pain/Inflammation
Colace®	docusate sodium	Laxative	Constipation
Combivent® Respimat®	ipratropium bromide/albuterol	Antiasthmatic	COPD

† Pharmaceutical uses listed are not all-inclusive; does not include all FDA approved and off-label uses. ER, XR, CR, LA, XL = Extended-release formulations.
Names in red = Generic not available **NSAID** = Nonsteroidal Anti-inflammatory Drug **COPD** = Chronic Obstructive Pulmonary Disease **GERD** = Gastroesophageal Reflux Disease

Brand	Generic	Therapeutic class	Pharmaceutical uses†
Constulose®	lactulose	Laxative	Constipation
Conzip®	tramadol extended-release	Opioid analgesic	Pain
Coreg®	carvedilol	Antihypertensive	High blood pressure/Heart failure
Corgard®	nadolol	Antihypertensive	High blood pressure/Angina
Coumadin®	warfarin	Anticoagulant	Blood thinner
Cozaar®	losartan potassium	Antihypertensive	High blood pressure
Crestor®	rosuvastatin	Antihyperlipidemic	High Cholesterol
Cymbalta®	duloxetine	Antidepressant	Depression/Pain/Anxiety
Daypro®	oxaprozin	NSAID	Pain/Inflammation
Deltasone®	prednisone	Corticosteroid	Inflammatory disorders
Depakote®	divalproex	Anticonvulsant	Seizures/Migraine/Bipolar disorder
Depakote® ER	divalproex extended-release	Anticonvulsant	Seizures/Migraine/Bipolar disorder
Desyrel®	trazodone	Antidepressant	Depression/Insomnia
Dexilant®	dexlansoprazole	Ulcer medication	Ulcers/GERD
Dilantin®	phenytoin	Anticonvulsant	Seizures
Dilaudid®	hydromorphone	Opioid analgesic	Pain
Diovan®	valsartan	Antihypertensive	High blood pressure/Heart failure
Ditropan XL®	oxybutynin extended-release	Urinary antispasmodic	Overactive bladder
Dolophine®	methadone	Opioid analgesic	Pain
Drizalma Sprinkle™	duloxetine	Antidepressant	Depression/Pain/Anxiety
Duexis®	ibuprofen/famotidine	NSAID/Histamine blocker	Arthritis/Ulcer Risk reduction
Dulcolax® Suppository	bisacodyl	Laxative	Constipation
Duragesic®	fentanyl	Opioid analgesic	Pain
EC-Naprosyn®	naproxen delayed-release	NSAID	Pain/Inflammation
Ecotrin®	aspirin	Non-Opioid analgesic	Pain/Inflammation/Fever
Effexor®	venlafaxine	Antidepressant	Depression
Effexor® XR	venlafaxine extended-release	Antidepressant	Depression
Elavil®	amitriptyline	Antidepressant	Depression/Insomnia/Nerve pain
Eliquis®	apixaban	Anticoagulant	Blood thinner
Elyxyb™	celecoxib solution	Migraine product	Migraine
Emgality®	galcanezumab-gnlm	Migraine product	Migraine
Eprontia®	topiramate solution	Anticonvulsant	Seizures/Migraine
Esgic®/Fioricet®	butalbital/acetaminophen/caffeine	Non-Opioid analgesic	Headache
Exalgo®	hydromorphone extended-release	Opioid analgesic	Pain
Feldene®	piroxicam	NSAID	Pain/Inflammation
Flector® Patch	diclofenac patch	Topical NSAID	Pain/Inflammation
Flexeril®	cyclobenzaprine	Skeletal muscle relaxant	Muscle spasm
Flomax®	tamsulosin	Misc. genitourinary product	Enlarged Prostate
Flonase®	fluticasone	Corticosteroid - Nasal	Allergies
Glucophage®	metformin	Antidiabetic	High blood sugar
Gralise®	gabapentin	Anticonvulsant	Nerve pain
Horizant®	gabapentin enacarbil	Anticonvulsant	Restless Legs Syndrome
Hydrodiuril®	hydrochlorothiazide	Diuretic	High blood pressure/Heart failure

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Names in red = Generic not available **NSAID** = Nonsteroidal Anti-inflammatory Drug **COPD** = Chronic Obstructive Pulmonary Disease **GERD** = Gastroesophageal Reflux Disease

Brand	Generic	Therapeutic class	Pharmaceutical uses†
Hysingla® ER	hydrocodone extended-release	Opioid analgesic	Pain
Imitrex®	sumatriptan	Migraine Product	Migraine
Inderal®	propranolol	Antihypertensive	High blood pressure/Migraine
Inderal® LA	propranolol extended-release	Antihypertensive	High blood pressure/Migraine
Isentress®	raltegravir	Antiviral	Human immunodeficiency virus infection
Kadian®	morphine extended-release	Opioid analgesic	Pain
Keflex®	cephalexin	Antibiotic	Bacterial Infections
Kenalog®	triamcinolone	Corticosteroid - Topical	Inflammatory disorders
Keppra®	levetiracetam	Anticonvulsant	Seizures
Klonopin®	clonazepam	Anticonvulsant	Antianxiety agent
Klor-Con®	potassium chloride	Mineral and electrolyte	Potassium deficiency
Lamictal®	lamotrigine	Anticonvulsant	Seizures/Bipolar Disorder
Lasix®	furosemide	Diuretic	High Blood Pressure/Heart failure
Latuda®	lurasidone	Antipsychotic	Schizophrenia/Bipolar disorder
Levaquin®	levofloxacin	Antibiotic	Bacterial infections
Lexapro®	escitalopram	Antidepressant	Depression
Licart® Patch	diclofenac patch	Topical NSAID	Pain/Inflammation
Lidoderm® Patch	lidocaine patch	Topical analgesic - Anesthetic	Nerve pain
Linzess®	linaclotide	Gastrointestinal agent	Constipation/Irritable bowel syndrome
Lioresal®	baclofen	Skeletal muscle relaxant	Spasticity
Lipitor®	atorvastatin	Antihyperlipidemic	High cholesterol
Lodine®	etodolac	NSAID	Pain/Inflammation
Lodine® ER	etodolac extended-release	NSAID	Pain/Inflammation
Lopressor®	metoprolol tartrate	Antihypertensive	High blood pressure/Angina
Loreev XR™	lorazepam extended-release	Antianxiety agent	Anxiety
Lovenox®	enoxaparin	Anticoagulant	Blood Thinner
Lunesta®	eszopiclone	Hypnotic	Insomnia
Lyrica®	pregabalin	Anticonvulsant	Fibromyalgia/Seizures/Nerve pain
Medrol®	methylprednisolone	Corticosteroid	Inflammatory Disorders
Miacalcin®	calcitonin/salmon	Endocrine/Metabolic agent	Osteoporosis
Minipress®	prazosin	Antihypertensive	High Blood Pressure
MiraLAX®	polyethylene glycol	Laxative	Constipation
Mobic®	meloxicam	NSAID	Pain/Inflammation
Motegrity®	prucalopride	Gastrointestinal agent	Constipation
Movantik®	naloxegol	Gastrointestinal agent	Opioid-Induced Constipation
Moxatag®	amoxicillin extended-release	Antibiotic	Bacterial infections
MS Contin®	morphine extended-release	Opioid analgesic	Pain
Namenda®	memantine	Psychotherapeutic/Neurological agent	Alzheimer's disease
Naprosyn®	naproxen	NSAID	Pain/Inflammation
Narcan®	naloxone nasal spray	Opioid antagonist	Opioid overdose
Neurontin®	gabapentin	Anticonvulsant	Seizures/Nerve pain
New Terocin Lotion	methyl salicylate/capsaicin/menthol	Dermatological - Topical	Topical pain relief
Nexium®	esomeprazole magnesium	Ulcer medication	Ulcers/GERD

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Names in red = Generic not available **NSAID** = Nonsteroidal Anti-inflammatory Drug **COPD** = Chronic Obstructive Pulmonary Disease **GERD** = Gastroesophageal Reflux Disease

Brand	Generic	Therapeutic class	Pharmaceutical uses†
Norco®	hydrocodone/acetaminophen	Opioid analgesic	Pain
Norflex®	orphenadrine	Skeletal muscle relaxant	Muscle Spasm
Norvasc®	amlodipine	Antihypertensive	High blood pressure/Angina
Nucynta®	tapentadol	Opioid analgesic	Pain
Nucynta® ER	tapentadol extended-release	Opioid analgesic	Pain
Nurtec® ODT	rimegepant	Migraine product	Migraine
Nuvigil®	armodafinil	Stimulant	Narcolepsy/Sleep apnea/Shift work disorder
Opana®	oxymorphone	Opioid analgesic	Pain
Opana® ER	oxymorphone extended-release	Opioid analgesic	Pain
Opvee®	nalmefene	Opioid antagonist	Opioid overdose
Orudis®	ketoprofen	NSAID	Pain/Inflammation
OxyContin®	oxycodone extended-release	Opioid analgesic	Pain
Pamelor®	nortriptyline	Antidepressant	Depression/Insomnia/Nerve pain
Parafon Forte® DSC	chlorzoxazone	Skeletal muscle relaxant	Muscle spasm
Paxil®	paroxetine	Antidepressant	Depression
Pennsaid® Solution	diclofenac solution	Topical NSAID	Pain/Inflammation
Pepcid®/Zantac 360™	famotidine	Ulcer medication	Ulcers/GERD
Percocet®	oxycodone/acetaminophen	Opioid analgesic	Pain
Phenergan®	promethazine	Antihistamine	Nausea/Vomiting
Plavix®	clopidogrel	Hematological	Post Stroke/Heart attack
Pradaxa®	dabigatran etexilate	Anticoagulant	Blood thinner
Pred Forte®	prednisolone	Ophthalmic	Eye inflammation
Prevacid®	lansoprazole	Ulcer medication	Ulcers/GERD
Prilosec®	omeprazole	Ulcer medication	Ulcers/GERD
Pristiq®	desvenlafaxine extended-release	Antidepressant	Depression
ProAir® HFA	albuterol sulfate	Antiasthmatic	Asthma
Protonix®	pantoprazole	Ulcer medication	Ulcers/GERD
Provigil®	modafinil	Stimulant	Narcolepsy/Sleep apnea/Shift work disorder
Prozac®	fluoxetine	Antidepressant	Depression
Qdolo®	tramadol solution	Opioid analgesic	Pain
Qmiiz® ODT	meloxicam	NSAID	Pain/inflammation
Qudexy® XR	topiramate extended-release	Anticonvulsant	Seizures/Migraine
Qulipta™	atogepant	Migraine product	Migraine
Quviviq®	daridorexant	Hypnotic	Insomnia
Relafen®	nabumetone	NSAID	Pain/Inflammation
Relistor®	methylnaltrexone	Gastrointestinal agent	Opioid-induced constipation
Relpax®	eletriptan	Migraine product	Migraine
Remeron®	mirtazapine	Antidepressant	Depression
Requip®	ropinirole	Antiparkinsonian	Parkinson's disease/Restless legs syndrome
Restoril™	temazepam	Hypnotic	Insomnia
Revia®	naltrexone	Opioid antagonist	Opioid dependence
Reyvow®	lasmiditan	Migraine product	Migraine
Risperdal®	risperidone	Antipsychotic	Schizophrenia/Bipolar disorder

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Names in red = Generic not available **NSAID** = Nonsteroidal Anti-inflammatory Drug **COPD** = Chronic Obstructive Pulmonary Disease **GERD** = Gastroesophageal Reflux Disease

Brand	Generic	Therapeutic class	Pharmaceutical uses†
Ritalin®	methylphenidate	Stimulant	Attention deficit hyperactivity disorder
Robaxin®	methocarbamol	Skeletal muscle relaxant	Muscle Spasm
Roxicodone®	oxycodone	Opioid analgesic	Pain
Savella®	milnacipran	Psychotherapeutic/Neurological agent	Fibromyalgia
Seglentis®	celecoxib/tramadol	NSAID/Opioid analgesic	Pain
Senokot®	sennosides	Laxative	Constipation
Senokot-S®	senna/docusate sodium	Laxative	Constipation
Seroquel XR®	quetiapine extended-release	Antipsychotic	Schizophrenia/Bipolar disorder/Depression
Seroquel®	quetiapine	Antipsychotic	Schizophrenia/Bipolar disorder
Silenor®	doxepin	Hypnotic	Insomnia
Silvadene®	silver sulfadiazine	Antiinfective - Topical	Burn wound
Sinequan®	doxepin	Antidepressant	Depression/Insomnia
Singulair®	montelukast	Antiasthmatic	Asthma/Allergic rhinitis
Skelaxin®	metaxalone	Skeletal muscle relaxant	Muscle spasm
Soma®	carisoprodol	Skeletal muscle relaxant	Muscle Spasm
Spiriva® Handihaler®	tiotropium	Antiasthmatic	COPD
Suboxone®	buprenorphine/naloxone	Opioid analgesic	Opioid dependence
Subutex®	buprenorphine	Opioid analgesic	Opioid dependence
Symbicort®	budesonide/formoterol	Antiasthmatic	Asthma/COPD
Symproic®	naldemedine	Gastrointestinal agent	Opioid-induced constipation
Synthroid®	levothyroxine	Thyroid	Thyroid hormone deficiency
Tegretol®	carbamazepine	Anticonvulsant	Seizures/Bipolar disorder/Nerve pain
Tenormin®	atenolol	Antihypertensive	High blood pressure/Angina
Terocin Patch	lidocaine/menthol	Dermatological - Topical	Topical pain relief
Tivorbex®	indomethacin	NSAID	Pain/Inflammation
Topamax®	topiramate	Anticonvulsant	Seizures/Migraine
Toprol-XL®	metoprolol extended-release	Antihypertensive	High blood pressure/Heart failure/Angina
Toradol®	ketorolac	NSAID	Pain/Inflammation
Tricor®	fenofibrate	Antihyperlipidemic	High cholesterol
Trileptal®	oxcarbazepine	Anticonvulsant	Seizures
Trintellix®	vortioxetine	Antidepressant	Depression
Trokendi XR®	topiramate extended-release	Anticonvulsant	Seizures/Migraine
Trudhesa™	dihydroergotamine mesylate	Migraine product	Migraine
Truvada®	emtricitabine/tenofovir	Antiviral	Human immunodeficiency virus infection
Tylenol® Extra Strength	acetaminophen extra-strength	Non-Opioid analgesic	Pain/Fever
Tylenol® with Codeine #4	acetaminophen/codeine	Opioid analgesic	Pain
Ubrelvy®	ubrogepant	Migraine product	Migraine
Ultracet®	tramadol/acetaminophen	Opioid analgesic	Pain
Ultram®	tramadol	Opioid analgesic	Pain
Ultram® ER	tramadol extended-release	Opioid analgesic	Pain
Valium®	diazepam	Antianxiety agent	Anxiety/Muscle spasms
Ventolin®/Proventil®	albuterol nebulizer solution	Antiasthmatic	Asthma
Viagra®	sildenafil	Misc. cardiovascular	Erectile dysfunction/Pulmonary hypertension

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Names in red = Generic not available **NSAID** = Nonsteroidal Anti-inflammatory Drug **COPD** = Chronic Obstructive Pulmonary Disease **GERD** = Gastroesophageal Reflux Disease

Brand	Generic	Therapeutic class	Pharmaceutical uses†
Vibramycin®	doxycycline hyclate	Antibiotic	Bacterial infections
Vicoprofen®	hydrocodone/ibuprofen	Opioid analgesic	Pain
Viibryd®	vilazodone	Antidepressant	Depression
Vimovo®	naproxen/esomeprazole	NSAID/Proton pump inhibitor	Arthritis/Ulcer risk reduction
Vistaril®	hydroxyzine pamoate	Antianxiety agent	Anxiety/Itching
Vivlodex®	meloxicam	NSAID	Pain/inflammation
Voltaren®	diclofenac	NSAID	Pain/Inflammation
Voltaren® Arthritis Pain	diclofenac gel	Topical NSAID	Pain/Inflammation
Voltaren®-XR	diclofenac extended-release	NSAID	Pain/Inflammation
Wellbutrin XL®	bupropion extended-release	Antidepressant	Depression
Wellbutrin®	bupropion	Antidepressant	Depression
Xanax®	alprazolam	Antianxiety agent	Anxiety/Panic disorder
Xarelto®	rivaroxaban	Anticoagulant	Blood Thinner
Xylocaine®	lidocaine ointment	Dermatological - Topical	Numbing/Nerve pain
Zanaflex®	tizanidine	Skeletal muscle relaxant	Muscle Spasm
Zavzpret™	zavegepant nasal spray	Migraine product	Migraine
Zestril®	lisinopril	Antihypertensive	High blood pressure/Heart failure
Zetia®	ezetimibe	Antihyperlipidemic	High cholesterol
Zimhi™	naloxone injection	Opioid antagonist	Opioid overdose
Zipsor®	diclofenac potassium	NSAID	Pain/Inflammation
Zithromax®	azithromycin	Antibiotic	Bacterial infections
Zocor®	simvastatin	Antihyperlipidemic	High cholesterol
Zofran®	ondansetron	Antiemetic	Nausea/Vomiting
Zohydro® ER	hydrocodone extended-release	Opioid analgesic	Pain
Zoloft®	sertraline	Antidepressant	Depression
Zonegran®	zonisamide	Anticonvulsant	Seizures
Zorvolex®	diclofenac	NSAID	Pain/Inflammation
ZTlido®	lidocaine patch	Topical analgesic - Anesthetic	Nerve pain
Zyprexa®	olanzapine	Antipsychotic	Schizophrenia/Bipolar disorder/Depression

† Pharmaceutical uses listed are not all-inclusive; does not include all FDA approved and off-label uses. ER, XR, CR, LA, XL = Extended-release formulations.
Names in red = Generic not available **NSAID** = Nonsteroidal Anti-inflammatory Drug **COPD** = Chronic Obstructive Pulmonary Disease **GERD** = Gastroesophageal Reflux Disease

