Mike Burns

2025 Special Committee on Pharmaceutical Studies

Committee Members,

My name is Mike Burns, pharmacist and owner of AuBurn Pharmacy. I have been operating community pharmacies in Kansas for over 30 years. My wife, Eileen and I also own several other small businesses here in Kansas. I am here today to share with you my personal experiences as a patient, pharmacist and more specifically, a small business owner. You will hear a lot today about PBM's, their practices, and the devastating effects on healthcare in Kansas. You will also hear testimony that attempts to defend those practices. I will present facts - facts as a patient, pharmacist, business owner and healthcare provider.

The vertical and horizontal integration of PBMs and large insurers has resulted in an oligopoly that functions today as a monopoly. This monopoly allows PBMs to drive out competition, forcing more patients and employers into their integrated models where they inflate prices, driving greater profits to themselves and increase costs to taxpayers, employers and patients.

These corporate giants claim that their models control cost. I agree - but for whose benefit? Theirs and theirs alone. In this wake of destruction, we see more pharmacy closures, limiting access to quality, local and affordable care. However, they create fear by spreading the narrative that if PBM reform happens, costs will increase. It is quite the opposite. PBM reform creates transparency, increases patient access to quality care and lowers costs.

Dozens of other states have already taken these steps. Kansas is simply behind, denying Kansans patients, taxpayers, patients and providers of what they deserve. Please review the attached results of PBM reform in other states. The evidence is clear. PBM reform SAVES money for all stakeholders.

In addition to states' savings from PBM reform, dozens of states, including Kansas, have caught many PBMs in fraud, waste and abuse. These practices have resulted in overcharges, hidden fees, and contract violations. Please note that Kansas AG Derek Schmidt settled fraud allegations with Centene in 2021 for $27.6M.

What does all this mean for Kansas employers, employees and taxpayers? It means that each year we don't get PBM reform, we continue to support a broken system. A system that adds billions in profits to the PBMs and their health plan partners and contributes to the escalation of healthcare costs in Kansas.

Mercer, a benefits consultancy firm, predicts an average of a 9% increased healthcare costs for employers and employees in 2026. (https://www.npr.org/2025/09/12/nx-s1-5534416/health-care-costs-soaring-blame-your-employer)

I now want to share a personal story with you.

About six years ago, I heard three words: "You have cancer". As a result of my diagnosis, my team of doctors created a plan that included radiation and chemotherapy. I was in a unique situation where I was now the patient, the pharmacist, pharmacy owner, and plan sponsor (the one responsible for providing the health plan for myself and our employees).

Along with my radiation and IV therapies, I was prescribed capecitabine, an oral chemotherapy.

Mike Burns

AuBurn Pharmacy was contracted with BCBS Kansas, with OptumRx as their PBM. In preparation for my treatment, I attempted to fill my prescription at my pharmacy. I had the medication on my shelf and was contracted to fill AuBurn employee prescriptions through BCBS KS/OptumRx. Much to my surprise, the claim was rejected, with the direction to fill the medication at the OptumRx “specialty” pharmacy. Please refer to documents I have attached that show the results of sending my prescription to the PBM-owned “specialty” pharmacy.

The PBM determines which medications are “special”. They claim medications are special due to cost and/or a more complicated, complex therapy.

My pharmacy had capecitabine on the shelf, and I was contracted with OptumRx to dispense prescriptions for my employees. My cost for capecitabine, after all rebates, for the full 6 months of therapy, was around $2000. Acceptable professional fees to fill those prescriptions for 6 months would have been $300, for a total of $2300 total billed to the plan.

Please pay particular attention to what was billed to my plan and allowed by the PBM, once the prescription went to the PBM-owned “specialty” pharmacy.

My plan paid $15,300 to the PBM-owned pharmacy vs what would have been $2,300 if dispensed at my own Kansas pharmacy. Not only did this practice prohibit a patient from accessing their local pharmacy but it INCREASED the plan cost by $13,000, an over 4000% increase in costs. This obviously increases my plan expenses, which in turn would trigger an increase in premiums the following plan year. To add insult to injury, not once did I get a phone call from the PBM-owned pharmacy offering to counsel me on this incredibly “complex” therapy.

I don’t have to explain how wrong this is. And this is happening thousands of times daily across our country and right here in Kansas.

