October 9, 2024

Good Morning. My name is Noah Karn. I am the Vice President of the Insurance Federation of Pennsylvania, a multi-line state trade association that includes commercial workers' compensation carriers among its members.

I appreciate the opportunity to testify today on the subject of drug pricing in Pennsylvania's workers' compensation system, specifically in the context of the **Federated Insurance Company v. Summit Pharmacy** case.

Our industry is focused on promoting fair, transparent, and cost-efficient insurance practices that protect both employers and injured workers. One of the major cost drivers in the workers' compensation system is the price of prescription drugs.

Just last week, the Workers' Compensation Research Institute (WCRI) released new findings that will help contextualize today's discussion:

- **Injured workers in Pennsylvania receive more prescriptions than in almost any other state.** While the total percentage of workers' compensation claims with a prescription has steadily decreased since 2014, the average number of prescriptions per claim is among the highest in the country at 7.6.

- **Drugs provided to injured workers are more expensive in Pennsylvania than in other states.** At $2,262, prescription costs per claim are the second highest nationally behind Louisiana. Since 2018, average prescription payments per claim have increased 21% year-over-year.

- **Certain drug categories are driving the cost of prescriptions in the workers' compensation setting.** Dermatological agents (55%) and musculoskeletal therapy agents (13%) together account for over two-thirds of all prescription drug payments in Pennsylvania.

Overutilization and inflated drug prices lead to higher workers' compensation premiums for Pennsylvania businesses. Controlling these costs is crucial, not just for maintaining competitive insurance rates, but also for ensuring that injured workers have access to the medications they need without delay or dispute.

The primary way we control drug costs in the workers' compensation system is through the use of pricing benchmarks. But the benchmarks we use must accurately reflect market prices. When pricing data is inflated or inconsistent with real-world acquisition costs, it leads to payment disputes, inflated reimbursements, and ultimately higher costs for the entire system.

With respect to the litigation currently pending before the state Supreme Court, the central issue is the Bureau's reliance on the IBM Health Watson "Red Book" as its benchmark for prescription drug values in payment disputes between pharmacies and workers' compensation insurers.

It's important to note that Section 306(f.1)(3)(vi)(A) of the Workers' Compensation Act and the Bureau's accompanying cost containment regulations cap reimbursement for drugs and professional pharmaceutical services to 110% of the Average Wholesale Price (AWP) of the product, calculated on a per unit basis, as of the date of dispensing. The term "Average Wholesale Price" is especially relevant as it relates to the litigation.

In most cases, especially with in-network pharmacies, drug reimbursements are contractually predetermined at a discounted rate. These negotiations begin with benchmark values that are agreed upon by the network pharmacy and the insurer.

However, with out-of-network pharmacies, reimbursement disputes can and do arise and the pharmacy can initiate the fee review process to dispute the payment made for services rendered to an injured worker. Since November 1995, the Bureau has relied on the Red Book as its benchmark for determining the AWP of drugs and, therefore, pharmacy reimbursement rates in the event of a dispute.

In **Federated**, the Commonwealth Court determined that the Red Book values adopted and used by the Bureau to resolve payment disputes are inconsistent with the statutory language of the Workers' Compensation Act, which caps reimbursement at 110% of the Average Wholesale Price (AWP).

In its statement of policy, IBM Health Watson notes that the AWP it publishes "is, in most cases, the manufacturer's *suggested* AWP and does not reflect the *actual* AWP charged by a wholesaler" – something akin to the MSRP or "sticker price" of an automobile.

The AWP values published in the Red Book are reported directly by drug manufacturers, and IBM Health Watson does not independently verify the data to ascertain the amounts actually paid by providers (pharmacies) to wholesalers.

The Commonwealth Court rejected Summit Pharmacy's argument that AWP is a "term of art" and instead relied on precedential case law which held that "AWP was intended to be an objective estimate of the costs of acquiring drugs derived on a national basis."

Stated differently, "the plain meaning of AWP is a price that is an industry average, not one that is charged by a single manufacturer, and is a number derived by averaging the wholesale prices of all manufacturers or wholesalers."

In short, the AWPs found in the Red Book are inaccurate, inflated, and have distorted the true market value of prescription drugs.

In response to this ruling, the court directed the Bureau to identify an alternative benchmark, one based on nationally recognized and verifiable drug acquisition cost data. Notwithstanding the appeal that is currently before the Supreme Court, this directive has set the stage for a more equitable and accurate drug pricing system in Pennsylvania's workers' compensation program.

As discussed in the litigation, the National Average Drug Acquisition Cost (NADAC) index is often lauded as a more accurate reflection of the prices pharmacies pay to acquire medications. While it is true that NADAC data omits rebates, discounts, and other post-purchase financial arrangements, unfortunately, NADAC does not publish Average Wholesale Prices (as required by the statute) and comes with some significant limitations.

First, NADAC primarily reflects retail pharmacy prices and may not fully account for specialty or compound drugs, which are increasingly prevalent in workers' compensation claims. Based on a survey of our members, NADAC may only capture 70-90% of drugs commonly prescribed to injured workers. If NADAC became the new pricing benchmark and a drug not listed on NADAC were prescribed, insurers could be left paying exorbitant charges for unproven or even experimental therapies.

Data lag is another major concern. NADAC is updated periodically, but there can be delays between market price fluctuations and their reflection in NADAC data. This could lead to discrepancies in drug pricing during periods of rapid price change. Furthermore, NADAC relies exclusively on voluntary data submissions from pharmacies, which can result in incomplete data, potentially skewing price averages.

From our perspective, the General Assembly should wait for the litigation to play out before exploring any possible legislative remedy. That said, the limiting language of Section 306 may necessitate further amendments to the Workers Compensation Act, otherwise the Bureau will continue to struggle in identifying a pricing benchmark that conforms to the statutory Average Wholesale Price standard.

Regardless, the **Federated Insurance Company v. Summit Pharmacy** case has exposed the limitations of relying on outdated and inflated pricing benchmarks like the Red Book. Moving forward, we must adopt more transparent and accurate pricing systems to ensure fairness for both injured workers and the employers who support them.

Thank you again for the opportunity to address this important issue. I look forward to answering any questions you may have.