Generic-Brand index

Generic	Brand	Therapeutic class	Pharmaceutical uses†
acetaminophen extra-strength	Tylenol® Extra Strength	Non-Opioid analgesic	Pain/Fever
acetaminophen/codeine	Tylenol® with Codeine #4	Opioid analgesic	Pain
albuterol/budesonide	Airsupra™	Antiasthmatic	Asthma
albuterol nebulizer solution	Ventolin®/Proventil®	Antiasthmatic	Asthma
albuterol sulfate	ProAir® HFA	Antiasthmatic	Asthma
alprazolam	Xanax®	Antianxiety agent	Anxiety/Panic disorder
amitriptyline	Elavil®	Antidepressant	Depression/Insomnia/Nerve pain
amlodipine	Norvasc®	Antihypertensive	High blood pressure/Angina
amoxicillin extended-release	Moxatag®	Antibiotic	Bacterial infections
amoxicillin/clavulanate potassium	Augmentin®	Antibiotic	Bacterial infections
amphetamine/ dextroamphetamine	Adderall®	Stimulant	Attention deficit hyperactivity disorder
apixaban	Eliquis®	Anticoagulant	Blood thinner
aripiprazole	Abilify®	Antipsychotic	Schizophrenia/Bipolar disorder/Depression
armodafinil	Nuvigil®	Stimulant	Narcolepsy/Sleep apnea/Shift work disorder
aspirin	Ecotrin®	Non-Opioid analgesic	Pain/Inflammation/Fever
atenolol	Tenormin®	Antihypertensive	High blood pressure/Angina
atogepant	Qulipta™	Migraine product	Migraine
atorvastatin	Lipitor®	Antihyperlipidemic	High cholesterol
azithromycin	Zithromax®	Antibiotic	Bacterial infections
baclofen	Lioresal®	Skeletal muscle relaxant	Spasticity
benzhydrocodone/acetaminophen	Apadaz®	Opioid analgesic	Pain
bisacodyl	Dulcolax® Suppository	Laxative	Constipation
budesonide/formoterol	Symbicort®	Antiasthmatic	Asthma/COPD
buprenorphine	Butrans®	Opioid analgesic	Pain
buprenorphine	Subutex®	Opioid analgesic	Opioid dependence
buprenorphine	Brixadi®	Opioid analgesic	Opioid dependence
buprenorphine/naloxone	Suboxone®	Opioid analgesic	Opioid dependence
bupropion	Wellbutrin®	Antidepressant	Depression
bupropion extended-release	Wellbutrin XL®	Antidepressant	Depression
buspirone	BuSpar®	Antianxiety agent	Anxiety
butalbital/acetaminophen/caffeine	Esgic®/Fioricet®	Non-Opioid analgesic	Headache
calcitonin/salmon	Miacalcin®	Endocrine/Metabolic agent	Osteoporosis
carbamazepine	Tegretol®	Anticonvulsant	Seizures/Bipolar disorder/Nerve pain
carisoprodol	Soma®	Skeletal muscle relaxant	Muscle Spasm
carvedilol	Coreg®	Antihypertensive	High blood pressure/Heart failure
celecoxib	Celebrex®	NSAID	Pain/Inflammation
celecoxib solution	Elyxyb™	Migraine product	Migraine
celecoxib/tramadol	Seglentis®	NSAID/Opioid analgesic	Pain
cephalexin	Keflex®	Antibiotic	Bacterial Infections
chlorzoxazone	Parafon Forte® DSC	Skeletal muscle relaxant	Muscle spasm
ciprofloxacin	Cipro®	Antibiotic	Bacterial Infections
citalopram	Celexa®	Antidepressant	Depression

† Pharmaceutical uses listed are not all-inclusive; does not include all FDA approved and off-label uses. ER, XR, CR, LA, XL = Extended-release formulations.
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Generic	Brand	Therapeutic class	Pharmaceutical uses†
clindamycin	Cleocin®	Antibiotic	Bacterial infections
clonazepam	Klonopin®	Anticonvulsant	Antianxiety agent
clonidine	Catapres®	Antihypertensive	High blood pressure
clopidogrel	Plavix®	Hematological	Post Stroke/Heart attack
cyclobenzaprine	Flexeril®	Skeletal muscle relaxant	Muscle spasm
cyclobenzaprine wextended-release	Amrix®	Skeletal muscle relaxant	Muscle spasm
dabigatran etexilate	Pradaxa®	Anticoagulant	Blood thinner
daridorexant	Quviviq®	Hypnotic	Insomnia
desvenlafaxine extended-release	Pristiq®	Antidepressant	Depression
dexlansoprazole	Dexilant®	Ulcer medication	Ulcers/GERD
diazepam	Valium®	Antianxiety agent	Anxiety/Muscle spasms
diclofenac	Voltaren®	NSAID	Pain/Inflammation
diclofenac	Zorvolex®	NSAID	Pain/Inflammation
diclofenac extended-release	Voltaren®-XR	NSAID	Pain/Inflammation
diclofenac gel	Voltaren® Arthritis Pain	Topical NSAID	Pain/Inflammation
diclofenac patch	Flector® Patch	Topical NSAID	Pain/Inflammation
diclofenac patch	Licart® Patch	Topical NSAID	Pain/Inflammation
diclofenac potassium	Cambia®	Migraine product	Migraine
diclofenac potassium	Cataflam®	NSAID	Pain/Inflammation
diclofenac potassium	Zipsor®	NSAID	Pain/Inflammation
diclofenac solution	Pennsaid® Solution	Topical NSAID	Pain/Inflammation
diclofenac/misoprostol	Arthrotec®	NSAID	Pain/Inflammation
dihydroergotamine mesylate	Trudhesa®	Migraine product	Migraine
divalproex	Depakote®	Anticonvulsant	Seizures/Migraine/Bipolar disorder
divalproex extended-release	Depakote® ER	Anticonvulsant	Seizures/Migraine/Bipolar disorder
docusate sodium	Colace®	Laxative	Constipation
donepezil	Aricept®	Neurological agent	Alzheimer's Disease
doxepin	Silenor®	Hypnotic	Insomnia
doxepin	Sinequan®	Antidepressant	Depression/Insomnia
doxycycline hyclate	Vibramycin®	Antibiotic	Bacterial infections
duloxetine	Cymbalta®	Antidepressant	Depression/Pain/Anxiety
duloxetine	Drizalma Sprinkle™	Antidepressant	Depression/Pain/Anxiety
eletriptan	Relpax®	Migraine product	Migraine
emtricitabine/tenofovir	Truvada®	Antiviral	Human immunodeficiency virus infection
enoxaparin	Lovenox®	Anticoagulant	Blood Thinner
erenumab-aooe	Aimovig®	Migraine product	Migraine
escitalopram	Lexapro®	Antidepressant	Depression
esomeprazole magnesium	Nexium®	Ulcer medication	Ulcers/GERD
eszopiclone	Lunesta®	Hypnotic	Insomnia
etodolac	Lodine®	NSAID	Pain/Inflammation
etodolac extended-release	Lodine® ER	NSAID	Pain/Inflammation
ezetimibe	Zetia®	Antihyperlipidemic	High cholesterol

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Names in red = Generic not available **NSAID** = Nonsteroidal Anti-inflammatory Drug **COPD** = Chronic Obstructive Pulmonary Disease **GERD** = Gastroesophageal Reflux Disease

Generic	Brand	Therapeutic class	Pharmaceutical uses†
famotidine	Pepcid®/Zantac 360®	Ulcer medication	Ulcers/GERD
fenofibrate	Tricor®	Antihyperlipidemic	High cholesterol
fentanyl	Duragesic®	Opioid analgesic	Pain
fluoxetine	Prozac®	Antidepressant	Depression
fluticasone	Flonase®	Corticosteroid - Nasal	Allergies
fluticasone/salmeterol	Advair Diskus®	Antiasthmatic	Asthma/COPD
fremanezumab-vfrm	Ajovy®	Migraine product	Migraine
furosemide	Lasix®	Diuretic	High Blood Pressure/Heart failure
gabapentin	Neurontin®	Anticonvulsant	Seizures/Nerve pain
gabapentin	Gralise®	Anticonvulsant	Nerve pain
gabapentin enacarbil	Horizant®	Anticonvulsant	Restless Legs Syndrome
galcanezumab-gnlm	Emgality®	Migraine product	Migraine
hydrochlorothiazide	Hydrodiuril®	Diuretic	High blood pressure/Heart failure
hydrocodone extended-release	Hysingla® ER	Opioid analgesic	Pain
hydrocodone extended-release	Zohydro® ER	Opioid analgesic	Pain
hydrocodone/acetaminophen	Norco®	Opioid analgesic	Pain
hydrocodone/ibuprofen	Vicoprofen®	Opioid analgesic	Pain
hydromorphone	Dilaudid®	Opioid analgesic	Pain
hydromorphone extended-release	Exalgo®	Opioid analgesic	Pain
hydroxyzine	Atarax®	Antianxiety agent	Anxiety/Itching
hydroxyzine pamoate	Vistaril®	Antianxiety agent	Anxiety/Itching
ibuprofen	Advil®	NSAID	Pain/Inflammation
ibuprofen/acetaminophen	Advil® Dual Action	Non-Opioid analgesic	Minor aches and pain
ibuprofen/famotidine	Duexis®	NSAID/Histamine blocker	Arthritis/Ulcer Risk reduction
indomethacin	Tivorbex®	NSAID	Pain/Inflammation
ipratropium bromide/albuterol	Combivent® Respimat®	Antiasthmatic	COPD
ketoprofen	Orudis®	NSAID	Pain/Inflammation
ketorolac	Toradol®	NSAID	Pain/Inflammation
lactulose	Constulose®	Laxative	Constipation
lamotrigine	Lamictal®	Anticonvulsant	Seizures/Bipolar Disorder
lansoprazole	Prevacid®	Ulcer medication	Ulcers/GERD
lasmiditan	Reyvow®	Migraine product	Migraine
levetiracetam	Keppra®	Anticonvulsant	Seizures
levofloxacin	Levaquin®	Antibiotic	Bacterial infections
levothyroxine	Synthroid®	Thyroid	Thyroid hormone deficiency
lidocaine ointment	Xylocaine®	Dermatological - Topical	Numbing/Nerve pain
lidocaine patch	Lidoderm® Patch	Topical analgesic - Anesthetic	Nerve pain
lidocaine patch	ZTlido®	Topical analgesic - Anesthetic	Nerve pain
lidocaine/menthol	Terocin Patch	Dermatological - Topical	Topical pain relief
linaclotide	Linzess®	Gastrointestinal agent	Constipation/Irritable bowel syndrome
lisinopril	Zestril®	Antihypertensive	High blood pressure/Heart failure
lorazepam	Ativan®	Antianxiety agent	Anxiety/Insomnia

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Names in red = Generic not available **NSAID** = Nonsteroidal Anti-inflammatory Drug **COPD** = Chronic Obstructive Pulmonary Disease **GERD** = Gastroesophageal Reflux Disease

Generic	Brand	Therapeutic class	Pharmaceutical uses†
lorazepam extended-release	Loreev XR™	Antianxiety agent	Anxiety
losartan potassium	Cozaar®	Antihypertensive	High blood pressure
lubiprostone	Amitiza®	Gastrointestinal agent	Constipation/Opioid-Induced constipation
lurasidone	Latuda®	Antipsychotic	Schizophrenia/Bipolar disorder
meclizine	Antivert®	Antiemetic	Nausea/Vomiting
meloxicam	Mobic®	NSAID	Pain/Inflammation
meloxicam	Qmiiz® ODT	NSAID	Pain/inflammation
meloxicam	Vivlodex®	NSAID	Pain/inflammation
memantine	Namenda®	Psychotherapeutic/Neurological agent	Alzheimer's disease
menthol	Bengay®	Dermatological - Topical	Muscle pain
metaxalone	Skelaxin®	Skeletal muscle relaxant	Muscle spasm
metformin	Glucophage®	Antidiabetic	High blood sugar
methadone	Dolophine®	Opioid analgesic	Pain
methocarbamol	Robaxin®	Skeletal muscle relaxant	Muscle Spasm
methyl salicylate/capsaicin/menthol	New Terocin Lotion	Dermatological - Topical	Topical pain relief
methylnaltrexone	Relistor®	Gastrointestinal agent	Opioid-induced constipation
methylphenidate	Ritalin®	Stimulant	Attention deficit hyperactivity disorder
methylprednisolone	Medrol®	Corticosteroid	Inflammatory Disorders
metoprolol extended-release	Toprol-XL®	Antihypertensive	High blood pressure/Heart failure/Angina
metoprolol tartrate	Lopressor®	Antihypertensive	High blood pressure/Angina
milnacipran	Savella®	Psychotherapeutic/Neurological agent	Fibromyalgia
mirtazapine	Remeron®	Antidepressant	Depression
modafinil	Provigil®	Stimulant	Narcolepsy/Sleep apnea/Shift work disorder
montelukast	Singulair®	Antiasthmatic	Asthma/Allergic rhinitis
morphine extended-release	Avinza®	Opioid analgesic	Pain
morphine extended-release	Kadian®	Opioid analgesic	Pain
morphine extended-release	MS Contin®	Opioid analgesic	Pain
mupirocin	Bactroban®	Antiinfective - Topical	Skin infections
nabumetone	Relafen®	NSAID	Pain/Inflammation
nadolol	Corgard®	Antihypertensive	High blood pressure/Angina
naldemedine	Symproic®	Gastrointestinal agent	Opioid-induced constipation
nalmefene	Opvee®	Opioid antagonist	Opioid overdose
naloxegol	Movantik®	Gastrointestinal agent	Opioid-Induced Constipation
naloxone injection	Zimhi®	Opioid antagonist	Opioid overdose
naloxone nasal spray	Narcan®	Opioid antagonist	Opioid overdose
naltrexone	Revia®	Opioid antagonist	Opioid dependence
naproxen	Naprosyn®	NSAID	Pain/Inflammation
naproxen delayed-release	EC-Naprosyn®	NSAID	Pain/Inflammation
naproxen sodium	Anaprox® DS	NSAID	Pain/Inflammation
naproxen/esomeprazole	Vimovo®	NSAID/Proton pump inhibitor	Arthritis/Ulcer risk reduction
nebivolol	Bystolic®	Antihypertensive	High blood pressure

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Names in red = Generic not available **NSAID** = Nonsteroidal Anti-inflammatory Drug **COPD** = Chronic Obstructive Pulmonary Disease **GERD** = Gastroesophageal Reflux Disease

Generic	Brand	Therapeutic class	Pharmaceutical uses†
nortriptyline	Pamelor®	Antidepressant	Depression/Insomnia/Nerve pain
olanzapine	Zyprexa®	Antipsychotic	Schizophrenia/Bipolar disorder/Depression
omeprazole	Prilosec®	Ulcer medication	Ulcers/GERD
ondansetron	Zofran®	Antiemetic	Nausea/Vomiting
orphenadrine	Norflex®	Skeletal muscle relaxant	Muscle Spasm
oxaprozin	Daypro®	NSAID	Pain/Inflammation
oxcarbazepine	Trileptal®	Anticonvulsant	Seizures
oxybutynin extended-release	Ditropan XL®	Urinary antispasmodic	Overactive bladder
oxycodone	Roxicodone®	Opioid analgesic	Pain
oxycodone extended-release	OxyContin®	Opioid analgesic	Pain
oxycodone/acetaminophen	Percocet®	Opioid analgesic	Pain
oxymorphone	Opana®	Opioid analgesic	Pain
oxymorphone extended-release	Opana® ER	Opioid analgesic	Pain
pantoprazole	Protonix®	Ulcer medication	Ulcers/GERD
paroxetine	Paxil®	Antidepressant	Depression
phenytoin	Dilantin®	Anticonvulsant	Seizures
piroxicam	Feldene®	NSAID	Pain/Inflammation
polyethylene glycol	MiraLAX®	Laxative	Constipation
potassium chloride	Klor-Con®	Mineral and electrolyte	Potassium deficiency
prazosin	Minipress®	Antihypertensive	High Blood Pressure
prednisolone	Pred Forte®	Ophthalmic	Eye inflammation
prednisone	Deltasone®	Corticosteroid	Inflammatory disorders
pregabalin	Lyrica®	Anticonvulsant	Fibromyalgia/Seizures/Nerve pain
promethazine	Phenergan®	Antihistamine	Nausea/Vomiting
propranolol	Inderal®	Antihypertensive	High blood pressure/Migraine
propranolol extended-release	Inderal® LA	Antihypertensive	High blood pressure/Migraine
prucalopride	Motegrity®	Gastrointestinal agent	Constipation
quetiapine	Seroquel®	Antipsychotic	Schizophrenia/Bipolar disorder
quetiapine extended-release	Seroquel XR®	Antipsychotic	Schizophrenia/Bipolar disorder/Depression
rabeprazole	Aciphex®	Ulcer medication	Ulcers/GERD
raltegravir	Isentress®	Antiviral	Human immunodeficiency virus infection
ramipril	Altace®	Antihypertensive	High blood pressure/Heart failure
rimegepant	Nurtec® ODT	Migraine product	Migraine
risperidone	Risperdal®	Antipsychotic	Schizophrenia/Bipolar disorder
rivaroxaban	Xarelto®	Anticoagulant	Blood Thinner
ropinirole	Requip®	Antiparkinsonian	Parkinson's disease/Restless legs syndrome
rosuvastatin	Crestor®	Antihyperlipidemic	High Cholesterol
senna/docusate sodium	Senokot-S®	Laxative	Constipation
sennosides	Senokot®	Laxative	Constipation
sertraline	Zoloft®	Antidepressant	Depression
sildenafil	Viagra®	Misc. cardiovascular	Erectile dysfunction/Pulmonary hypertension
silver sulfadiazine	Silvadene®	Antiinfective - Topical	Burn wound

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Names in red = Generic not available **NSAID** = Nonsteroidal Anti-inflammatory Drug **COPD** = Chronic Obstructive Pulmonary Disease **GERD** = Gastroesophageal Reflux Disease

Generic	Brand	Therapeutic class	Pharmaceutical uses†
simvastatin	Zocor®	Antihyperlipidemic	High cholesterol
sulfamethoxazole/trimethoprim	Bactrim® DS	Antibiotic	Bacterial infections
sulindac	Clinoril®	NSAID	Pain/Inflammation
sumatriptan	Imitrex®	Migraine Product	Migraine
tadalafil	Cialis®	Misc. cardiovascular	Erectile dysfunction/Enlarged prostate
tamsulosin	Flomax®	Misc. genitourinary product	Enlarged Prostate
tapentadol	Nucynta®	Opioid analgesic	Pain
tapentadol extended-release	Nucynta® ER	Opioid analgesic	Pain
temazepam	Restoril™	Hypnotic	Insomnia
testosterone	Androgel®	Androgen	Testosterone deficiency
tiotropium	Spiriva® Handihaler®	Antiasthmatic	COPD
tizanidine	Zanaflex®	Skeletal muscle relaxant	Muscle Spasm
topiramate	Topamax®	Anticonvulsant	Seizures/Migraine
topiramate extended-release	Qudexy® XR	Anticonvulsant	Seizures/Migraine
topiramate extended-release	Trokendi XR®	Anticonvulsant	Seizures/Migraine
topiramate solution	Eprontia®	Anticonvulsant	Seizures/Migraine
tramadol	Ultram®	Opioid analgesic	Pain
tramadol extended-release	Conzip®	Opioid analgesic	Pain
tramadol extended-release	Ultram® ER	Opioid analgesic	Pain
tramadol/acetaminophen	Ultracet®	Opioid analgesic	Pain
tramadol solution	Qdolo®	Opioid analgesic	Pain
trazodone	Desyrel®	Antidepressant	Depression/Insomnia
triamcinolone	Kenalog®	Corticosteroid - Topical	Inflammatory disorders
ubrogepant	Ubrelvy®	Migraine product	Migraine
valsartan	Diovan®	Antihypertensive	High blood pressure/Heart failure
venlafaxine	Effexor®	Antidepressant	Depression
venlafaxine extended-release	Effexor® XR	Antidepressant	Depression
vilazodone	Viibryd®	Antidepressant	Depression
vortioxetine	Trintellix®	Antidepressant	Depression
warfarin	Coumadin®	Anticoagulant	Blood thinner
zavegepant nasal spray	Zavzpret™	Migraine product	Migraine
zolpidem	Ambien®	Hypnotic	Insomnia
zolpidem extended-release	Ambien CR®	Hypnotic	Insomnia
zonisamide	Zonegran®	Anticonvulsant	Seizures

† Pharmaceutical uses listed are not all-inclusive; does not include all FDA approved and off-label uses. ER, XR, CR, LA, XL = Extended-release formulations.
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About Optum Workers' Compensation and Auto No-Fault Solutions

Optum Workers' Compensation and Auto No-Fault Solutions collaborates with clients to lower costs while improving health outcomes for the injured persons we serve. Our comprehensive pharmacy, ancillary, managed care services, and settlement solutions, combine data, analytics, and extensive clinical expertise with innovative technology to ensure injured persons receive safe, appropriate and cost-effective care throughout the lifecycle of a claim. For more information, email us at expectmore@optum.com.