I want to also share my experience as the plan sponsor when I decided to finally cut out the middleman, the PBM and move to a self-funded health plan with a fully transparent PBM, who only processes claims. No mail order, no specialty, no spread pricing, no manufacturer kickbacks kept by the PBM and insurance company. Please refer to documents provided regarding health plan costs for AuBurn over the last 5 years.

Once AuBurn removed the PBM and other middlemen, our costs have remained flat. Very remarkable, when annual increases had been nearly 10% before the change and at the same time, we increased our benefits for employees, adding an HSA and a buy-up plan option.

The facts are clear. Meaningful PBM reform does not increase costs - it reduces costs. Other states have shown that. AuBurn Pharmacy proved that.

Today, pharmacy is not a free market - it is a monopoly. I have been told by Kansas legislators that they don’t feel it is right to get in the middle of private negotiations with businesses. When a monopoly exists, you must. You owe it to all that you represent.

On behalf of Kansas taxpayers, patients, employers and employees, I urge you to enact PBM reform legislation to eliminate anticompetitive practices, ensure access to quality pharmacy service and restore a competitive market.

Thank you and I welcome any questions.

DEMONSTRATED STATE SAVINGS

State	Reform Type	Estimated Savings / Impact
Ohio	Pass-through pricing, single PBM	~$184M annual savings; pharmacy reimbursements ↑
West Virginia	Pharmacy carve-out in Medicaid	$54.4M first year; $122M to pharmacies
Kentucky	Ban spread pricing, transparency	$123M spread uncovered; led to reforms
New Jersey	Reverse auction for PBM procurement	25% drop in drug cost first 9 months
Colorado / MN / NH	Reverse auctions	$6–28M estimated savings annually
Maine / Washington	Rebate pass-through and data reporting	Better pass-through, increased transparency

References:

https://nashp.org/states-assert-their-drug-purchasing-power-to-capture-savings-for-medicaid/

https://ncpa.org/sites/default/files/2022-11/spread-pricing-infographic-2022.pdf

https://ncpa.org/spread-pricing-101

https://www.techtarget.com/pharmalifesciences/feature/Understanding-spread-pricing-how-PBMs-influence-drug-costs

https://www.ncsl.org/health/pharmacy-benefit-manager-reform?utm_source=chatgpt.comhttps://www.techtarget.com/pharmalifesciences/feature/Understanding-spread-pricing-how-PBMs-influence-drug-costs

https://nashp.org/legislative-approaches-to-curbing-drug-costs-targeted-at-pbms-2017-2021/

https://www.pbmaccountability.org/policy-ideas

STATES WITH NADAC+ DISPENSING FEE MODELS:

State	Model	Dispensing Fee	Reported Savings / Impact
California	FFS NADAC + $10.05	$10.05	~$380M net state savings; $144M pharmacy payment gain
Ohio	Managed care → NADAC/AAC + tiered fee	Tiered COD-based fee	$10–13M program-level NCC savings; pharmacy revenue ↑
West Virginia	Fee-for-service NADAC+fee	State survey–based	$54.5M savings; ~$116M more pharmacy reimbursement
Minnesota	FFS NADAC (or WAC–2%) + $11.35	$11.35	+2.5% financial boost across pharmacy types; $6.5M FY cost
Iowa, MT, NC, NE, NM, KY, MI	Legislative mandates of NADAC+fee & no spread	~$10–15 (varies)	Pending implementation; framework increasingly adopted

https://www.ipcrx.com/government-relations-for-independent-pharmacies/advocacy-in-action/

https://www.ipcrx.com/pharmacy-blog/legislative-advocacy/state/state-medicaid-managed-care-reforms/

https://omny.fm/shows/pharmacy-podcast-network/capital-rx-and-3-axis-advisors-study-finds-potenti

https://ohiopharmacists.org/aws/OPA/pt/sd/news_article/152198/_PARENT/layout_interior_details/false

https://www.pharmacytimes.com/view/pbm-reform-takes-off-in-2025

https://www.pharmacytimes.com/view/two-surprising-developments-in-1-week-shake-up-the-pbm-mail-order-business

State-Level PBM Reform Report: NADAC + Dispensing Fee Models and Their Impact

Overview
States that have adopted NADAC (National Average Drug Acquisition Cost) plus professional dispensing fee reimbursement models for Medicaid prescriptions have demonstrated:

- Significant taxpayer and Medicaid program savings
- Improved reimbursement and financial stability for independent pharmacies
- Increased pricing transparency and reduced PBM influence