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March 26, 2025

The Honorable C.T. Wilson
Chairman, Economic Matters Committee
Maryland House of Delegates
231 Taylor Office Building
Annapolis, MD 21401

RE: Favorable with <u>AMENDMENT ONLY</u>

Dear Chair Wilson and the Honorable Members of the Economic Matters Committee,

I am the CEO of RescueMeds Work Injury Pharmacy, a workers compensation pharmacy located in Annapolis, Maryland and serving injured workers. I would like to share how SB306, as sent from the Senate, will be costly, harmful to injured workers, and why an Amendment which understands the true impact of a Fee Guide, and uses data from other states would be the best course forward.

🚨 The Real Impact of SB306: Costly, Harmful, and Unnecessary 🚨

❗ The Problem

• SB306 only applies to less than 5% of prescriptions.

• Pharmacy Benefit Managers (PBMs) and self-dispensing doctors are excluded from the fee guide.

🚫 Access Will Decline

• Independent pharmacies that serve injured workers will be forced out of business.

• Patients will face delays, denials, and complete loss of access to medication.

RESCUEMEDS

💸 Costs Will Rise

• PBMs are not regulated under SB306 and continue profiting through rebates (legal kickbacks).

• Branded, high-cost drugs are incentivized, driving up overall spend.

• Patients may shift to Medicaid, ER visits, or go untreated.

🏪 Small Business Impact

• Independent pharmacies—essential to underserved populations—will be eliminated.

• This benefits large corporate PBMs and hurts local access.

📉 No Real Savings

• Chesapeake Employers Insurance paid RescueMeds only $25,000 total across all patients.

• RescueMeds accounts for <1% of prescription spend. Eliminating them won't yield savings.

• What’s charged ≠ what’s paid. The true cost is in PBM fees and undisclosed rebates.

🧾 Flawed Justifications

• Testimonies rely on 'charges', not 'payments'.

• Anne Arundel had zero out-of-network prescriptions, meaning zero savings from SB306.

• Baltimore City and others paid under 50% of billed charges.

✅ A Better Path Forward

• Amend SB306 to include PBMs and all stakeholders.

• Base reforms on transparent data: actual paid amounts, rebates, and admin costs.

• Ensure continued access and support injured workers' return to work.

Vote *yes* on the amendment. Let's do this right—for the injured worker, for access, for equity, and for real cost control. Thank you.

Sincerely,

Colleen Shields

Colleen Shields
CEO
RescueMeds, LLC

🚨 Deeper Dive: Pharmacy Benefits Managers DRIVE UP Prescription Costs

💥 PBMs: A Corrupt Industry Under Fire

· • PBMs like CVS Caremark, OptumRx, and Express Scripts control over 80% of the market and use their dominance to steer patients to their own pharmacies.

· • These middlemen profit from spread pricing—charging insurers more than they reimburse pharmacies—and keep the difference.

· • Retroactive fees and clawbacks have put many local pharmacies out of business, destabilizing community healthcare infrastructure.

· • PBMs manipulate formularies not based on medical necessity, but based on which drugs yield the largest rebates for them.

• PBMs are under investigation by the Federal Trade Commission (FTC) and 39 state Attorneys General for anticompetitive practices, patient steering, and pricing abuses.

• The U.S. House Oversight Committee found that PBMs inflate prescription costs, suppress competition, and use their market power to prioritize profits over patient care.

• PBMs collect manufacturer rebates in exchange for placing high-cost drugs on formularies—at the expense of lower-cost generics and biosimilars.

• They've even created offshore entities in Ireland and the Cayman Islands to avoid regulations and hide rebate profits.

🧩 Chesapeake: Minority Opinion in Fee Guide, Now a Work Around The Fee Guide

· • Chesapeake is the largest writer of workers' compensation insurance in Maryland, giving them significant market leverage.

· • Their proposal to use NADAC pricing was rejected by the Fee Guide Committee in the official September 2023 meeting minutes.

· • Instead of accepting this democratic process, they are attempting to legislate their rejected recommendation through SB306.

· • The $55 million dividend reported in 2023 proves that cost containment could have been accomplished without harming pharmacies or access.

• Chesapeake Employers Insurance Company (CEIC) is attempting to override the Maryland Workers' Compensation Fee Guide Committee's decisions.

• In September 2023, the Committee reviewed options and determined that using NADAC (National Average Drug Acquisition Cost)—proposed by CEIC's Carmine D'Alessandro—was the *least favored* reimbursement model.

• Despite this, Mr. D'Alessandro is leveraging political contacts in the Senate to bypass stakeholder input and force SB306 through.

• CEIC is financially strong, having reported a $55 million surplus in 2023 alone—hardly an argument for urgent cost-cutting measures targeting pharmacies.

Wide-ranging FTC probe may bring new crackdown on

Uploaded by: Colleen Shields
Position: FWA

PAYERS

Experts say broad FTC probe could bring new crackdown and laws on PBM industry

By **Robert King** • Jun 10, 2022 03:00pm

pharmacy benefit management | FTC | Express Scripts | OptumRx

It may take more than six months for the Federal Trade Commission to issue its final report on the pharmacy benefit management industry, experts have predicted. (AlexanderFord/Getty Images)

The Federal Trade Commission's (FTC's) decision to probe the pharmacy benefit management industry could spark lawmakers in Congress and states to crack down on practices such as clawback fees and rebates, several experts said.

Earlier this week, the FTC announced an investigation of six large PBMs (https://www.fiercehealthcare.com/payers/ftc-launches-investigation-major-pharmacy-benefit-managers-business-practices) in the U.S., sending orders for information and records on business practices. Experts say that while a report on the practices could take months, it would have lasting implications on a market that has received increased scrutiny from Congress and state legislatures.

"This is a very comprehensive study and reflects the FTC's recognition there is a broad scope of anti-competitive and anti-consumer conduct going on," said David Balto, a former FTC policy director and current antitrust attorney.

A 6(b) study gives the FTC special authority to compel parties to turn over information. Previously, the FTC has used that authority to study the generic drug industry, which led to reforms in Congress.

"This 6(b) authority has been called the strongest investigatory power that almost any agency within the government has," said A.J. Barbarito, an associate with the law firm Frier Levitt, in an interview with Fierce. "It has been likened to a grand jury. It is not a criminal investigation. The reason it is like a grand jury investigation is that it is an extremely broad authority to look into frankly whatever the agency is interested in."

The FTC announced that the scope of the study will focus on a series of practices used by PBMs and their role in the drug system. The agency said its investigation will examine possibly unfair audits of independent pharmacies, the impact of drug rebates, specialty drug policies and fees or clawbacks charged to pharmacies not affiliated with the PBM.

Critics have also complained that PBMs have become vertically integrated with large insurers and that patients are only steered to pharmacies affiliated with the insurer. But the PBM industry counters that the companies fulfill a major need for employers by managing drug benefits and negotiating with drug companies for rebates and lower prices.

The commission, which is comprised of three Democrats and two Republicans, voted unanimously to launch the study.

Now, the six PBMs—CVS Caremark, Express Scripts, OptumRx, Humana, Prime Therapeutics and Medimpact Healthcare Systems—will have 90 days to comply with the requirements for turning over information and records. However, PBMs can file a dispute and even go to court over whether the company has to turn over the documents, Barbarito said.

It could be six months until the FTC has the data, and then the agency must go through them to craft the report. However, the report itself has the potential to spark major reforms in the industry, experts say.

"It can bring enforcement actions—not only antitrust, but it simply could be consumer protection actions going after deceptive and fraudulent practices," Balto said.

FTC actions could take the form of consent decrees against specific PBMs, which could result in civil monetary penalties.

"If the FTC does determine that PBMs are unfairly advantaging their own wholly owned pharmacies they may seek some kind of injunction to prevent them from continuing to engage in those activities," Barbarito said.

The report will also be sent to Congress, which can consider further action on PBMs. Some lawmakers have already introduced legislation (https://www.fiercehealthcare.com/payers/senate-bill-aims-ban-pbm-practices-such-spread-pricing-and-boost-ftc-enforcement-powers) to give the FTC more powers to go after PBMs.

Retail | Finance | Regulatory | Payers | CVS Caremark | Humana | Prime Therapeutics | Congress

PAYERS

'Podnosis': The challenges with new email policies, and the importance of diverse investors and founders.

By **Teresa Carey**, **Dave Muoio**, **Anastassia Gliadkovskaya** • Aug 16, 2023 06:00am

Electronic Data | Patient Portal | Diversity | Podnosis

(Teledoc)

A limited, but growing, number of healthcare providers are announcing policies to charge patients for electronic messages sent to clinicians. The organizations say it's necessary in light of the time commitment doctors and others spend on each message. Patient advocacy groups say otherwise. This week on 'Podnosis,' Fierce's Dave Muoio talks with John Hargraves, the director of data strategy for the Health Care Cost Institute. They discuss the background of these policies, their pushback, and whether they're likely to spread.

Also on the show: Jake Prigoff, general partner at Gaingels, an LGBTQ-ally collective with more than 2,000 members interested in investing in diverse and inclusive companies. Prigoff talks with Fierce's Anastassia Gliadkovskaya about the importance of diverse investors and founders.

To learn more about topics in this episode:

- Reflecting on Pride Month, industry leaders see progress—and persistent challenges—for better LGBTQIA+ healthcare (https://www.fiercehealthcare.com/providers/look-pressing-lgbtq-healthcare-pride-month-ends)
- LGBTQ+ care providers calling for advocacy, education to push back against anti-transgender efforts (https://www.fiercehealthcare.com/providers/abbott-assault-trans-rights-texas-has-far-reaching-consequences)
- Fierce Healthcare's most influential minority executives in healthcare for 2022 (https://www.fiercehealthcare.com/special-reports/fierce-healthcares-2022-most-influential-minority-executives-healthcare)
- As major hospitals now bill for some patient-provider messaging, the move could usher wider adoption (https://www.fiercehealthcare.com/providers/major-providers-decision-bill-time-consuming-electronic-patient-messages-could-usher)
- UCSF Health received fewer patient portal messages after letting clinicians choose when to charge (https://www.fiercehealthcare.com/providers/ucsf-health-received-fewer-patient-portal-messages-after-letting-clinicians-choose-when)

"Podnosis" and "The Top Line" are produced by senior producer Teresa Carey. The stories are by all our "Fierce" journalists. Like and subscribe wherever you listen to your podcasts.

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Payers

EZ Scripts Written Testimony SB 306 ECM Hearing 3-

Uploaded by: Darren Thomas

Position: FWA

March 26, 2025

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

Senate Bill 306 – Favorable with Amendment

Dear Chairman Wilson:

EZ Scripts Pharmacy is a national home delivery pharmacy specializing in serving injured workers. We respectfully submit this testimony as **favorable with amendment to Senate Bill 306**, which proposes a pharmaceutical fee guide for prescription drugs and pharmaceutical services under Maryland's workers' compensation law:

Concerns with Senate Bill 306

While **EZ Scripts Pharmacy does not oppose the establishment of a reimbursement fee guide** for workers' compensation medications, the current construction of Senate Bill 306 does not consider all factors for servicing injured workers and has the potential to limit access to medications for injured workers, create cost shifting to other insurance and government programs, increase pharmacy benefit costs to insurance carriers and employers, and require more litigation within the workers' compensation system.

Disruptions to Standard Reimbursement Practices

Currently Maryland is absent of a pharmacy fee schedule for the reimbursement of prescription drugs. Under the current regulations the Maryland Workers' Compensation Commission has the ability to regulate, review, and create fee guides for workers' compensation. The Maryland Fee Guide Committee in 2023 worked to create a pharmacy reimbursement fee guide. The fee guide that was proposed was National Average Drug Acquisition Cost (NADAC). During an open hearing in October 2023 there was opposition from Pharmacy Benefit Managers (Healthesystems and Mitchell), Non-network pharmacies, dispensing doctors, and patients.

Currently 35 states utilize a reimbursement fee guide based on Average Wholesale Price (AWP). AWPs are published by national recognized sources Medi-Span and Red Book. These publications incorporate all National Drug Codes (NDC) utilized in the prescribing of medication including workers' compensation. AWP is the established mechanism utilized by pharmacy benefit managers (PBM) to process medications in workers' compensation systems nationwide including Maryland.

Senate Bill 306 proposes utilizing acquisition cost index or indexes such as NADAC or Wholesale Acquisition Cost (WAC) for the reimbursement of prescription drugs. These indexes do not incorporate all drug NDCs utilized in workers' compensation thus creating the need for a tiered and complicated fee guide. Additionally, NADAC is a voluntary survey asking pharmacies to provide acquisition costs for the drugs they purchase. None of the major chain pharmacies respond to this survey, in fact less than 25% of pharmacies surveyed respond. Due to this NADAC is not a complete and true metric and should not be utilized to determine reimbursement for medicines in workers' Compensation.

Risks to Injured Workers, Employers, and the Workers' Compensation System

Radical changes to reimbursement structures can create significant challenges. One major concern is reduced access to medications, as the complexity of workers' compensation may lead to pharmacies to opt out of servicing workers' compensation patients. Additionally, cost shifting can occur, potentially increasing out-of-pocket expenses for injured workers and transferring costs to other insurance programs including government programs like Medicare and Medicaid.

An acquisition cost fee guide would make Maryland an outlier as it pertains to other states' reimbursement schedules, this would result in higher administrative costs as PBMs would have to create a unique carve out to process workers' compensation related medications. These costs would be passed through to the insurance carriers and ultimately to Maryland employers. Lastly, there could be significant increases in litigation due to the complex issues surrounding providing injured workers with medications. Delays in authorization, validity of claims, updating coverage will force claimant attorneys to file petitions in front of the Maryland Workers' Compensation Commission, as opposed to an injured worker receiving their medications from a pharmacy like EZ Scripts while the issues are worked out outside of litigation.

Proposed Amendments

EZ Scripts offers amendments to Senate Bill 306 that will allow the Maryland Workers Compensation Commission to do its authorized duty in working with relevant stakeholders, including but not limited to pharmacies servicing injured workers to examine all options for reimbursement methodologies including current schedules available in other states, and conduct a comprehensive study of Maryland's workers' compensation pharmacy spend including in-network, out-of-network, and doctor dispensed medications. Additionally, any carve out for other system participants to contract for indexes and rates separate from what is set forth by the commission should be eliminated from Senate Bill 306.

Thank you for your time and consideration. We urge the committee to adopt our proposed amendments to SB 306.

Darren Thomas
Chief Operating Officer

Proposed Amendments to SB 306:

A SENATE BILL 306

K1 5lr0818

By: **Senator Beidle**

Introduced and read first time: January 13, 2025
Assigned to: Finance

Committee Report: Favorable with amendments
Senate action: Adopted
Read second time: February 22, 2025

CHAPTER _____

AN ACT concerning

Workers' Compensation – Prescription Drug and Pharmaceutical Services – Reimbursements

FOR the purpose of requiring the State Workers' Compensation Commission to regulate fees and other charges for the reimbursement of prescription drugs and pharmaceutical services under certain circumstances; limiting reimbursements to a certain cost index or indexes; requiring the Maryland Prescription Drug Affordability Board to conduct a certain study; and generally relating to reimbursement for prescription drugs and pharmaceutical services under workers' compensation law.

BY repealing and reenacting, with amendments,
Article – Labor and Employment
Section 9–663
Annotated Code of Maryland
(2016 Replacement Volume and 2024 Supplement)

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That the Laws of Maryland read as follows:

Article – Labor and Employment

9–663.

(a) (1) The Commission shall adopt regulations setting standards for the assessment of fines under § 9–664 of this Part IX of this subtitle.

EXPLANATION: **CAPITALS INDICATE MATTER ADDED TO EXISTING LAW.**

[Brackets**]** indicate matter deleted from existing law. Underlining indicates amendments to bill.

~~Strike out~~ indicates matter stricken from the bill by amendment or deleted from the law by amendment.

(2) The Commission may adopt regulations about:

(i) the provision of medicine and medical, nursing, and hospital services to a covered employee;

(ii) payment for the medicine and services; and

(iii) the exercise by the Chairman of the Commission of the powers granted under § 9–662 of this subtitle.

(b) (1) The Commission may regulate fees and other charges for medical services or treatment under this subtitle.

(2) (I) ~~THE~~ NOT LATER THAN SEPTEMBER 1, 2026, THE **COMMISSION SHALL REGULATE FEES AND OTHER 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.