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1. California (Medi-Cal)
Model: NADAC + $10.05 dispensing fee (fee-for-service Medicaid)
Implementation: January 2021 (carve-out from managed care)
Results:

- Estimated **$380 million in taxpayer savings** in first year
- **$144 million restored** to independent pharmacies through elimination of clawbacks
- Significant improvement in claim-level reimbursements and fewer underpaid claims
  Source: IPCRx – California PBM Reform

2. West Virginia
Model: NADAC + state-calculated dispensing fee (fee-for-service Medicaid)
Implementation: July 2017 (full carve-out from managed care)
Results:

- **$54.5 million in state Medicaid savings** in first year
- **$116 million increase in pharmacy reimbursements**
- Successful restoration of payment predictability and stability for independents
  Source: IPCRx – West Virginia Medicaid Reform

3. Ohio
Model: NADAC or AAC + tiered dispensing fee (single PBM contract under managed care)
Implementation: 2022
Results:

- Reimbursement to independents increased by approximately **995%** (especially for generics)
- Estimated **$10–13 million in Medicaid program savings**
- Pharmacy reimbursements now based on actual acquisition costs plus professional fees
  Source: IPCRx – Ohio Medicaid Reform

4. Michigan
Model: NADAC + tiered dispensing fee ($9–$20 per script depending on volume and drug type)
Implementation: 2021 (applied to Medicaid MCOs)
Results:

- Eliminated spread pricing and PBM clawbacks
- Improved reimbursement transparency and viability for rural and independent pharmacies
  Source: IPCRx – Michigan Medicaid Reform

5. New York
Model: NADAC + $10.18 dispensing fee (fee-for-service Medicaid)
Implementation: Scheduled for full rollout by November 2024
Expected Impact:

- Replaces managed care PBM payment models with standardized, transparent pricing
- Guarantees pharmacy reimbursement meets or exceeds acquisition cost plus fee
- Anticipated improvement in pharmacy sustainability
  Source: NY Medicaid Update – November 2024

Other States with Legislative NADAC + Fee Models or Proposals

- **Kentucky, Iowa, Montana, North Dakota, Nebraska, New Mexico**: Enacted or pending bills mandating NADAC + dispensing fee models and banning spread pricing.

- Dispensing fees vary from **$10 to $15 per script**, often tiered by pharmacy volume or drug type.

- Reforms often include PBM transparency, rebate pass-through, and anti-steering provisions.
  Source: NCPA – State PBM Reform Tracker
  Source: RxBenefits – 2024 State-Level Regulatory Update

Key Takeaways

- States implementing NADAC + dispensing fee models **consistently realize savings** and **support independent pharmacies**.

- Transparent reimbursement standards reduce audit risk, post-claim clawbacks, and spread pricing.

- Pharmacies report **positive margins on most Medicaid scripts** under these models, often earning $10–12 gross profit per claim.

- Policymakers, especially in rural states, are increasingly turning to this model to **stabilize access to pharmacy care**.

Medicaid giant Centene settles fraud allegations with Kansas for $27.6M

BY: **MARTY SCHLADEN** - DECEMBER 7, 2021 3:05 PM

Kansas Attorney General Derek Schmidt on Monday announced the state had reached a $27.6 million settlement with Centene as part of an investigation into pharmacy benefit managers. (Joe Raedle/Getty Images)

Centene, the nation's largest Medicaid managed care provider, has settled fraud allegations with a fifth state, Kansas Attorney General Derek Schmidt announced Monday.

The $27.6 million Kansas settlement comes after Mississippi, Illinois and Arkansas announced settlements totaling $154 million. All of those follow

a settlement with Ohio — the only state to sue the company — of $88.3 million.

At the time it announced the Ohio settlement, Centene said it was setting aside $1.1 billion to settle such claims with 22 states.

In a statement, the Kansas Attorney General's office said Centene shirked its duty to protect taxpayers.

"In general, Schmidt accused the company of failing to satisfy its obligation to represent the state's best interests in negotiations with other companies that supply drugs to the state Medicaid program," the statement said.

It added that Schmidt's office started investigating pharmacy middlemen known as pharmacy benefit managers, or PBMs, after investigations by Ohio Attorney General Dave Yost became public in 2019. Yost has been investigating the middlemen on several fronts and currently is suing two — Express Scripts and OptumRx — on allegations they defrauded the Ohio Highway Patrol Retirement System and the Ohio Bureau of Workers Compensation, respectively.

"We take seriously our role of protecting Kansas taxpayers and finding and stopping fraud and overpayments in the state Medicaid program," Schmidt said. "Today's settlement involving PBM practices is the first of its sort in Kansas, and other investigations continue."

Among their duties, PBMs reimburse pharmacies for drugs, and Yost's lawsuits accuse the companies of not living up to such contractual obligations as passing along discounts as well as overcharging in other ways.

Centene's main business is as a managed care provider, meaning that it acts as an insurance company on behalf of such government programs as Medicaid, which serves the poor and disabled, and Medicare, which serves Americans over 65. But it also has PBMs of its own.

Yost's Ohio investigation of Centene was announced after The Columbus Dispatch in 2018 revealed that Centene's managed-care plan used its own PBM in conjunction with CVS Caremark and appeared to bill taxpayers $20 million for duplicate services in 2017. CVS initially said it provided the services Centene's PBM supposedly was providing, but later said it and Centene provided distinct services that fell into the same categories.

On June 16 — two days after announcing settlements with Ohio and Mississippi — Centene held a virtual investor day. During it, Michael Neidorff, the company's $25 million-a-year CEO, stressed that the company admitted no wrongdoing and he added that his No. 1 and No. 2 priorities were to grow profits.

Discussing what he hoped investors would take away from the event, Neidorff said, "First, our absolute priority moving forward is margin expansion to 4% pre-tax and no less than 3.3% adjusted net income on a sustainable basis. Secondly, margin expansion."

In response to news coverage, the company later issued a statement attempting to walk that statement back.

"It is not accurate to say that Michael Neidorff indicated that profits are a higher priority than providing quality care to the members we serve and being a good steward of taxpayer dollars," it said.

Centene didn't immediately respond Tuesday when asked why, if it did nothing wrong, the company was prepared to pay out more than $1 billion to settle fraud claims. The company also didn't respond when asked, if Centene was unwilling to be transparent about that issue, it should be trusted with billions of taxpayer dollars.

At least among Ohio Medicaid officials, Centene retains that trust. The company was one of six to be awarded part of $22 worth of managed-care business starting next year. Also receiving a contract was a UnitedHealth subsidiary even though that company's PBM is still being sued by Yost.

In court, Medicaid officials conceded that the procurement didn't consider past allegations of wrongdoing against the applicants.

There may have been some consequence of the actions by the attorneys general, however. It's unclear whether the move is related to this year's settlements, but Centene — the nation's 24th largest corporation by revenue — in late October announced that it was getting out of the PBM business.

Meanwhile, investigations into the practices of pharmacy middlemen are ongoing.

Yost, the Ohio AG, has a team dedicated to investigating such companies. Schmidt, his Kansas counterpart, is doing something similar.

"We take seriously our role of protecting Kansas taxpayers and finding and stopping fraud and overpayments in the state Medicaid program," he said in a statement. "Today's settlement involving PBM practices is the first of its sort in Kansas, and other investigations continue."

Court Findings vs. PBMs

Kansas

Kansas v. Centene/Envolve (2021) –
*Settled for **$27.6M***
Allegations: Overbilling Kansas Medicaid; failure to pass through discounts; transparency reforms.

"Kansas Will Get $27.6 Million from Settlement over Medicaid Pharmacy Benefits." *KCUR*, 30 June 2021, https://www.kcur.org/news/2021-12-06/one-of-americas-richest-companies-pays-kansas-27-6-million-over-medicaid-misconduct

Carpenter, Tim. "Centene to Pay Kansas $27.6 Million in Medicaid Drug Benefits Settlement." *Kansas Reflector*, 30 June 2021, https://kansasreflector.com/2021/12/07/medicaid-giant-centene-settles-fraud-allegations-with-kansas-for-27-6m/

Other States & Federal

Ohio v. OptumRx (2022) –
*Settled for **$15M***
Allegations: Overcharges to the **Bureau of Workers' Compensation** (contract/pricing issues).

"Attorney General Yost Announces $15 Million Settlement with OptumRx." *Ohio Attorney General*, 15 June 2022, https://www.ohioattorneygeneral.gov/Media/News-Releases/October-2022/%2415-Million-OptumRx-Settlement-Pushes-AG-Yost

Mississippi v. Centene/Envolve (2021) –
*Settled for **$55.5M***
Allegations: Overpayments to Medicaid; required transparency on pharmacy claims.