~~(II) REIMBURSEMENT 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:~~

(I) REIMBURSEMENT FOR PRESCRIPTION DRUGS AND PHARMACEUTICAL SERVICES UNDER THIS SECTION SHALL BE BASED ON A FEE SCHEDULE DETERMINED BY THE WORKERS COMPENSATION COMMISSION. THE

COMMISSION SHALL HAVE THE AUTHORITY TO CONSIDER ALL RECOGNIZED PRICING BENCHMARKS, INCLUDING BUT NOT LIMITED TO:

1. AVERAGE WHOLESALE PRICE (AWP),

2. NATIONAL AVERAGE DRUG ACQUISITION COST (NADAC),

3. WHOLESALE ACQUISITION COST (WAC),

4. USUAL AND CUSTOMARY PRICING.

THE COMMISSION SHALL DETERMINE THE MOST APPROPRIATE FEE SCHEDULE BASED ON A STATE-BY-STATE COMPARISON OF EXISTING PHARMACY REIMBURSEMENT MODELS, THE IMPACT ON PATIENT ACCESS, AND COST CONTAINMENT STRATEGIES.

(II) AND

1. REASONABLE DISPENSING FEES; AND

2. ANY OTHER PERCENTAGE INCREASE OR DECREASE DETERMINED BY THE COMMISSION.

~~(III) THIS PARAGRAPH DOES NOT PROHIBIT AN INSURANCE CARRIER OR EMPLOYER FROM CONTRACTING WITH A PHARMACY BENEFITS MANAGER, A NETWORK OF PHARMACIES, OR DISPENSING PROVIDERS:~~

~~1. FOR REIMBURSEMENT RATES DIFFERENT THAN THOSE ESTABLISHED BY THE COMMISSION; OR~~

~~2. TO USE A PRICING INDEX OR INDEXES DIFFERENT THAN THOSE SELECTED BY THE COMMISSION.~~

(3) Each fee or other charge for medical service or treatment under this subtitle is limited to the amount that prevails in the same community for similar treatment of an injured individual with a standard of living that is comparable to that of the covered employee.

[(3)**] (4)** At least once every 2 years, the Commission shall:

(i) review its guide of medical and surgical fees for completeness and reasonableness; and

- (ii) payment for the medicine and services; and

~~(ii)~~ (iii) make appropriate revisions to the guide of medical and surgical fees.

~~SECTION 2. AND BE IT FURTHER ENACTED, That:~~

~~(a) The Maryland Prescription Drug Affordability Board:~~

~~(1) shall conduct a study on prescription drug affordability challenges related to workers' compensation claims that includes:~~

~~(i) an overview of prescription drug prescribing and billing practices and trends that are specialized to the workers' compensation market;~~

~~(ii) research into specific prescribing, billing, and dispensing practices, including:~~

~~1. prescribing high cost formulations and compounded formulations of commonly available drugs;~~

~~2. billing and dispensing from entities that do not bill or provide services in the health insurance market; and~~

~~3. billing practices using billing codes without standardized pricing metrics; and~~

~~(iii) making recommendations, if applicable, for policies to address identified affordability challenges; and~~

~~(2) may require, subject to applicable federal and State laws, entities that pay, prescribe, bill, and dispense prescription drugs under workers' compensation claims to report information to the Board as necessary to complete the study.~~

~~(b) On or before March 1, 2026, the Prescription Drug Affordability Board shall report its findings and any recommendations to the Senate Finance Committee and the House Economic Matters Committee, in accordance with § 2–1257 of the State Government Article.~~

SECTION ~~2.~~ 3. AND BE IT FURTHER ENACTED, That this Act shall take effect ~~October~~ July 1, 2025.

SB306_ProficientRx_Setser_FWA.pdf
Uploaded by: Destry Setser
Position: FWA

ProficientRx

3607 Old Conejo Road, Thousand Oaks, CA 91320 Tel: (800) 787.7824

Testimony in Support of Senate Bill 306 – Workers' Compensation – Prescription Drug and Pharmaceutical Services – Reimbursements (Favorable with Amendments)

Maryland House Economic Matters Committee

Date: March 24th, 2025

Dear Chairperson and Members of the Committee,

I am writing to express my support for **Senate Bill 306** with the understanding that certain critical amendments must be adopted. After reviewing the bill, our organization, which was initially strongly opposed due to concerns about its impact on prescription drug access for Maryland's injured workers and healthcare providers, has shifted its position to one of support—**with amendments**. These amendments are vital to ensuring that the bill is implemented in a way that balances cost containment with the need for accessible, affordable care for injured workers.

Support for the Establishment of a Fee Schedule

We **fully support the establishment of a fee schedule** for prescription drugs and pharmaceutical services under the workers' compensation system. A standardized fee schedule will provide greater transparency and consistency, helping both injured workers and healthcare providers navigate the reimbursement process. It will also offer clear guidelines that can help contain costs without sacrificing the quality of care that workers rely on during their recovery.

However, while we support the idea of a fee schedule, we **strongly oppose** the notion of using **acquisition cost** as the sole basis for reimbursement rates. Maryland should not be the **first state in the nation** to base its reimbursement structure solely on acquisition costs, a model that is untested and speculative. Such a move would introduce significant risks to the system and could have unintended negative consequences, especially for injured workers in critical professions such as **police, fire, and first responders**.

Concerns with Acquisition Cost-Based Reimbursement

The proposal to base reimbursement rates on acquisition costs—without considering other industry-standard benchmarks—poses a number of significant risks:

1. **Negative Impact on Prescription Drug Access**:
   Limiting reimbursement to acquisition costs would make it extremely difficult for

pharmacies to remain financially viable, especially for smaller, independent pharmacies. This would lead to **reduced access to necessary medications** for injured workers, as pharmacies may be forced to stop accepting workers' compensation claims due to financial infeasibility. This is particularly concerning for workers in critical fields, such as first responders, who rely on timely access to medication for their recovery.

2. **Unintended Consequences for Workers**:
   Basing reimbursement solely on acquisition cost could discourage pharmacies and healthcare providers from participating in the workers' compensation system. This could lead to **increased delays** in care, poorer health outcomes, and a backlog of patients who are unable to receive the medications they need in a timely manner. Injured workers, particularly those facing long-term recovery, could be forced to seek alternative treatments that may not be as effective or appropriate for their conditions.
3. **Economic Unsustainability for Providers**:
   Many pharmacies, especially in rural or underserved areas, are already facing financial difficulties. Reimbursing at acquisition cost would further erode the ability of these pharmacies to sustain their operations and continue to provide critical services to injured workers. This would not only hurt pharmacies but also place a burden on the workers who rely on them for recovery.

Proposed Amendments for a Balanced Approach

To ensure that SB306 creates a sustainable, fair, and effective system for both injured workers and healthcare providers, we support the following **critical amendments**:

1. **Use of Proven Industry Standards for Reimbursement**:
   Rather than relying on acquisition cost, we urge the Committee to adopt **industry-standard pricing benchmarks** such as the **Average Wholesale Price (AWP)**, **Wholesale Acquisition Cost (WAC)**, and **Usual and Customary Pricing**. These models are well-established, widely accepted across the nation, and have been shown to be both practical and effective in ensuring fair reimbursements. Adopting these standards would allow Maryland to move forward with a proven approach without the risks associated with using acquisition cost as the sole reimbursement measure.
2. **Inclusion of Reasonable Dispensing Fees**:
   We support the inclusion of **reasonable dispensing fees** in the bill. However, we recommend that the **Workers' Compensation Commission** have the flexibility to review and adjust these fees periodically to account for market fluctuations and ensure that pharmacies can continue to provide necessary services to injured workers.
3. **Comprehensive Study of Prescription Drug Affordability**:
   We support the study to be conducted by the **Maryland Prescription Drug Affordability Board** on prescription drug affordability in the workers' compensation system. However, we recommend that the study include a detailed analysis of **billing practices, pharmacy benefit managers (PBMs)**, and **compounding medications**—all of which significantly impact drug prices and reimbursement rates. This study should help identify fair, long-term solutions for controlling costs without compromising access to care.

Conclusion

We strongly support **Senate Bill 306**, as it offers a positive framework for regulating prescription drug reimbursements in Maryland's workers' compensation system. However, we believe that the current approach to base reimbursement on acquisition costs would have unintended negative consequences, especially for Maryland's injured workers. By adopting proven **industry-standard benchmarks** such as **AWP** for reimbursement, we can create a sustainable system that ensures access to necessary medications without risking the economic viability of pharmacies and healthcare providers.

We urge the **Economic Matters Committee** to support **SB306 with amendments** to ensure that the bill is balanced and fair, protecting both the interests of injured workers and the pharmacies that serve them. Thank you for your attention to this critical issue, and we look forward to working together to create a better system for Maryland's workers.

Sincerely,

Destry T Setser, CEO

Proficient Rx LP

SB 306 Gil Genn FWA ONLY Written Testimony 2.pdf
Uploaded by: Gil Genn
Position: FWA

BELLAMY GENN
GROUP

March 26, 2025

The Honorable C.T. Wilson, Chairman
House Economic Matters Committee
231 Taylor House Office Building
Annapolis, MD 21401

RE: **SB 306** – Workers' Compensation – Prescription Drugs & Pharmaceutical Services – Reimbursements - **FAVORABLE ONLY WITH AMENDMENTS**

Dear Chairman Wilson, Vice Chair Crosby and Members of the Committee:

On behalf of RescueMeds, an independent pharmacy that fills the crucial gap in pharmacy access for injured workers while their cases are being contested at the Workers' Compensation Committee, we ask for a Favorable Report - *ONLY if the attached amendments are adopted.*

Without these fair, compromise amendments - Maryland will be the first state in the nation to statutorily adopt the 'acquisition cost' model for pharmacy reimbursement for injured first responders and other workers. Thirty-five other states have *rejected* "Acquisition Cost" ('National Average Drug Acquisition Cost') reimbursement for Workers' Compensation and use an "Average Wholesale Price (AWP) methodology. Maryland currently uses a 'usual and customary' reimbursement model.

WE DO NOT WANT TO BE FIRST STATE IN THE NATION TO ADOPT "ACQUISITION COST" FOR WORKERS' COMPENSATION BY STATUTE. That is exactly what SB 306 does. Thirty-Five+ other states use an 'Average Wholesale Price' (AWP) methodology. They have done the "heavy lifting", vetted with stakeholders and recognize that such a low reimbursement hurts injured workers, eliminates competition, and prevents access to care.

These independent pharmacies which serve injured workers, provide prescriptions while cases are in dispute (47.5% of all cases are contested and 100% of occupational disease for Public Safety Police and other first responders are contested at the Workers' Compensation Committee).

Access to these prescriptions by injured worker's for prescriptions dispensed by these independent pharmacies is critical while these cases are being contested. Yet, just over 5% of the cases that are contested are ultimately denied compensation! Delay and deny.

We are providing you with suggested amendments as a result of conversations by the independent pharmacies with Workers' Compensation Subcommittee Chair, Delegate Andrea Harrison. Delegate Harrison suggested that we also add a specific list of stakeholders to review *all* recognized pharmacy reimbursement pricing benchmarks by the Workers' Compensation Committee.

We included all benchmarks and stakeholders - highlighted in yellow. The substantive language on page 2 on the bill, highlighted, simply asks the Commission to do its job and look at all the pharmacy reimbursement models available with the enumerated stakeholders and after a fair and reasonable overview of the pros and cons of each option, report back to the legislature with its decision.

I would just like to point out that the perception is the Worker's Compensation Commission has been intimidated by a small minority who are seeking to impose a NADAC ("Acquisition Cost') methodology. *All* the Workers' Compensation Medical Fee Guide notes from September, October, November 2023 (attached and highlighted) explicitly show either a desire to adopt an Average Wholesale Price (AWP) Model or recommend that the Commission review all the data available for a state-by-state comparison of the pharmacy reimbursement models.

See:
September 21, 2023 - " Commissioner Kittleman suggested having experts in the pharmaceutical industry share their knowledge with the Committee members and as well as representatives from states that have workers compensation prescription fee guides share their process and any issues they encountered while formulating the prescription fee guide."
https://www.wcc.state.md.us/PDF/MFG/MFG_Minutes/Minutes09_21_23.pdf

October 26, 2023 - " The consensus of the comments is that most presenters favored AWP vs. NADAC. Comments of the difficulty faced by injured workers obtaining their prescriptions were shared by Yvette Cade and retired Baltimore City police officer Daryl Buhrman."
https://www.wcc.state.md.us/PDF/MFG/MFG_Minutes/Minutes10_%2026_23.pdf

November 27, 2023 - "A suggestion was made to obtain data from surrounding states that have prescription fee guides to compare prescriptions costs and determine what “guardrails” might be needed if a prescription fee guide is adopted...Mr. Garza suggested using AWP because anything else would be too low of a reimbursement."
https://www.wcc.state.md.us/PDF/MFG/MFG_Minutes/11_27_2023MFGMinutes.docx

Chairman Kittleman said the next meeting will be in January 2024, but no meetings were held in 2024, because Chesapeake didn’t get its way. So, they brought their minority position to the legislature to ask you to rubber stamp the minority position of a few to the detriment of injured workers and first responders who will be denied access to care.

Why would the legislature mandate “Acquisition Cost’ when in the MFG notes on November 27, 2023, they specifically state, NADAC (Acquisition Cost) does not even cover 30% of drugs dispensed, doesn’t include medical specialists, self-dispensing doctors or mail order! Why would you legislate a policy that doesn’t even cover 30% of the drugs? Don’t make public policy in a vacuum at the last minute with inadequate and incomplete information.

The proponents of this bill, Chesapeake Insurance, who possesses the largest market share of Worker's Comp. insurance, will try and argue that since Medicaid uses an 'Acquisition Cost' model of pharmacy reimbursement, this is also logical to use 'Acquisition Cost' for Workers' Compensation Claims. This ignores the reality of an incredible amount of overhead that goes into sending in medical records to the doctors, sending the records to the pharmacies and acquiring the medications while the injured worker's case is being contested. Again, thirty-five plus states have rejected this argument.

The PowerPoint of the SB 306 proponents is incomplete, inaccurate and skewed.

Where is the "usual and customary" Maryland standard to compare to the other figures in columns presented in the PowerPoint so you can ascertain what was paid under the current Maryland standard?

Where is the column on the PowerPoint of the litigation costs indicating how much was spent arguing over maybe a few hundred dollars in prescription costs that are totally eaten up by hourly defense attorney fee costs – and who really benefits from the litigation contesting the injured workers claims?

Not all the drugs represented on the PowerPoint are broken out as to whether they are 'brand' drugs (more expensive) or whether they are 'generic' drugs, (less expensive). This specific information is essential for accurate analysis to test any credibility.

Where is the column that show how much the PBMs were paid for each or aggregate prescriptions?

You must allow all stakeholders at the table for informed input to finally make a decision that all agree with - Maryland should have a Prescription Fee Guide which considers the impact on injured workers, pharmacies, and insurance carriers alike. But SB 306 before you, is not the consensus answer.

PBM's should not be exempted under this bill. In fact, by exempting PBM's under this bill, pharmacy prices will increase as the PBM's will be allowed to further inflate the rebates and profits they collect from manufacturers. The lower the acquisition cost of a drug, the greater the opportunity for PBM's to exploit the reimbursement structure – pocketing a larger portion of the "spread" between what they pay and what they are reimbursed. This creates a corrosive incentive that drives up costs for patients and distorts the pharmacy reimbursement system.

Additionally, the Prescription Drug Affordability Board does not have the resources and staff to do what is being requested in SB 306.

For these reasons, and others, RescueMeds respectfully asks for a Favorable Report With Amendments, ONLY if the amendments that include all reimbursement pricing benchmarks and an opportunity for full and fair input before the Workers' Compensation Commission by enumerated stakeholders is adopted.

Respectfully submitted,
Gil Genn
On behalf of RescueMeds

Testimony -SB 306 - Injured Workers Pharmacy - FWA

Uploaded by: Jayne Kresac

Position: FWA

Testimony of Injured Workers Pharmacy (IWP)
SB 306 – Pharmaceutical Reimbursement in Workers' Compensation
Economic Matter Committee | March 26, 2025

Chairman Wilson, Vice Chair Crosby, and members of the Committee:

My name is Jayne Kresac, and I'm here on behalf of Injured Workers Pharmacy (IWP), a specialized pharmacy serving injured workers across Maryland. We ensure that patients receive necessary medications quickly, while navigating the often-complex workers' compensation system.

We support SB 306's goal to establish a pharmacy fee schedule, which may reduce administrative burdens, control costs, and provide reimbursement consistency. However, **we urge the Committee to amend the bill to give the Maryland Workers' Compensation Commission the authority to study and choose the best reimbursement model for Maryland.**

As currently drafted, **SB 306 limits the Commission to only one model—Acquisition Cost.** That approach is deeply flawed. It fails to account for the full cost of dispensing medication, including pharmacist expertise, claims processing, and administrative overhead. **No state in the country—nor the federal government—uses Acquisition Cost as the sole basis for a workers' compensation pharmacy fee schedule.** Of the 37 states with a fee schedule, 35 use **Average Wholesale Price (AWP)** or a model that blends acquisition with operational costs.

Other states tried to move to Acquisition Cost-based models and reversed course when confronted with potential **pharmacy closures, reduced access, and delays in care for injured workers.** Maryland shouldn't be an outlier.

We propose a simple amendment: Allow the Workers' Compensation Commission, through its existing Medical Fee Guide Committee, to:

1. Compare pharmacy fee schedules used in other states;
2. Evaluate the impact of each model on patient access, pharmacy sustainability, and system costs;
3. Recommend the reimbursement model that works best for Maryland's injured workers, providers, and payers.

This is how Maryland has long approached other reimbursement rates in workers' compensation—by trusting the Commission's expertise.

If the state limits reimbursement to Acquisition Cost alone, **many pharmacies, especially small and independent ones, may stop serving workers' compensation patients altogether.** That would hurt injured workers and potentially increase long-term costs for the system.

Let's not lock Maryland into a model that was rejected elsewhere. Instead, let the Commission do its job—evaluate the data, and adopt a fee schedule that balances access, sustainability, and fiscal responsibility.

Thank you and I'm happy to answer any questions.

Josh White - Primer for Understanding SB 306.pdf
Uploaded by: Josh White
Position: FWA

	Brand FS	Generic FS
Alabama	AWP +5% +$10.75	AWP +5% +$13.97
Alaska	AWP +$5.00	AWP +$10.00
Arizona	AWP -15% +$7.00	AWP -25% +$7.00
Arkansas	AWP +$5.13	AWP +$5.13
California	Medi-cal AWP -17% +$7.25	Medi-cal AWP -17% +$7.25
Colorado	AWP +$4.00	AWP +$4.00
Connecticut	AWP +$5.00	AWP +$8.00
Delaware	AWP -31.9% +$3.29 DF	AWP -38% +$4.10 DF
Florida	AWP +$4.18	AWP +$4.18
Georgia	AWP +$4.74	AWP +$7.11
Hawaii	AWP +40%	AWP +40%
Idaho	AWP +$5.00	AWP +$8.00
Kansas	AWP -10% +$3.00	AWP -15% +$5.00
Kentucky	AWP -10% +$5.00	AWP of the lowest priced therapeutically equivalent in stock -15% +5.00
Louisiana	AWP +10% +$10.99	AWP +40% +$10.99
Massachusetts	Lesser of language- Medicaid	Lesser of language- Medicaid
Michigan	AWP -10% +$3.50	AWP-10% +$5.50
Minnesota	AWP -12% +$3.65	AWP -12% +$3.65
Mississippi	AWP +$5.00	AWP-5% +$5.00
Montana	AWP -10% +$3.00	AWP-25% +$3.00
Nevada	AWP +$12.96	AWP +$12.96
New Mexico	AWP -10% +$5.00	AWP -10% +$5.00
New York	AWP -12% +$4.00	AWP -20% +$5.00
North Carolina	AWP -5%	AWP -5%
North Dakota	$4.00 DF MONOPOLISTIC	$5.00 DF MONOPOLISTIC
Ohio	AWP -15% +$3.50	AWP -15% +$3.50
Oklahoma	AWP -10% +$5.00	AWP -10% +$5.00
Oregon	AWP -16.5% +$2.00	AWP -16.5% +$2.00
Pennsylvania	AWP +10%	AWP +10%
Rhode Island	AWP -10%	AWP -10%
South Carolina	AWP + $5.00	AWP +$5.00
Tennessee	AWP + $5.10	AWP + $5.10
Texas	AWP + 9% +$4.00	AWP +25% +$4.00
Vermont	AWP + $3.15	AWP + $3.15
Washington	AWP -10% +$4.50	AWP -50% +$4.50
Wisconsin	AWP +$3.00	AWP +$3.00
Wyoming	AWP -10% +$5.00	AWP -10% +$5.00

***Data pulled from Optum Pharmacy Resource Guide for 2024 ***

Primer for Understanding SB 306
and Workers' Compensation Pharmacy Fee Schedules

What Does This Bill Do?
SB 306 proposes to limit pharmacy reimbursement in Maryland's workers' compensation system to ONLY Acquisition Cost (AC)—the price a pharmacy pays to purchase a drug.

Why is This Problematic?
While the intent may be to control costs, **Acquisition Cost alone does not cover the full cost of dispensing medications**, which includes:

- **Pharmacist expertise** – Reviewing prescriptions, checking for drug interactions, and ensuring proper dosage.
- **Administrative work** – Processing claims, handling prior authorizations, and managing insurer disputes.
- **Overhead costs** – Staff wages, rent, storage, and compliance costs.

How Do Other States Handle This?

- 35 of 37 states with a workers' compensation fee schedule use Average Wholesale Price (AWP) or a similar pricing model that factors in both acquisition and operational costs.
- Other states that considered Acquisition Cost-based reimbursement rejected it because it led to pharmacy closures, longer wait times, and reduced access to medications for injured workers.

Real-World Example
Imagine if a restaurant could only charge customers for the raw cost of ingredients but not for rent, staff, or electricity. They wouldn't be able to stay in business. Pharmacies operate similarly—filling prescriptions involves more than just the cost of the drug.

Key Concerns

1. Why should Maryland be one of the only states to limit reimbursement to Acquisition Cost when nearly every other state uses a different model?
2. How will Maryland ensure pharmacies continue to serve injured workers if they are forced to operate at a loss?
3. Why is the legislature preventing the Workers' Compensation Commission from considering all pricing models to determine the best approach?
4. Does this bill primarily benefit insurers by reducing reimbursements while increasing burdens on pharmacies and injured workers?

Bottom Line
If Maryland passes SB 306 in its current form, pharmacies may stop participating in the workers' compensation system, leading to fewer options and delays for injured workers. Legislators should consider allowing the Workers' Compensation Commission to review all pricing models instead of locking Maryland into a flawed system that other states have already rejected.

Why Acquisition Cost is Problematic for Workers' Compensation Pharmacy Reimbursement

1. **Acquisition Cost Does Not Cover the Full Cost of Dispensing Medications**
   - ***Pharmacies do more than just purchase medications*.** They handle prescription verification, patient counseling, prior authorizations, and claim adjudication—all of which require time and resources.
   - ***Real-world example:*** If a grocery store was forced to sell milk at only the price they paid the dairy supplier—without factoring in transportation, refrigeration, and labor costs—it would quickly go out of business. The same principle applies to pharmacies.

2. **Acquisition Cost is Highly Variable & Unpredictable**
   - Drug prices fluctuate due to supply chain issues, bulk purchasing discounts, and pharmacy size.
   - ***Real-world example:*** If a construction company could only charge customers the price they paid for raw materials, but couldn't factor in labor or operational costs, they'd struggle to sustain their business.
   - ***Fact:*** Smaller and independent pharmacies pay higher acquisition costs than large chains that negotiate bulk discounts, meaning they will be disproportionately harmed.

3. **Acquisition Cost-Based Reimbursement Leads to Pharmacy Closures & Reduced Access**
   - Other states have rejected Acquisition Cost as a stand-alone metric because it fails to ensure that pharmacies can afford to participate in workers' compensation claims.
   - ***Real-world example:*** If Uber drivers were only reimbursed for gas expenses and not for maintenance, insurance, and their time, many would stop driving—leading to longer wait times and reduced access to rides.
   - Likewise, if pharmacies lose money on workers' compensation prescriptions, many will stop participating, forcing injured workers to travel farther and wait longer for essential medications.

4. **Other States Have Found That Acquisition Cost Alone is Inadequate**
   - ***35 out of 37 states use AWP*** (Average Wholesale Price) as the foundation for workers' compensation pharmacy reimbursement because it offers **stability, predictability, and fair compensation.**
   - ***Real-world example:*** In Kentucky, independent pharmacists testified that NADAC (a similar acquisition cost-based model) would drive them out of workers' compensation because it did not account for operational expenses.

5. **Insurers Benefit at the Expense of Pharmacies and Injured Workers**
   - ***An Acquisition Cost-only model would allow insurers to dictate reimbursement levels*** while pharmacies bear all the financial risk.
   - ***Real-world example:*** If airlines could only charge passengers the cost of fuel, they wouldn't be able to afford pilots, maintenance, or safety measures. Similarly, pharmacies need reimbursement that covers the full cost of dispensing medications—not just the price of the drug itself.

Summary of Workers' Compensation Pharmacy Fee Schedules

Understanding how different fee schedules work is critical in ensuring fair reimbursement for pharmacies while maintaining cost controls in Maryland's workers' compensation system. Below is a brief summary of the key fee schedule models:

Maryland's Current Workers Compensation Fee Schedule:

Usual and Customary (U&C) Pricing – Stability Issues

- **What it is:** U&C pricing is the price a pharmacy typically charges for a prescription drug outside of negotiated rates.
- **How it works:** Pharmacies submit their standard retail price as the reimbursement rate, which may fluctuate over time.
- **Pros:** Reflects real-world pricing but is inconsistent across pharmacies and regions.
- **Cons:** Unpredictable and is not as widely accepted as a standalone pricing model in workers' compensation.

Mandated by Senate Bill 306:

National Average Drug Acquisition Cost (NADAC) – Unreliable and Rejected by Most States

- **What it is:** NADAC is based on voluntary surveys of pharmacy drug acquisition costs, collected by the Centers for Medicare & Medicaid Services (CMS).
- **Why it's problematic: NADAC has been rejected by multiple states** because it does not account for all medications, excludes physician-dispensed drugs, and relies on voluntary reporting, making it unreliable.
- **How it works:** NADAC prices are updated weekly based on self-reported data, creating inconsistencies in reimbursement rates.
- **Pros:** In theory, it reflects real market-based drug costs.
- **Cons: Does not cover all drugs, lacks transparency, and has led to pharmacy access issues where attempted.**

Wholesale Acquisition Cost (WAC) – Not a Viable Standalone Model

- **What it is:** WAC represents the manufacturer's list price for a drug **before** any rebates, discounts, or price reductions.
- **Why it's problematic:** WAC does not reflect what pharmacies actually pay for drugs and can be manipulated by manufacturers.

- **How it works:** Used primarily as a reference price in contracts between manufacturers and wholesalers.
- **Pros:** Provides a uniform starting point.
- **Cons: Does not account for pharmacy operational costs, making it unsuitable for workers' compensation reimbursement.**

Prohibited by Senate Bill 306:

Average Wholesale Price (AWP) – The Industry Standard

- **What it is:** AWP is a nationally recognized benchmark for drug pricing, reflecting the list price set by drug manufacturers before any discounts or rebates.
- **Why it's used: AWP is used by 35 of 37 states** with workers' compensation fee schedules because it provides a predictable, standardized, and transparent method for determining reimbursement.
- **How it works:** AWP allows states to set fair and balanced rates by applying a slight discount (e.g., AWP - 10%) plus a dispensing fee to ensure pharmacies are compensated for their services.
- **Pros:** Ensures pharmacies are fairly reimbursed, predictable for insurers, and easy to administer.
- **Cons:** Critics argue that AWP may not always reflect the actual acquisition cost, but it remains the best available model for stability and access.

Key Takeaways:

- **AWP is the industry standard and used by nearly all states** because it balances fair reimbursement with cost controls.
- **NADAC, WAC, and U&C have been rejected or deemed inadequate** in many states because they do not provide predictable, fair pharmacy reimbursements.
- **Maryland should align with national best practices** and allow the Workers' Compensation Commission to consider AWP-based models, rather than being forced into an acquisition-cost-only model that would drive pharmacies out of workers' compensation.

Proposed Amendment to SB 306

On page 2, strike lines 14-17 in their entirety and insert the following:

(I) REIMBURSEMENT FOR PRESCRIPTION DRUGS AND PHARMACEUTICAL SERVICES UNDER THIS SECTION SHALL BE BASED ON A FEE SCHEDULE DETERMINED BY THE WORKERS' COMPENSATION COMMISSION. THE COMMISSION SHALL HAVE THE AUTHORITY TO CONSIDER ALL RECOGNIZED PRICING BENCHMARKS, INCLUDING BUT NOT LIMITED TO:

1. **AVERAGE WHOLESALE PRICE (AWP),**
2. **NATIONAL AVERAGE DRUG ACQUISITION COST (NADAC),**
3. **WHOLESALE ACQUISITION COST (WAC),**
4. **USUAL AND CUSTOMARY PRICING.**

THE COMMISSION SHALL DETERMINE THE MOST APPROPRIATE FEE SCHEDULE BASED ON A STATE-BY-STATE COMPARISON OF EXISTING PHARMACY REIMBURSEMENT MODELS, THE IMPACT ON PATIENT ACCESS, AND COST CONTAINMENT STRATEGIES.

On Page 2, strike lines 21-27.

On Page 3, strike lines 6-28.

Why Maryland Should Consider All Fee Schedules in Worker's Compensation

1. **Flexibility to Determine the Best Model:** Maryland should have the ability to review and adopt the best pricing model instead of being locked into one approach.
2. **Majority of States Use AWP:** 35 of 37 states with a workers' compensation fee schedule use AWP, demonstrating its effectiveness in balancing cost control and patient access
3. **NADAC and Acquisition Cost Have Been Rejected in Other States:** States like Kentucky and Arizona rejected NADAC because it does not cover all medications and relies on voluntary surveys rather than fixed pricing benchmarks.
4. **Protecting Patient Access to Medication**: If Maryland limits reimbursement to Acquisition Cost, small and independent pharmacies may stop filling workers' comp prescriptions, reducing access for injured workers.
5. **Regulatory Best Practices:** Many states have structured their workers' compensation reimbursement models with built-in adjustments (e.g., AWP - 10% + $4.00 dispensing fee) to maintain fairness for both pharmacies and insurers.

SB306_MACDS_FWA.pdf
Uploaded by: Sarah Price
Position: FWA

MARYLAND ASSOCIATION
OF CHAIN DRUG STORES
171 CONDUIT STREET, ANNAPOLIS, MD 21401 | 410-269-1440

SB306 Workers' Compensation - Prescription Drug and Pharmaceutical Services - Reimbursements
Economic Matters Committee
March 26, 2025

Position: Favorable with Amendments

Background: SB306 would require the Workers' Compensation Commission (WCC) to regulate all fees and other charges for the reimbursement of prescription drugs and pharmaceutical services provided through the workers' compensation system.

Comments: The Maryland Association of Chain Drug Stores (MACDS) would respectfully express concerns that **SB306 Workers' Compensation – Prescription Drug and Pharmaceutical Services – Reimbursements** as introduced could have a negative impact on pharmacy operations and medication access in Maryland due to inappropriately low dispensing fees. We recommend that the Committee amend the bill to require the WCC to establish reasonable dispensing fees and consider pricing benchmarks such as average wholesale price, national average drug acquisition cost, and wholesale acquisition cost when determining the appropriate fee schedule for reimbursement for prescription drugs and pharmaceutical services provided for workers' compensation patients. We would also request that, should a list of stakeholders be identified for collaboration with the WCC, a representative from MACDS be included.

MACDS has consistently supported legislation to increase pharmacy reimbursement rates in Maryland and address the growing issue of pharmacy closures as the state has experienced a net 2% decrease in pharmacy locations per year over the last two fiscal years, including the closure of 37 chain locations between 2023 and 2024. These closures are due in large part to the inadequate dispensing fees negotiated by pharmacy benefits managers (PBMs); for example, the Maryland Department of Budget and Management is currently issuing dispensing fees of $0.35 and $0.50 per prescription for the State Employee and Retiree Health and Welfare Benefits Program. The State Medicaid Managed Care Organizations (MCOs) paid an average dispensing fee of $0.67 per prescription to pharmacists in 2021 and $0.59 per prescription in 2022. A study conducted by the Maryland Department of Health as mandated by HB382 in 2023 found that if Medicaid had been required to issue a dispensing fee for MCO medications based on the National Average Drug Acquisition Cost (NADAC) in 2021 and 2022, without undertaking any reform of PBM activities that artificially inflate the price of drugs and increase operational costs for pharmacies, it would have cost the State over $78 million – which, read another way, is the dollar amount which the State underpaid pharmacists for dispensing prescriptions to Medicaid MCO patients.

Since the Department's study was issued, MACDS has continued to advocate for legislation which would establish adequate dispensing fees for pharmacies treating

Medicaid patients in Maryland and has, at the same time, promoted PBM reform to offset the associated cost of paying reasonable fees to pharmacists. Other states across the country have implemented policies such as carving out pharmacy benefits from MCOs and mandating pass-through pricing for MCOs, and have saved tens-to-hundreds of millions of dollars while also paying appropriate dispensing fees to pharmacists. MACDS is, to that end, supporting HB813 in 2025 which, as amended, would establish a work group to review different strategies for implementing PBM reform and increasing pharmacist dispensing fees. Our efforts in this area have informed our position of concern regarding SB306 and the impact that the language as introduced could have on pharmacies that serve workers' compensation patients.

The State legislature considers bills every year to increase the State minimum wage and expand leave options and other benefits for employees, but this body has not yet passed legislation to implement reform around PBM activity. While operating costs for labor increase, the pharmacy community continues to be left behind, consistently dispensing medications at a loss due to insurance and reimbursement policies outside of our control. SB306 as introduced would allow unsustainably low rates to be established for reimbursement for medication for workers' compensation patients, further exacerbating operational issues for pharmacies in Maryland.

We again respectfully request the Committee to amend the bill to require reasonable dispensing fees and the consideration of a variety of pricing benchmarks when fee schedules are set. Thank you for your attention to this matter.

Aaron Boston - Testimony Opposing MD SB306.pdf
Uploaded by: Aaron Boston
Position: UNF

Aaron Boston
15180 Hickory Wood Drive
Annapolis, MD 21409

March 26, 2025

The Honorable C.T. Wilson
Chairman, Economic Matters Committee
Maryland House of Delegates
231 Taylor Office Building
Annapolis, MD 21401

RE: Strong Opposition to Senate Bill 306 - Workers' Compensation - Prescription Drug & Pharmaceutical Services - Reimbursements

Dear Members of the Maryland State House and Senate,

This bill is terrible, another blow to the people. I oppose SB306. If it weren't for the company facilitating and ensuring I received the medicine to aid in getting better, I don't know what I would have done. RescueMeds went beyond just coordinating and distributing medicine, occasionally I would get a phone call just to check on my well being.

Sincerely,

Aaron Boston

Aaron Boston

Letter to CT Wilson.pdf
Uploaded by: Brennan McCarthy
Position: UNF

BRENNAN McCARTHY & ASSOCIATES
1116 West Street, Suite C
Annapolis, Maryland 21401
Telephone: (443) 294-1083 Facsimile: (443) 200-6135
E-Mail: bmccarthy@brennanmccarthy.com

March 24, 2025

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

Daryl Buhrman - Testimony Opposing SB306.pdf
Uploaded by: Daryl Buhrman
Position: UNF

Daryl Buhrman
1534 Fountain Glen Drive
Bel Air, MD 21015

March 26, 2025

The Honorable C.T. Wilson
Chairman, Economic Matters Committee
Maryland House of Delegates
231 Taylor Office Building
Annapolis, MD 21401

RE: **Strong Opposition** to Senate Bill 306 - Workers' Compensation - Prescription Drug

Dear Chairman Wilson,

My name is Daryl Buhrman. I am 79 years old. I am a retired Baltimore City Police Officer. I joined in 1972 and retired in 1991 on a medical disability. I was injured in the line of duty. Since then, my physical condition is deteriorating day by day. As a result of my injuries, I am disabled, and I have been on several different types of medications since 1989. With RescueMeds, they are affordable, and delivered to my door. I do not have to find a way to a pharmacy and wait in lines. They are always ready and on time with no problems. I do not have to pay anything. If Igo to CVS I have to pay for it and then get reimbursed. The reimbursement rates being proposed are unreasonable with the use of an acquisition cost index, and will prevent my and others access to critical medicine. That’s why it’s so important for me to have another option to get my prescriptions and without companies like RescueMeds, things could have gotten much worse for me. Through no fault of my own I got hurt, and I should not have to go through the expense of paying for my medicines and wait to be reimbursed seeing as I am disabled. RescueMeds is a God-send to me. Next to my wife, they are the best thing that happened to me.