"State Auditor Shad White Announces $55 Million Settlement with Centene." *Mississippi Office of the State Auditor*, 14 June 2021, https://attorneygenerallynnfitch.com//2021/06/14/ag-lynn-fitch-auditor-shad-white-announce-55-5-million-settlement-with-centene/?fbclid=IwAR3mwi3euJAu7eSoDk3VFjy0HB-fWSH1md2xRYJaDXqipe4p2zI0u2OIcAc

Illinois & Arkansas v. Centene/Envolve (2021) –
*Settled for **$71.2M** (IL **$56M**, AR **$15.2M**)*
Allegations: Inaccurate billing/overpayments; failure to disclose discounts.

"Attorney General Raoul Secures $56.7 Million from Centene for Medicaid Settlement." *Illinois Attorney General*, 14 June 2021, https://illinoisattorneygeneral.gov/dA/4e66c37126/202109-30%20ANNOUNCES%2056%20MILLION%20SETTLEMENT%20WITH%20PHARMACY%20BENEFIT%20MANAGER.pdf

U.S. (DOJ) v. OptumRx (2024) –
*Settled for **$20M***
Allegations: **Controlled Substances Act** violations (improperly filled "trinity" opioid combos, 2013–2015).

"United States and DEA Reach $20 Million Settlement with OptumRx to Resolve Controlled Substances Act Violations." *U.S. Department of Justice*, 27 Feb. 2024, https://www.justice.gov/archives/opa/pr/optumrx-agrees-pay-20m-resolve-allegations-it-filled-certain-opioid-prescriptions-violation

U.S. (FCA) v. CVS Caremark (2025) –
*Judgment (trial): **$95M → $289.9M** after trebling + penalty*
Findings: Court found Caremark caused insurers to submit **inflated Medicare Part D prices** (False Claims Act).

Raymond, Nate. "Court Triples CVS Penalty to $290 Million in Medicare Fraud Case." *Reuters*, 20 Aug. 2025, https://www.reuters.com/legal/government/cvs-unit-must-pay-290-million-drug-whistleblower-lawsuit-judge-rules-2025-08-20/

Oklahoma v. CVS Caremark (2025) –
*Settled for **$32.1M***
Allegations: Retained rebates/discounts owed to **HealthChoice** (state employee plan).

"Attorney General Drummond Announces $32.1 Million Settlement with CVS Caremark." Oklahoma Attorney General, 23 Apr. 2025, https://oklahoma.gov/oag/news/newsroom/2025/september/drummond-secures-32m-in-settlement-with-cvs-caremark.html