Sincerely,

Daryl Buhrman
Retired Baltimore City Police Officer

Diana Lyles - Testimony Opposing SB306 (1).pdf
Uploaded by: Diana Lyles
Position: UNF

Diana Lyles
5450 Bluecoat Lane
Columbia, Maryland 21045
Therealdianalyles@gmail.com
410-852-7676

March 26, 2025

The Honorable C.T. Wilson
Chairman, Economic Matters Committee
Maryland House of Delegates
231 Taylor Office Building
Annapolis, MD 21401

RE: **Strong Opposition** to Senate Bill 306 - Workers' Compensation - Prescription Drug & Pharmaceutical Services - Reimbursements

Dear Members of the Maryland State Senate,

My name is Diana Lyles, and I am a retired Maryland state employee who was injured in the line of duty and received Accidental Disability Pension. I currently receive workers' compensation benefits, but those benefits have stopped covering my medical treatment—leaving me to fight for the care I need to live with dignity.

I am writing today to urge you to vote **NO** on Senate Bill 306.

This bill will severely restrict access to care for injured workers like myself by undermining the role of independent insurance companies that currently provide critical coverage. If passed, this bill could force injured individuals to rely on Medicare or Medicaid for treatment. That shift would not only delay or disrupt necessary medical care—it would also increase costs for counties and burden taxpayers throughout Maryland.

Independent insurance companies play a vital role in making sure injured workers receive timely, effective treatment. Stripping away that access will leave many of us in limbo, with fewer options and more obstacles to recovery. This is not just a workers' comp issue—it's a public health and financial issue that will impact state and local resources.

Please do not throw away the lifeline that independent insurance companies provide. I and many others have sacrificed in the line of duty to serve this state. We should not be punished in retirement for injuries sustained in service.

Senate Bill 306 does not solve a problem—it creates a bigger one. For the sake of those who served, and for the fiscal health of our state, I respectfully ask that you vote NO on this harmful bill.

Thank you for your attention and consideration.

Sincerely,

Diana Lyles

Diana Lyles
Retired Maryland State Employee
Accidental Disability Pension

Donald Kelley - Testimony Opposing SB306.pdf
Uploaded by: Donald Kelley
Position: UNF

March 26, 2025

The Honorable C.T. Wilson
Chairman, Economic Matters Committee
Maryland House of Delegates
231 Taylor Office Building
Annapolis, MD 21401

RE: Strong Opposition to Senate Bill 306 - Workers' Compensation - Prescription Drug & Pharmaceutical Services - Reimbursements

Dear Members of the Maryland State House and Senate,

My name is Donald Kelley and I was a career firefighter/paramedic for a local jurisdiction for over 35 years. I retired a little earlier than planned due to a cardiac arrest event at work. Due to the unwillingness of the jurisdiction to consider it a work related injury, I was forced to use almost a year's worth of my sick leave before the Worker's Comp. The administrator forced the jurisdiction to return my leave. I currently work part time teaching CPR and transporting transplant teams and organs.

I'm concerned about SB 306, especially the part where it says "Reimbursement ... shall be limited to an index or indexes based on acquisition cost ... " I'm concerned this will tend to drive some pharmacies out of business - making it more difficult for people - especially those dealing with Worker's Compensation - to obtain medications when needed. I currently use RescueMeds Work Injury Pharmacy for my necessary Worker's Comp. medications. They are the epitome of a "small town pharmacy", with their excellent, personalized customer service. They, along with other smaller pharmacies will have a hard time staying in business if SB 306 is passed. This will make it harder for people to obtain the medications they need to take because of their job related injuries.

Thank you,

Donald Kelley

Donald Kelley

Daryl Buhrman - Testimony Opposing SB306.pdf
Uploaded by: Donald Poole
Position: UNF

Daryl Buhrman
1534 Fountain Glen Drive
Bel Air, MD 21015

March 26, 2025

The Honorable C.T. Wilson
Chairman, Economic Matters Committee
Maryland House of Delegates
231 Taylor Office Building
Annapolis, MD 21401

RE: **Strong Opposition** to Senate Bill 306 - Workers' Compensation - Prescription Drug

Dear Chairman Wilson,

My name is Daryl Buhrman. I am 79 years old. I am a retired Baltimore City Police Officer. I joined in 1972 and retired in 1991 on a medical disability. I was injured in the line of duty. Since then, my physical condition is deteriorating day by day. As a result of my injuries, I am disabled, and I have been on several different types of medications since 1989. With RescueMeds, they are affordable, and delivered to my door. I do not have to find a way to a pharmacy and wait in lines. They are always ready and on time with no problems. I do not have to pay anything. If Igo to CVS I have to pay for it and then get reimbursed. The reimbursement rates being proposed are unreasonable with the use of an acquisition cost index, and will prevent my and others access to critical medicine. That’s why it’s so important for me to have another option to get my prescriptions and without companies like RescueMeds, things could have gotten much worse for me. Through no fault of my own I got hurt, and I should not have to go through the expense of paying for my medicines and wait to be reimbursed seeing as I am disabled. RescueMeds is a God-send to me. Next to my wife, they are the best thing that happened to me.

Sincerely,

Daryl Buhrman
Retired Baltimore City Police Officer

Duncan Munro - Testimony Opposing SB306.pdf
Uploaded by: Duncan Munro
Position: UNF

Duncan Munro
13103 Ivy Drive
Beltsville MD 20705

March 26, 2025

The Honorable C.T. Wilson
Chairman, Economic Matters Committee
Maryland House of Delegates
231 Taylor Office Building
Annapolis, MD 21401

RE: **Strong Opposition** to Senate Bill 306 - Workers' Compensation - Prescription Drug & Pharmaceutical Services - Reimbursements

Dear Chairman Wilson,

By way of introduction, my name is Duncan Munro, and I am a resident of Beltsville MD, where my wife and I have resided for just over 52 years.

After a career that spanned about 26 years, I retired from the Prince George's County Fire Department in 1992, and followed that with a briefer, 12 year career as a Legislative Assistant for the Maryland House of Delegates.

Following my retirement from the Fire Department, I experienced the following medical issues: [1] a heart attack in 2001; [2] Prostate Cancer in 2017; and bladder cancer in 2022. The good news is that due to fairly early detection and appropriate treatment, all three conditions are behind me at this time.

I was also fortunate that all three situations were found to have been job related, thus qualifying me for Workmen's Compensation. As a result of this classification, I have been fortunate to have connected with RescueMeds, of Annapolis, to provide several follow up medications that are intended to prolong my decent health.

Dealing with Rescue Meds has been one of the most positive experiences of my medical history. These folks have been prompt, caring and incredibly supportive throughout my journey. They are a small pharmacy filled with folks with big hearts.

However, this company that does so well for me, and other small pharmacies are facing the possibility of being forced out of business as a result of this legislation. That is simply not right. Small companies should not be burdened with this type of future.

I ask the Committee to consider this very real possibility while considering this bill.

Thank you for the opportunity to present my view on this matter.

Sincerely,

Duncan Munro
Retired Prince George's County Firefighter

CURRENT WORK COMP PHARMACY FEE SCHEDULE.pdf
Uploaded by: Greg May
Position: UNF

CURRENT WORK COMP PHARMACY FEE SCHEDULE'S

	Brand FS	Generic FS
Alabama	AWP +5% +$10.75	AWP +5% +$13.97
Alaska	AWP +$5.00	AWP +$10.00
Arizona	AWP -15% +$7.00	AWP -25% +$7.00
Arkansas	AWP +$5.13	AWP +$5.13
California	Medi-cal AWP -17% +$7.25	Medi-cal AWP -17% +$7.25
Colorado	AWP +$4.00	AWP +$4.00
Connecticut	AWP +$5.00	AWP +$8.00
Delaware	AWP -31.9% +$3.29 DF	AWP -38% +$4.10 DF
Florida	AWP +$4.18	AWP +$4.18
Georgia	AWP +$4.74	AWP +$7.11
Hawaii	AWP +40%	AWP +40%
Idaho	AWP +$5.00	AWP +$8.00
Kansas	AWP -10% +$3.00	AWP -15% +$5.00
Kentucky	AWP -10% +$5.00	AWP of the lowest priced therapeutically equivalent in stock -15% +5.00
Louisiana	AWP +10% +$10.99	AWP +40% +$10.99
Massachusetts	Lesser of language-Medicaid	Lesser of language-Medicaid
Michigan	AWP -10% +$3.50	AWP-10% +$5.50
Minnesota	AWP -12% +$3.65	AWP -12% +$3.65
Mississippi	AWP +$5.00	AWP-5% +$5.00
Montana	AWP -10% +$3.00	AWP-25% +$3.00
Nevada	AWP +$12.96	AWP +$12.96
New Mexico	AWP -10% +$5.00	AWP -10% +$5.00
New York	AWP -12% +$4.00	AWP -20% +$5.00
North Carolina	AWP -5%	AWP -5%
North Dakota	$4.00 DF MONOPOLISTIC	$5.00 DF MONOPOLISTIC
Ohio	AWP -15% +$3.50	AWP -15% +$3.50
Oklahoma	AWP -10% +$5.00	AWP -10% +$5.00
Oregon	AWP -16.5% +$2.00	AWP -16.5% +$2.00
Pennsylvania	AWP +10%	AWP +10%
Rhode Island	AWP -10%	AWP -10%
South Carolina	AWP + $5.00	AWP +$5.00
Tennessee	AWP + $5.10	AWP + $5.10
Texas	AWP + 9% +$4.00	AWP +25% +$4.00
Vermont	AWP + $3.15	AWP + $3.15
Washington	AWP -10% +$4.50	AWP -50% +$4.50
Wisconsin	AWP +$3.00	AWP +$3.00
Wyoming	AWP -10% +$5.00	AWP -10% +$5.00

Jacqueline Kline - Testimony Opposing SB306.pdf
Uploaded by: Jacqueline Kline
Position: UNF

Jacqueline Kline
370 Old Bachmans Valley Road
Westminster, MD 21157

March 26, 2025

The Honorable C.T. Wilson
Chairman, Economic Matters Committee
Maryland House of Delegates
231 Taylor Office Building
Annapolis, MD 21401

RE: **Strong Opposition** to Senate Bill 306 - Workers' Compensation - Prescription Drug & Pharmaceutical Services - Reimbursements

Dear Chairman Wilson,

My name is Jacqueline Kline, and I am a medically retired Maryland State Trooper.

On October 6, 2013, I was on night shift patrol in Anne Arundel County, Maryland. My shift partner had pulled over a suspected drunk driver and called me for backup. At approximately 1:00am, I pulled up behind his vehicle on the slow shoulder of Eastbound MD-100. As I exited my patrol vehicle and began walking toward my shift partner in front of me, a vehicle traveling on MD-100 at approximately 50 mph drove over the shoulder line and struck my body from behind. My body hit the hood of the car and was then propelled into the rear end of my shift partner's vehicle, smashing out the rear windshields and hiding the metal K9 cage inside of the car.

I was airlifted to University of Maryland Shock Trauma where I spent the next week in critical condition with a severe diffuse axonal traumatic brain injury and many fractures. After a few weeks at Shock Trauma, I was transferred to Sinai Hospital in Baltimore for rehabilitation.

As one would imagine, I spent the past 11 years in pain. I've tried physical therapy a number of times to no avail. Over the years, I have had 3 surgeries on my right elbow to remove glass and debris, my jaw dislocated itself in 2020, I had a lumbar fusion in 2021, a cervical fusion in 2023, and continue to be monitored and treated for spinal pain.

I went to work one night to do the job I love, a job that most would never consider doing themselves, and I went home to a hospital on the brink of death. I say NO to Senate Bill 306. It's not fair for me to EVER pay in any way to get the prescription medication I need when Worker's Comp. has agreed to take care of me for the injuries I had so unfairly obtained.

Please don't do away with our independent pharmacies. They have made my painful and inconvenient life so much more bearable. Senate Bill 306 will cost more for the Counties and taxpayers, when individuals are forced to use Medicare and Medicaid.

Please hear my cries when I beg you not to pass Senate Bill 306.

Sincerely,

Jacqueline Kline

Jacqueline Kline
Medically Retired Maryland State Trooper

Paul Johnson - Testimony Opposing SB306.pdf
Uploaded by: Jacqueline Kline
Position: UNF

Paul Johnson
939 Kenwood Drive
Hagerstown, MD 21740

March 26, 2025

The Honorable C.T. Wilson
Chairman, Economic Matters Committee
Maryland House of Delegates
231 Taylor Office Building
Annapolis, MD 21401

RE: **Strong Opposition** to Senate Bill 306 - Workers' Compensation - Prescription Drug & Pharmaceutical Services - Reimbursements

Dear Chairman Wilson,

My name is Paul Johnson, and I am writing to you as an injured worker in the State of Maryland who is currently navigating the workers' compensation system. I urge you to oppose Senate Bill 306.

Before I found RescueMeds, I was unable to get the prescriptions I desperately needed—even with an official order from the Workers' Compensation Commission. My local pharmacy would not approve the medications, and I was left without help, in pain, and unsure of what to do next.

RescueMeds changed that. When they receive prescriptions from my doctor, they send the medications directly to me without delay. They may very well have saved my life. I don't say that lightly.

SB306 would take this lifeline away from me and others like me who are fighting to survive, physically and financially. I've been in the system for years. Despite a ruling from the Commission that I am disabled, the insurance company is still fighting to stop my benefits. Just days ago, they filed again, claiming I've reached "maximum medical improvement." I don't even know what that really means. Am I supposed to believe this is it for me? That I'll never get better—and now I'm just out of work, out of options, and abandoned?

While my attorney continues to fight for my rights, RescueMeds is the only reason I'm able to keep breathing. Other pharmacies turn me away, telling me the insurance has cut me off and there's nothing they can do. But not RescueMeds. They continue to help me during the fight.

Please don’t take this critical support away. Oppose SB 306—for me, and for every injured worker in Maryland who still deserves a chance to heal and be heard.

Sincerely,

Paul Johnson

Paul Johnson

Jonathan Carrier - Testimony Opposing SB306.pdf
Uploaded by: Jonathan Carrier
Position: UNF

Jonathan E. Carrier
1100 Thomas Swann Lane
Davidsonville, MD 2135

March 26, 2025

The Honorable C.T. Wilson
Chairman, Economic Matters Committee
Maryland House of Delegates
231 Taylor Office Building
Annapolis, MD 21401

RE: **Strong Opposition** to Senate Bill 306 - Workers' Compensation - Prescription Drug & Pharmaceutical Services - Reimbursements

Dear Chairman Wilson,

I am a retired Anne Arundel County Police Corporal of thirty years. I have 36 years of service as a police officer in Maryland. I have worked many assignments during my career and have been injured many times in the line of duty in the very dangerous job that police in our nation do every day.

Being a police officer takes a toll on the body of the officers who are working, and of the few of us who make it to full retirement, we are left with the enduring scars both physically and emotionally of our experiences on the job.

I want to write to you expressing my DISAPPROVAL of the proposed SENATE BILL 306.

Companies like Rescue Meds are truly oriented to serving and partnering with our first responders. They know me and I know them. When they can't get paid by the County or Municipalities for workman's compensation cases, they go to bat for me to get me my medications and get them to me in a timely manner. I have been in need of refills and new medications and they take care of it and then deliver them to my home.

Dealing with CVS and other larger retailers is a nightmare and highly impersonal. They have NO interest in taking care of first responders who are injured, we are just another number to them. Sad, but true.

This is yet another Maryland Bill which intrudes on a company and system that are already working well. To what end and benefit?
I have been using Rescue Meds for years and their service is second to none. They know and treat first responders with dignity and respect, and work on our behalf.

Please consider voting against this bill. Thank you for the opportunity to provide testimony in reference to this bill.

May you all be blessed in your service to our great State.

Sincerely,

Jonathon E. Carrier

Jonathan E. Carrier
Retired Police Cpl. Anne Arundel County

Kenneth Pardoe - Testimony Opposing SB306.pdf
Uploaded by: Kenneth Pardoe
Position: UNF

Kenneth L. Pardoe
8165 Silo Road
Severn, Maryland 21144
kbpardoe76@gmail.com
410-733-3436 (cell)

March 26, 2025

The Honorable C.T. Wilson
Chairman, Economic Matters Committee
Maryland House of Delegates
231 Taylor Office Building
Annapolis, MD 21401

RE: **Strong Opposition** to Senate Bill 306 - Workers' Compensation - Prescription Drug & Pharmaceutical Services - Reimbursements

Dear Members of the Maryland State House and Senate,

I am a retired Battalion Chief from the Anne Arundel County, Maryland Fire Department. Having served more than twenty-three years as an active firefighter/paramedic and officer, I had to retire in 2003 due to injury/illness associated with an on-the-job injury. I was unable to receive a disability through the county, so I had to take a “normal” retirement. Starting several years before that, I started receiving Workman’s Comp-related prescription medications. Over time, I have been denied medications, treatments and services through the county Risk Management Benefits Manager(s). Since retirement, I have struggled with Pharmacy benefits, accessibility, customer service, and medication availability. I’ve tried “professional” and commercial pharmacies, and the experience is the same.

Since starting with RescueMeds, the struggles I encountered with the other commercial and “professional” pharmacies have disappeared. With them, I’ve experienced unmatched customer service and convenience. I can call, text, or email and have an immediate response, even on weekends. I’ve never been out of medications due to availability or an error in billing from the pharmacy or with a refilled prescription.

This letter could go on with many pages, but the point here is to oppose SB306 which could compromise or eliminate the care and treatment I now receive. Big pharmacy chains and Pharmacy Benefits Managers will take control and those of us that have sacrificed and suffered in our health and lives will suffer even more while they improve their bottom line I can’t even conceive the notion that you would consider corporate interests over the lives of the thousands of injured firefighters, paramedics, police officers, or any other worker in Maryland for that matter.

Oppose SB 306 and save a life…

Respectfully Submitted

Kenneth L. Pardoe

Kenneth Wisniewski - Testimony Opposing SB306.pdf
Uploaded by: Kenneth Wisniewski
Position: UNF

March 26, 2025

The Honorable C.T. Wilson
Chairman, Economic Matters
Committee
Maryland House of Delegates
231 Taylor Office Building
Annapolis, MD 21401

RE: Strong Opposition to Senate Bill 306 - Workers' Compensation - Prescription Drug & Pharmaceutical Services - Reimbursements

Dear Members of the Maryland State House and Senate,

My name is Ken Wisniewski. I am a 22 year retired Army combat, 82nd Airborne, Ranger and nearly 19 year retired Prince George's County Police Officer. During my time as a police officer, I sustained injuries that I continue to receive medical care for under Worker's Compensation that include distribution of pharmaceuticals.

The legislation regarding reimbursement rates that is being proposed are unreasonable with the use of an acquisition cost index. This will prevent access to critical healthcare for myself and other injured workers. I have personally experienced delays with my own prescriptions that were unavailable at "traditional", store front pharmacies. Without RescuMeds, additional medical care might have been required because I couldn't receive my medication from the traditional pharmacies timely. Even though RescuMeds may have an additional cost for their services, it provides patient's, like me, peace of mind that I can get what I need in a timely fashion. Regulating charges for prescription drugs, under this legislation, would do a disservice to those of us who rely on RescuMeds services. Please reconsider this legislation for this reason.

Thank you for your time.

Kenneth Wisniewski

Kenneth Wisniewski

Lisa Dreszer - Testimony Opposing SB306.pdf
Uploaded by: Lisa Dreszer
Position: UNF

Lisa Dreszer
7499 Greenway Center Drive
Greenbelt, MD 20770

March 26, 2025

The Honorable C.T. Wilson
Chairman, Economic Matters Committee
Maryland House of Delegates
231 Taylor Office Building
Annapolis, MD 21401

RE: **Strong Opposition** to Senate Bill 306 - Workers' Compensation - Prescription Drug & Pharmaceutical Services - Reimbursements

Dear Chairman Wilson,

My name is Lisa Dreszer, I am writing to you as a Practice Administrator in the State of Maryland who is currently helping patients navigate the workers' compensation system. I urge you to **Oppose Senate Bill 306.**

Our practice specializes in pain management for injured workers and auto mobile accidents. Before RescueMeds, many of our patients were unable to get the prescriptions they desperately needed–even with an official order from the Workers' Compensation Commission. Local pharmacies would not approve the medications, and patients were left without help, in pain, and unsure of what to do next.

RescueMeds changed that. When they received prescriptions from our office, they sent the medications directly to the patients without delay.

SB306 would take this lifeline away from our patients who are fighting to survive, physically and financially.

Please don't take this crucial support away. **Oppose SB306** for every injured worker in Maryland who still deserves a chance to heal and be heard.

Sincerely,

Lisa Dreszer

Lisa Dreszer
Practice Administrator

Lisa Murray - Testimony Opposing SB306.pdf
Uploaded by: Lisa Murray
Position: UNF

Lisa M. Murray
8501 Veterans Highway
Millersville, MD 21108

March 26, 2025

The Honorable C.T. Wilson
Chairman, Economic Matters Committee
Maryland House of Delegates
231 Taylor Office Building
Annapolis, MD 21401

RE: **Strong Opposition** to Senate Bill 306 - Workers' Compensation - Prescription Drug & Pharmaceutical Services - Reimbursements

Dear Chairman Wilson,

Thank you for allowing me to speak today regarding SB306.

My name is Lisa M. Murray. I am a Line of Duty Medically Retired Firefighter from the Anne Arundel County Fire Department. I served Anne Arundel County for almost 14 years before being severely injured by a drunk driver while responding to a rescue in the fire engine. I did not leave my assignment until 5 months after the accident as I did not realize just how bad my injuries were; I could no longer perform daily activities, let alone work as a firefighter. When I was removed from my active-duty position and placed on Workman's Compensation, I obtained legal counsel. Although the evidence of the injury was clear and I had representation, I spent weeks awaiting approval from the Workman's Compensation Commission (WCC) for test and procedural approval which greatly increased my pain and suffering.

If there had been an independent pharmacy (like **Rescue Meds**) available to me at that time, I know they would have helped me immediately. The time that I spent worrying and waiting for approvals and availability of medication (from the WCC) negatively impacted my health and healing.

I am asking you to please **VOTE NO** to SB306 so that public safety employees (active and retired) who rely on independent pharmacies for their medications and/or other products are not waiting through the lengthy approval process of the Workman's

Compensation Commission. RescueMeds and independent pharmacies are a critical necessity as they take action immediately and have the employee's best interest in hand.

When a public safety employee is sick or injured the last thing they should be worried about is "How long do I need to suffer before someone gets me the help/medication I need?" or "How will I afford the medication I need and who can complete the paperwork while I am trying to recover?"

Please **VOTE NO** to SB306 so independent pharmacies may continue to provide immediate relief to the people they care about. If independent pharmacies are eliminated and the WCC or other agencies take over, people will suffer needlessly. This bill directly affects the very people who act immediately, rendering care to the public, without question or delay. Why would anyone want our public safety workers to trudge through the delays and red-tape when **Independent Pharmacies** have been and should be allowed, to continue exceeding "their" immediate needs? SB 306 is a detriment. Thank you.

Sincerely,

Lisa M. Murray

Lisa M. Murray
Retiree #730 AACoFD

Mark Chapline - Testimony Opposing SB306.pdf
Uploaded by: Mark Chapline
Position: UNF

Mark Chapline
1224 Delbert Ave
Baltimore, MD 21222

March 26, 2025

The Honorable C.T. Wilson
Chairman, Economic Matters Committee
Maryland House of Delegates
231 Taylor Office Building
Annapolis, MD 21401

RE: **Strong Opposition** to Senate Bill 306 - Workers' Compensation - Prescription Drug & Pharmaceutical Services - Reimbursements

Dear Chairman Wilson,

Hello my name is Mark, I am 39 and disabled. I'm also a student at CBC Dundalk. I think that bill 306 is corrupt, the fact that someone even wrote it down is justification that there is corruption in our government. It will hurt businesses and hard working people all over this state. The writer of this bill should be investigated and you will know why after I tell you my story.

I had to have back surgery because of my work injury in March of 2023, which the workmen's compensation company was court ordered to pay for all my medical expenses. I had to stay a few extra days due to pain and not being able to walk. My surgeon prescribed new medication while I was in the hospital. After a few days, I was able to walk again with a walker without a lot of pain. He said I could go home the next day.

That afternoon, I was ready to go home. The social worker from the hospital came to my room. And told me that the workmen's compensation insurance companies refused to pay for my walker and I didn't have the money. The hospital had to donate the walker to me. So that I could leave the hospital.

My surgeon walked me down to the lobby to make sure I got my prescriptions, because there was a nerve pain medication I had to take. He told me if I didn't take the medication regularly like I had been, I could have a seizure or possibly die. So we went to the pharmacy, which he put in the day before. The pharmacist told us that they were

still waiting for authorization. We waited for 2 hours, with the doctor checking every 15 minutes. Till the doctor saw me in so much pain, he paid for my prescriptions out of his own pocket, so I could go home. I felt bad because I didn't have the money, the little bit of money I get from workmen's compensation barely covers my mortgage.

When I got home, I called the social worker from the hospital. To schedule when the nurse and physical therapist will come. To help clean me, because I told them before I left the hospital I lived alone. The social worker told me that workmen's comp insurance denied my nurse and physical therapist, because the adjuster was on vacation and no one else could approve anything. I called my lawyer immediately. I told him about everything, and he said they were trying to contact them. And he told me about RescueMeds. It took over a month to get into physical therapy and only when I was able to get there myself.

Since I started with RescueMeds, my prescriptions have been delivered to my house the same day I see my doctor. Never been late once, and they call when they are on the way. They make my life easier, and I don't have to stress about not getting my medications and possibly having a seizure or dying. Because if it were up to workmen's compensation I would not get my prescriptions at all, and the Medicaid would pay for them. I have been waiting for a back brace for over 2 year's. Which was brought up in court several times.

So I went to a lawyer specialising in lawsuits, I told him what workmen's compensation did to me. And I quote him "workmen's compensation insurance companies are above the law". I can not sue them for anything even if I never walk right again, because of their negligence. There are laws already protecting workmen's compensation insurance companies and you want to give them more power? Someone is taking money to push this bill and trying to destroy American businesses. The American people will not stand for it.

I vote no for bill 306. Thank you, and God bless you and God bless America!

Sincerely,

Mark Chapline

Mark Chapline

Matthew Coster - Testimony Opposing MD SB0306.pdf
Uploaded by: Matthew Coster
Position: UNF

March 26, 2025

The Honorable C.T. Wilson
Chairman, Economic Matters
Committee
Maryland House of Delegates
231 Taylor Office Building
Annapolis, MD 21401

RE: Strong Opposition to Senate Bill 306 - Workers' Compensation - Prescription Drug & Pharmaceutical Services - Reimbursements

Thank you for the opportunity to provide written testimony in strong opposition to SB306, a bill that seeks to establish a fee guide for workers' compensation prescriptions based solely on "acquisition costs." As President of Baltimore Firefighters IAFF Local 734, I represent hundreds of brave men and women who risk their lives daily for the safety of our community. Many of these individuals rely on timely and effective prescription care to recover from the physical and mental toll of their work. SB306 poses a significant threat to their health and well-being.

Impact on Injured Workers

The proposed bill would limit pharmacy reimbursement to the exact purchase price of medications, without considering the additional costs of dispensing, managing claims, and handling inevitable payment delays and denials. The consequences of this legislation would be devastating:

1. **Loss of Access to Prescription Care:** By mandating reimbursement based solely on acquisition costs, pharmacies would face a financial loss with every workers' compensation prescription they fill. This will drive them to stop offering prescription services for injured workers altogether.
2. **Increased Financial Burden on Taxpayers:** Without pharmacy support, injured workers may turn to Medicaid or other taxpayer-funded programs for prescription coverage, shifting costs from insurers to the public.
3. **Delays in Treatment:** Injured workers already face lengthy delays—47.5% of cases are contested, and nearly 100% of occupational disease cases require months of litigation. Eliminating access to prescription care will only exacerbate these delays and hinder recovery.
4. **Deterioration of Mental and Physical Health:** Firefighters and other workers suffer from occupational diseases such as cancer, pulmonary issues, PTSD, and heart conditions. The proposed reimbursement changes will force them to navigate even more hurdles to receive essential medications.

Industry Standard Practices and Financial Realities

Currently, pharmacies bill using the Average Wholesale Price (AWP) model, which is recognized as the industry standard across 36 states. This model allows for fair reimbursement that accounts for the complexities of handling workers' compensation prescriptions, including claim denials and administrative overhead. The Chesapeake Workers' Insurance Fund's recent return of $50 million to policyholders demonstrates that prescription costs are not a financial burden requiring drastic intervention.

The Essential Role of Pharmacies

Pharmacies like RescueMeds play a critical role in supporting our Firefighters, Medics, and EMTs by providing immediate access to medications while navigating the bureaucratic complexities of workers' compensation claims. They absorb the financial strain of delayed reimbursements, sometimes waiting up to two years for payment, and handle numerous claim denials—all to ensure my members receive the care they need. Eliminating this vital service will leave thousands of Firefighters without adequate prescription coverage.

A Call to Protect Workers

SB306 undermines the already fragile balance between injured workers and insurers. The bill's approach would place pharmacies in an unsustainable financial position, jeopardizing access to essential medications for the thousands of injured firefighters per year in Maryland. As lawmakers, your responsibility is to protect the health and safety of Maryland's workforce. Passing this bill would do the opposite.

Conclusion

I urge you to oppose SB306 and preserve the essential prescription care that we depend on. The well-being of Maryland's firefighters and countless other workers is at stake. Thank you for your consideration and for your commitment to supporting those who serve our communities.

Respectfully Submitted,

Matthew Coster

Matthew Coster
President, Baltimore Firefighters IAFF Local 734
443-324-2401
Mcoster@baltimorefirefighters.net


BALTIMORE CITY
Firefighters
Local 734

Mike Linynsky - Testimony Opposing SB306.pdf
Uploaded by: Mike Linynski Linynski
Position: UNF

Michael Linynsky
836 Waterview Drive
Crownsville, MD 20132

March 26, 2025

The Honorable C.T. Wilson
Chairman, Economic Matters Committee
Maryland House of Delegates
231 Taylor Office Building
Annapolis, MD 21401

RE: **Strong Opposition** to Senate Bill 306 - Workers' Compensation - Prescription Drug & Pharmaceutical Services - Reimbursements

Dear Chairman Wilson,

My name is Michael Linynsky and I have been living in Maryland for over 51 years. By profession, I am a career firefighter in Prince George's County, Maryland. I am also currently attending law school while still working for the Fire Department. As you probably know, firefighters tend to get hurt A LOT. I will just tell you about my personal experience with workman's comp. Our workman's comp manager was so slow to approve things, that I had to use my own insurance when I broke my hand at work. I think that is their goal, to slow things down, so you just give up and go away. This seems like a calculated move to relieve their burden. I don't have any statistics, but if you have seen the denial rate from United Healthcare (around a third), you have a good comparator.

Until companies like RescueMeds came alone, we had no other choice but to constantly call and complain to get service from our carriers. Now that we have a choice, is it suddenly a big deal? This acquisition cost index that is being proposed will force these companies out of the Maryland market. The model you have now, at least gives workers in Maryland a choice. Isn't that what the free market is supposed to do? Instead, this bill will take us back in time and give a monopoly to the workman's comp carriers.

All the people do a great job in the General Assembly but this bill seems a little mis-guidded. Maybe more time should be spent on studying why Maryland workers use the services of companies like RescueMeds. What exactly is the root problem? If there was not a need for these services, these companies would not exist. I am not in favor of

this bill in its current format.

Respectfully,

Michael Linynsky

Mike Linynsky
Recording Secretary Local 1619 PGFD

Paul Johnson - Testimony Opposing SB306.pdf
Uploaded by: Paul Johnson
Position: UNF

Paul Johnson
939 Kenwood Drive
Hagerstown, MD 21740

March 26, 2025

The Honorable C.T. Wilson
Chairman, Economic Matters Committee
Maryland House of Delegates
231 Taylor Office Building
Annapolis, MD 21401

RE: **Strong Opposition** to Senate Bill 306 - Workers' Compensation - Prescription Drug & Pharmaceutical Services - Reimbursements

Dear Chairman Wilson,

My name is Paul Johnson, and I am writing to you as an injured worker in the State of Maryland who is currently navigating the workers' compensation system. I urge you to oppose Senate Bill 306.

Before I found RescueMeds, I was unable to get the prescriptions I desperately needed—even with an official order from the Workers' Compensation Commission. My local pharmacy would not approve the medications, and I was left without help, in pain, and unsure of what to do next.

RescueMeds changed that. When they receive prescriptions from my doctor, they send the medications directly to me without delay. They may very well have saved my life. I don't say that lightly.

SB306 would take this lifeline away from me and others like me who are fighting to survive, physically and financially. I've been in the system for years. Despite a ruling from the Commission that I am disabled, the insurance company is still fighting to stop my benefits. Just days ago, they filed again, claiming I've reached "maximum medical improvement." I don't even know what that really means. Am I supposed to believe this is it for me? That I'll never get better—and now I'm just out of work, out of options, and abandoned?

While my attorney continues to fight for my rights, RescueMeds is the only reason I'm able to keep breathing. Other pharmacies turn me away, telling me the insurance has cut me off and there's nothing they can do. But not RescueMeds. They continue to help me during the fight.

Please don’t take this critical support away. Oppose SB 306—for me, and for every injured worker in Maryland who still deserves a chance to heal and be heard.

Sincerely,

Paul Johnson

Paul Johnson

Raymond Gheen - Testimony Opposing MD SB306.pdf
Uploaded by: Raymond Gheen
Position: UNF

March 26, 2025

The Honorable C.T. Wilson
Chairman, Economic Matters
Committee
Maryland House of Delegates
231 Taylor Office Building
Annapolis, MD 21401

RE: Strong Opposition to Senate Bill 306 - Workers' Compensation - Prescription Drug & Pharmaceutical Services - Reimbursements

Dear Members of the Maryland State House and Senate,

My name is Raymond Gheen and I am a proud retired police officer of the Prince George's County, Maryland Police Department. Unfortunately, my career was cut short due to injuries sustained while effecting arrests in two separate incidents resulting in a disability retirement. I recently learned of Maryland Senate Bill 306 which to my understanding would limit reimbursement to companies providing meds to injured workers in Maryland. My supplier, RescueMeds has ALWAYS provided medications in a timely and efficient manner even when they are dealing with worker comp denials. Under this bill these companies will only be reimbursed for the actual cost of the medication. How can a company continue to exist under these rules? Numerous worker comp cases are contested yet companies like RescueMeds step up and take care of many injured workers. The reimbursement rates being proposed are unreasonable with the use of an acquisition cost index, and will prevent access to critical healthcare for injured workers. Common sense should prevail, Senate Bill 306 is bad for Maryland workers and would destroy these NEEDED companies.

Sincerely,
Raymond Gheen

Scott Baldwin - Testimony Opposing SB306.pdf
Uploaded by: Scott Baldwin
Position: UNF

Scott Baldwin
816 Buena Vista Avenue
Arnold, Maryland 21012

The Honorable C.T. Wilson
Chairman, Economic Matters Committee
Maryland House of Delegates
231 Taylor Office Building
Annapolis, MD 21401

RE: **Strong Opposition** to Senate Bill 306 - Workers' Compensation - Prescription Drug & Pharmaceutical Services - Reimbursements

Dear Chairman Wilson,

My name is Scott Baldwin, and I am writing to you as an injured worker in the State of Maryland. I urge you to oppose Senate Bill 306.

I have received my medications over the last several years from many sources including directly from my health care provider to local pharmacies to pharmacies many many states away. I was somewhat enticed to use a pharmacy that was out of state for the last several years and it proved to sometimes be a very frustrating task with poor communication and shipping inefficiencies.

RescueMeds changed that. When they receive prescriptions from my doctor, they send the medications directly to me without delay. RescueMeds has thus far been a game changer as a local pharmacy that has the staff and the ability to serve Maryland injured workers in a fast efficient manner. I personally support RescueMeds 110%.

Please don’t take this critical support away. Oppose SB 306—for me, and for every injured worker in Maryland who still deserves a chance to heal and be heard.

Sincerely,
Scott Baldwin

Scott Baldwin

Shantrece Davis FULL - Testimony Opposing SB306.pd
Uploaded by: Shantrice Davis
Position: UNF

March 26, 2025

The Honorable C.T. Wilson
Chairman, Economic Matters Committee
Maryland House of Delegates
231 Taylor Office Building
Annapolis, MD 21401

RE: **Strong Opposition** to Senate Bill 306 - Workers' Compensation - Prescription Drug & Pharmaceutical Services - Reimbursements

Dear Members of the Maryland State House and Senate,

My name is Shantrece Davis. I am 52 years old. I have been a Surgical Technologist for 25 years. I work on everything from general surgery to level one trauma. On June 13th 2024 I was injured in the O.R. starting robotic surgery. I went to employee health at the hospital and they transported me to the E.R. After two cat scans I was diagnosed with a closed head injury with concussion, a cervical spine injury and a pinched nerve. I was given information to start a workman's comp claim and discharged from the hospital. I filed my claim and several days went by with no response from anyone. I was informed that the person handling my claim was out of town at a workers comp conference and that was the reason for the delay. I did not know where to go to get my prescriptions from the E.R. filled or where to go for a follow up visit with a doctor.