BUSINESS

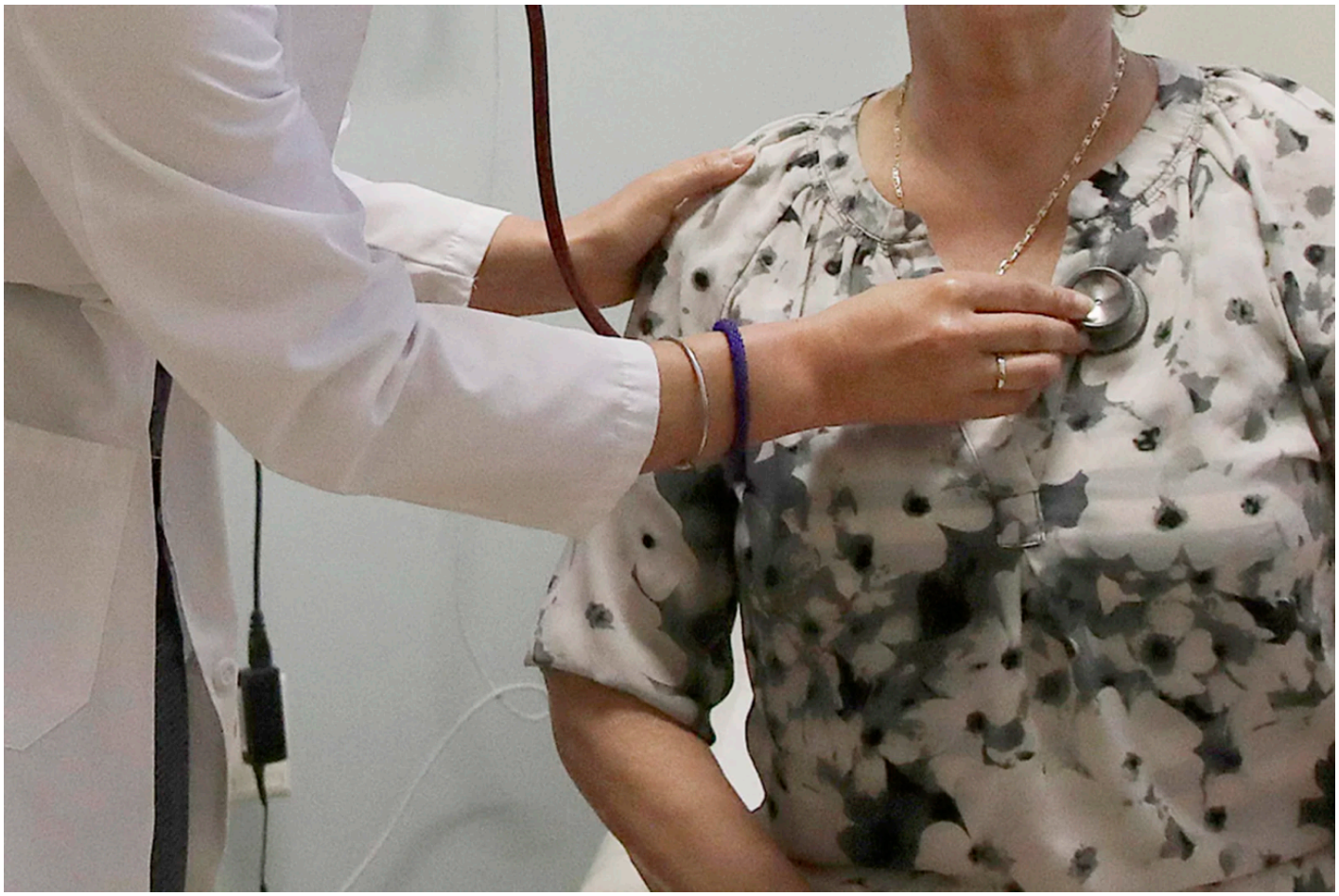
Health care costs are soaring. Blame insurers, drug companies — and your employer

SEPTEMBER 12, 2025 · 5:00 AM ET

HEARD ON ALL THINGS CONSIDERED

By Maria Aspan

3-Minute Listen PLAYLIST TRANSCRIPT



Some 154 million people get health insurance through their employer — and many could see their paycheck

deductions surge next year. Some will likely also see co-pays and other out-of-pocket costs rise.
Jeff Chiu/AP

The United States has the most expensive health care in the developed world. Now it's about to get even more expensive.

Some 154 million people get health insurance through their employer — and many could see their paycheck deductions surge next year, by 6% to 7% on average. Some will likely also see their out-of-pocket costs rise as employers pass along the spiking costs of care.

That's because employers will be paying a lot more — almost 9% more per employee on average, for the same level of coverage — to provide health benefits for their workers. Even after cutting or changing their health care benefits, employers are facing the biggest price increase in 15 years, according to a new survey of more than 1,700 organizations by Mercer, a benefits consultancy.

And 59% of those employers told Mercer they plan to pass those higher prices along to their workers in the form of "cost-cutting changes," such as higher deductibles, copays or other out-of-pocket costs, such as prices for filling prescriptions.

"It's almost a perfect storm that's hitting employers right now," says Larry Levitt, executive vice president for health policy at KFF, a health policy research nonprofit.

"The price of health care is going up faster than it has in a long time," he adds. "And typically when an employer is getting a big increase from an insurer, the employer is turning around and trying to pass on some or all of that to its workers."

The surging health benefit costs come at a time when consumers are still feeling the hangover of pandemic-era record inflation and are generally uneasy about the U.S. economy. Though inflation has cooled considerably in the past two years, prices are starting to tick up again, as many of President Trump's sweeping taxes on imports go into effect.

These soaring costs also underline a hidden-in-plain-sight truth about the broken

U.S. health care system: For the majority of Americans under age 65, their employers ultimately decide how much they pay for health insurance and medical care.