On February 8th, 2023 three days before my 50th birthday I had a house fire. I was burned on my hands, arms, chest and face. I covered my son and took him through the fire out of the house with no coat, shirt or shoes in the dead of winter. On my milestone 59th birthday I was in a hotel burned and blistered with my hands wrapped in bandages. I scrubbed for surgery and with the condition of my hands I could not work. We lived in hotels and Airbnbs for over a year. I was able to go back to work in the O.R. in December 2023. We moved into an apartment in May of 2024 with an air mattress and two chairs from a dining room set. I was injured at work the next month in June and a tree fell on my car from a bad storm the next month in July. My mother had a heart attack in September. She coded for six minutes but survived with a pacemaker, a balloon and 3 stents. Life was coming at fast and through all of this RescueMeds made sure that I had all of my medication on time with no delays. December 2024 was the first Christmas for my son and I that we were not living in a hotel or Airbnb. Sedgwick made my coverage pending from December 9th, 2024 until January 24th, 2025. There were no payments issued to me. Our first Christmas in our home was ruined because of this. The only light that I had in all of this sadness and pain was RescueMeds made sure that I had my much needed medicine. On February 6th, 2025 my Neurologist sent my prescriptions to RescueMeds and I received them on February 8th, 2025 the date of my fire and an extreme time of sadness for me. I was shocked when I opened my package to see my medication and a birthday card signed by all of the pharmacists of well wishes for my birthday. This made me cry tears of joy. This was a bright light and brought it in my life at a time of pain and darkness for me. RescueMeds and their excellent service was the only thing in my life that was consistent at my extreme time of need. I could never thank them enough for helping me through all of the intentional pain and struggle inflicted on me by Sedgwick.

Almost 3 weeks went by before I spoke with my adjuster Brad Newman. I was told that I had to provide him with 3 plus years of my medical and mental health history before he would even consider doing anything with my claim. At that time remembering the last 3 minutes of my life were almost impossible so

3 plus years would never happen. It was a battle from the beginning to get anything done with Sedgwick. I suffered daily with chronic pain and the only thing I had that helped me get through my day was my medication.
My first prescription was filled with no problems. There was an issue with each and every prescription afterwards. I was either pending coverage or not covered at all. I was assigned a nurse manager for my case to help me with my appointments and prescriptions and she was no help at all. She would be with me at an appointment to see the doctor giving me prescriptions and I would go to fill them and I was told that my prescriptions could not be filled because I was not covered by workers comp. I called the nurse and she told me that she did not know if she could help me because it was a Friday after 3pm so there was no guarantee that she would get anyone before Monday.
I called my attorney and was given the number for RescueMeds. I called RescueMeds and within minutes my prescriptions were being processed to be shipped directly to me with no delays! I have used this company with every prescription from July 18, 2024 until now it's been wonderful. Dealing with Sedgwick and this claim has been the worst experience ever. It's like psychological warfare and I'm being held hostage when it comes to my recovery needs and my financial situation. They take 4-6 weeks to approve any procedures and this adds a major delay to your recovery time. I need medication to function daily and it helps me a lot during my physical therapy. If I didn't have RescueMeds to fill my prescriptions I don't know where I would be. RescueMeds was the only protection that I had from the torture and unfair treatment that I was receiving from the insurance company. I am a single parent and filling all of my prescriptions out of pocket was not an option for me. I am still having a hard time with my insurance company but thanks to RescueMeds I have my medication and I'm able to function and get through my day. I'm doing well with my recovery and I'm progressing with my physical therapy and none of that would be possible without my medication needs being met by RescueMeds! I could never thank them enough for what they have done for me on my road to recovery!

The reimbursement rates being proposed are unreasonable with the use of an acquisition cost index, and will prevent access to critical healthcare for injured workers. We need to keep options like RescueMeds and companies like them who are DESPERATELY needed for all of the challenges that patients have to deal with from the insurance companies for workers comp cases.

Sincerley,

Shantrece Davis

Shantrece Davis

Sharon Jones - Testimony Opposing SB306.pdf
Uploaded by: Sharon Jones
Position: UNF

Sharon Jones
3818 Cassell Boulevard
Prince Frederick, MD 20678

March 26, 2025

The Honorable C.T. Wilson
Chairman, Economic Matters Committee
Maryland House of Delegates
231 Taylor Office Building
Annapolis, MD 21401

RE: **Strong Opposition** to Senate Bill 306 - Workers' Compensation - Prescription Drug & Pharmaceutical Services - Reimbursements

Dear Chairman Wilson,

I have been a Maryland resident my entire life. I am a dedicated and hardworking individual who has worked for a public safety company in Maryland for the past 19 years.

Unfortunately, I faced a significant challenge when I was injured on the job. Despite this setback, I am still dedicated and determined to do my job. Currently, I am utilizing the services of RescueMeds an Independent Pharmacy to obtain my doctor's prescribed prescription medications. I would like to say, "Say No to Senate Bill 306". While using RescueMeds, I have a choice of what day I would like for my prescription medications to be delivered and it doesn't take a week to get it. This is a very beneficial service for me, being I am in the office Monday through Thursday and being home on Friday allows me the opportunity to have my package delivered and me signing for it. I find it disturbing that legislation wants to take away small Independent Pharmacies. Not only is it important to have any day for delivery, but it also cuts down on the cost of workers compensation prescription medications.

I am asking the Maryland House, **DON'T** do away with our Independent Pharmacies. Senate Bill 306 will cost more for our counties and taxpayers, and even for those individuals who are on Medicare and Medicaid, They can't afford to pay more for prescription drugs.

Sincerely,

Sharon Jones

Sharon Jones

Steven McCombs - Testimony Opposing SB306.pdf
Uploaded by: Steven McCombs
Position: UNF

March 26, 2025

The Honorable C.T. Wilson
Chairman, Economic Matters
Committee
Maryland House of Delegates
231 Taylor Office Building
Annapolis, MD 21401

RE: Strong Opposition to Senate Bill 306 - Workers' Compensation - Prescription Drug & Pharmaceutical Services - Reimbursements

Dear Members of the Maryland State House and Senate,

My name is Steven McCombs, a 40yr “Life Member” of Grasonville Vol. Fire Dept. I’m currently the 1st Assistant Fire Chief and have been a Chief Officer for almost 25 years now. At the end of 2025 I’m going to step down mostly because I can’t physically do the one thing I love anymore! I’ve dedicated my life since the age of 14, to the Fire Service. During this time, I’ve broken my back twice. I also believe I’ve had 15-16 broken bones and a few minor burns in my time. I’m currently employed with Caroline DES where I’m the Shift Lt. on D Shift in the 911 Center. I was also a PG County Fireman for 17yrs and OC Fireman for maybe 3yrs. I’ve worked for 3 Dept’s during my career. The Centreville VFD, Denton VFC & Kent Rescue Squad in Chestertown, Md.

I’m here today in support of companies like RescuMeds, for the last 14yrs plus, I have been through hell with my back injuries and my quality of life now is horrible! I unfortunately rely on medications to just get out of bed on a daily basis. Without the medication RescuMeds provide, I tend to wake up depressed and very upset at my current situation. When I use pharmacies like CVS, I sometimes wait longer periods for the same Meds I get immediately from RescuMeds. They help me and I’ve had no issues getting these meds I need on a daily basis. The reimbursement rates being proposed are unreasonable and WITH THE USE OF AN ACQUISITION COST INDEX, it will prevent access to critical healthcare for injured Firman and other public safety personnel. We risk a lot on a daily basis and to go through what we do is unfair to us! I’m not alone on this. Many other Fireman and Police Officers are in the same situation.

The other point I’d like to include is how important it is to have ANOTHER OPTION to get my prescriptions and how without companies like RescuMeds, things could have gotten worse.

Steven McCombs

Steven McCombs
1st Assistant Chief

Grasonville Fire Department

Veronica Roderick - Testimony for MD Bill 306.pdf
Uploaded by: Veronica Roderick
Position: UNF

March 26, 2025

The Honorable C.T. Wilson
Chairman, Economic Matters Committee
Maryland House of Delegates
231 Taylor Office Building
Annapolis, MD 21401

RE: Strong Opposition to Senate Bill 306 - Workers' Compensation - Prescription Drug & Pharmaceutical Services - Reimbursements

Dear Members of the Maryland State House and Senate,

My name is Veronica Roderick and on March 4, 2012, I was a Resident Assistant/Med Tech and involved in a work-related incident, which resulted in the saving of four people's lives, including myself. I sustained trauma to my neck, back, bilateral shoulders and bilateral ulnar nerves. I have undergone two surgeries and am awaiting three, possibly four, additional procedures, including a total shoulder replacement, in addition to loss of use of one of my arms. These injuries have left me disabled and no longer able to work.

Since my injury, I have been denied the majority of monetary compensation, physical treatment, and medications. Resulting in loss of my home of 23 years to foreclosure, filing bankruptcy and indebted to personal loans. I had to place surgeries on my BCBS, friends paid for me to have transportation to physical therapy after surgery, along with paying for all my medications. All this while I was also fighting cancer.

I was at the "end of my rope." I needed these meds to get a small amount of relief and give me the ability to function just enough to manage some ADL, for a reasonable quality of life. I now have Rescue Meds; I no longer have to wonder how to get my medications. If I do not get the medical treatments and medications needed, I could end up being wheelchair bound. To some this is a fight for repayment, percentage of cost/reimbursement(s) and other politics, but to us, the injured worker and our loved ones, the fight is a matter of life, to which holds no price that can ever be paid.
The reimbursement rates being proposed are unreasonable with the use of an acquisition cost index and will prevent access to critical healthcare for the injured workers.
I pray that you or others standing in position not only show mercy but extend justice towards us.

Sincerely,

Veronica Roderick

Veronica Roderick

Victor Ferreira - Testimony Opposing SB306.pdf
Uploaded by: Victor Ferreira
Position: UNF

Victor Ferreira
6014 Traceys Landing RD
Tracys Landing, MD 20779

March 26, 2025

The Honorable C.T. Wilson
Chairman, Economic Matters Committee
Maryland House of Delegates
231 Taylor Office Building
Annapolis, MD 21401

RE: **Strong Opposition** to Senate Bill 306 - Workers' Compensation - Prescription Drug & Pharmaceutical Services - Reimbursements

Dear Chairman Wilson,

My name is Victor Ferreira, Fire Chief at Baltimore/Washington International Thurgood Marshall Airport and I am an injured worker residing in the State of Maryland, presently steering the complexities of the workers' compensation system. I am writing to formally request your opposition to Senate Bill 306.

Prior to my discovery of RescueMeds, I faced significant obstacles in obtaining necessary prescriptions, despite possessing an official order from the Workers' Compensation Commission. My local pharmacy categorically refused to fulfill my medication needs, resulting in prolonged pain and uncertainty regarding my next steps.

The introduction of RescueMeds has been transformative. Upon receiving prescriptions from my physician, they efficiently deliver the medications directly to my residence without delay. Their services have been instrumental to my well-being, and I do not express this sentiment lightly.

Senate Bill 306 threatens to eliminate this crucial support system for me and numerous other injured workers who are striving to survive both physically and financially. I have been engaged in this process for several years. Despite a ruling affirming my disability from the Commission, the insurance company continues to contest the provision of my benefits.

RescueMeds remains my sole source of assistance during this challenging time. Other pharmacies have informed me that the insurance has discontinued my coverage and

that they are unable to provide assistance. In contrast, RescueMeds has consistently supported me throughout this ordeal.

I urge you to carefully consider the ramifications of Senate Bill 306. It is imperative that this critical support not be removed. I implore you to stand in solidarity with all injured workers in Maryland who rightfully deserve the opportunity to heal and have their voices heard.

Sincerely,

Victor Ferreira

Victor Ferreira
Fire Chief at BWI Airport

Testimony Before the Maryland Economic Matters Com

Uploaded by: Yeshvant Navalgund

Position: UNF

Yeshvant Navalgund, MD
National Spine & Pain Centers
1600 Crain Highway South, Suite 301
Glen Burnie, MD 21061

2/24/2025

Dear Chairperson C. T. Wilson, Vice Chairperson Brian M. Crosby, and esteemed members of the Economic Matters Committee,

Thank you for the opportunity to provide testimony on Senate Bill SB 306. I serve as the Chief Medical Officer of National Spine & Pain Centers, which operates 12 locations across Maryland, staffed by 14 physicians and a dedicated team of employees.

As Interventional Pain Specialists, we work extensively with injured workers, where effective medication management is a crucial aspect of their treatment and recovery. We want to express our serious concerns regarding the changes proposed by SB 306, which would significantly impact access to essential medications for injured workers in Maryland.

Access to Medication: An Ongoing Challenge

- For many injured workers, obtaining prescribed medications is already a daunting hurdle.
    - Our offices frequently field calls with the same urgent concern, "The pharmacy won't fill my medication." This is a widespread and persistent issue that would only become worse under Senate Bill SB 306.
    - Pharmacies may be unwilling to fill prescriptions fearing they will not receive payment, or the sums received will not cover their expenses.

Delays in Treatment Harm Patient Outcomes

- The administrative barriers introduced by this bill are not simply inconvenient, they pose tangible, harmful delays in treatment for injured workers.
- These delays can force individuals to go days or even weeks without critical medications they need to manage pain and inflammation.
- Studies and professional experience demonstrate that untreated pain and inadequate treatment result in severe consequences, including:
    - Hindered recovery times
    - Extended disability durations
    - Escalating long-term medical costs
    - Burden on Employers

Unintended Consequences of SB 306

The changes proposed in this bill may unintentionally create widespread repercussions that extend far beyond the stated objectives. Specifically, there are three major concerns we urge you to carefully consider:

1. **Financial Burden on Workers**

Many injured workers could be forced to cover out-of-pocket medication costs or turn to their private insurance, which presents significant financial strains. Those without access to private insurance will likely rely on Medicaid, further pressuring an already stretched system.

2. **Provider Disengagement**

Physicians and providers may opt out of treating injured workers altogether due to delays, administrative burdens, and the negative impact these have on patient outcomes. This will significantly restrict access to care for those who need it most.

3. **No Documented Cost Concerns**

Our research has not revealed any evidence that medication costs for injured workers in Maryland have been a point of concern. Introducing such drastic changes without clear evidence risks solving a problem that doesn't exist, inadvertently creating new issues instead.

The Way Forward

Ensuring that injured workers in Maryland receive timely, effective treatment is non-negotiable. SB 306, while likely well-intentioned, introduces barriers that could severely impede access to care and drive unintended financial and systemic consequences.

We urge this Committee to revisit the proposal within this bill, prioritize the needs of those directly impacted, and collaborate with stakeholders to pursue alternatives that protect access to essential medications for our injured workers.

Thank you for your time and consideration.

Respectfully submitted,

Yeshvant Navalgund, MD
Chief Medical Officer
National Spine and Pain Centers

Letter to ECM - Prescription Fee Guide.pdf
Uploaded by: Maureen Quinn
Position: INFO

Maryland
WORKERS' COMPENSATION COMMISSION

10 East Baltimore Street, Baltimore, Maryland 21202-1641
Phone: 410-864-5100 • MD Toll Free: 1-800-492-0479
TTY Users Call Via Maryland Relay
www.wcc.state.md.us

March 24, 2025

C. T. Wilson, Chair
House Economic Matters Committee and Esteemed Committee Members

Re: WCC LETTER OF INFORMATION
2023 ATTEMPT TO ADOPT A PRESCRIPTION FEE GUIDE
BY REGULATION

The information below explains current pharmacy reimbursement rates and recounts our agency's unsuccessful effort in 2023 to adopt a pharmacy fee guide by regulation.

CURRENT LAW

Maryland pharmacies dispensing medication to workers' compensation patients are reimbursed at "usual and customary" rates. In practice, most pharmacies have contractually agreed to reimbursement rates so they don't need to repeatedly litigate "usual and customary" rates. A pharmacy that cannot reach an agreement with an insurance company has a hearing before the Workers' Compensation Commission to resolve their disagreement. These hearings can involve a single dose of medication or many months of prescriptions. It is important to note that these hearings do not involve the claimant: the sole issue is the rate of reimbursement and not the medical necessity for the medication (also, regardless of the outcome of the hearing, the claimant cannot be "balance billed" for their medications). A dissatisfied party can appeal the WCC Order to the Circuit Court.

WHY WE SOUGHT TO CHANGE CURRENT LAW

When I became Chair in March 2023, there was a 22 month backlog of pharmacy/insurance company disputes. In all of these instances, the petitioning pharmacy gave the Claimant the medication and litigated later. From the pharmacies' and the insurance companies' standpoint, this was an expensive way to do business. Both stakeholder groups urged our agency to adopt a prescription fee guide so that reimbursements could become a clerical function without any need for litigation.

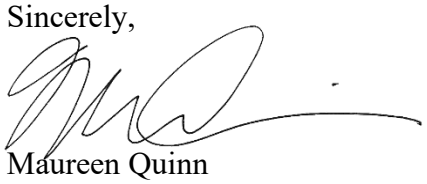
OUR EFFORTS AND THE OUTCOME

I asked the WCC Medical Fee Guide Committee, a COMAR created advisory Committee that regulates non-hospital medical fees, to find a broad consensus in favor of a reimbursement methodology. The Medical Fee Guide Committee is composed of physicians, medical providers and attorneys for claimants, governmental entities and private insurance companies. Members were asked to educate themselves on the various methodologies used by workers' compensation systems around the country. A public hearing was held before the WCC Medical Fee Guide Committee in October 2023.

After the hearing, the members of the Medical Fee Guide were roughly evenly divided between the AWP reimbursement methodology and the NADAC reimbursement methodology. This was not the broad consensus I had hoped for. I did not believe that AELR would approve regulations changing our reimbursement method if we lacked a consensus for change. As I pondered a way forward, another event occurred which affected our deliberations. The Pennsylvania Supreme Court, in January 2024, struck down the state's AWP reimbursement methodology on grounds that the publication for looking up AWP prices was not, in fact, the average wholesale price. Let me emphasize that the problem was not the AWP methodology, the problem was there wasn't a publication anywhere in the country that published AWP prices. If we cannot look up prices in a book (or an e-subscription), we cannot implement a fee schedule. I was concerned that if we adopted AWP, our regulation would be struck down by AELR or the courts for the same reason.

A second reason weighed upon me. I also believed that both our Fee Guide Committee members and our Commissioners (including myself) lacked the public policy knowledge that should underpin any decision that could potentially disrupt markets. For these two reasons, I pressed the "pause" button on the deliberations of the Medical Fee Guide Committee.

Sincerely,



Maureen Quinn
Chair

MQ:asl