Employers themselves are at the mercy of entities that have even more market power: Drug companies, pharmacy benefit managers, hospitals and others have collectively driven up the costs of accessing medical care in the United States. Health insurers, some owned by gigantic for-profit conglomerates, often draw the blame for the high costs of U.S. health care — as demonstrated by the national outpouring of rage and frustration against UnitedHealth Group, one of the world's largest companies, after the head of its health insurance business was shot and killed last December.

But when it comes down to determining how much most working Americans pay to stay healthy, the buck stops with employers. And now they're planning on charging a lot more.

"It's kind of hidden, because [premium deductions are] coming out of your paycheck and if you're not paying close attention, it may not be obvious," Levitt says. "But your take-home pay is going down."

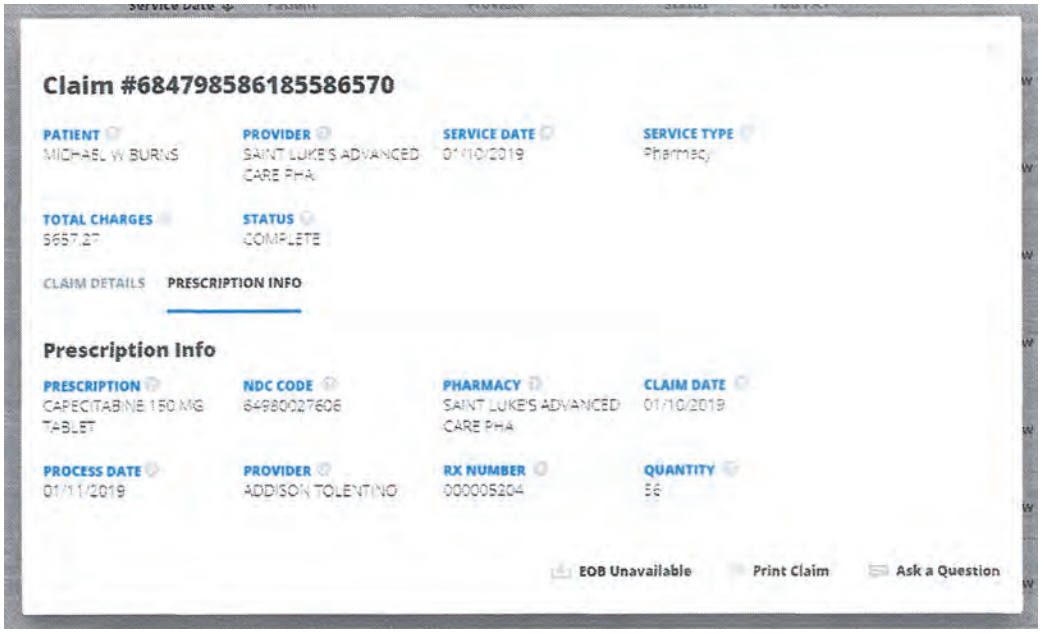
The good and bad news about why prices are rising

Some of the reasons for the rise in health care prices are actually good news. For example, pharmaceutical companies have developed more effective cancer treatments and weight-loss drugs — which they can also charge more for. And after several years when the COVID-19 pandemic and soaring inflation made many people reluctant to seek non-urgent care, more people are going to the doctor or other providers. But that surge in demand has also led to a surge in prices.

Other reasons have to do with a loss of competition. Some hospitals, doctors' offices, insurance companies and other businesses within the health care system have merged or consolidated, often allowing the remaining businesses to raise prices for their services.

"What's missing in health care is: It's not a traditional free market. You don't have those competitive forces," says Sunit Patel, Mercer's chief actuary for health and benefits in the United States.


NDC 70756-815-
Capecitabine
Tablets, USP
150 mg
Rx only
Lifestar
NDC 70756-816-
Capecitabine
Tablets, USP
500 mg
Rx only
Lifestar



Claim #684798586185586570

PATIENT
MICHAEL W BURNS

PROVIDER
SAINT LUKE'S ADVANCED CARE PHA

SERVICE DATE
01/10/2019

SERVICE TYPE
Pharmacy

TOTAL CHARGES
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STATUS
COMPLETE

CLAIM DETAILS | PRESCRIPTION INFO

Prescription Info

PRESCRIPTION
CAPECITABINE 150 MG TABLET

NDC CODE
64980027606

PHARMACY
SAINT LUKE'S ADVANCED CARE PHA

CLAIM DATE
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PROCESS DATE
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PROVIDER
ADDISON TOLENTINO

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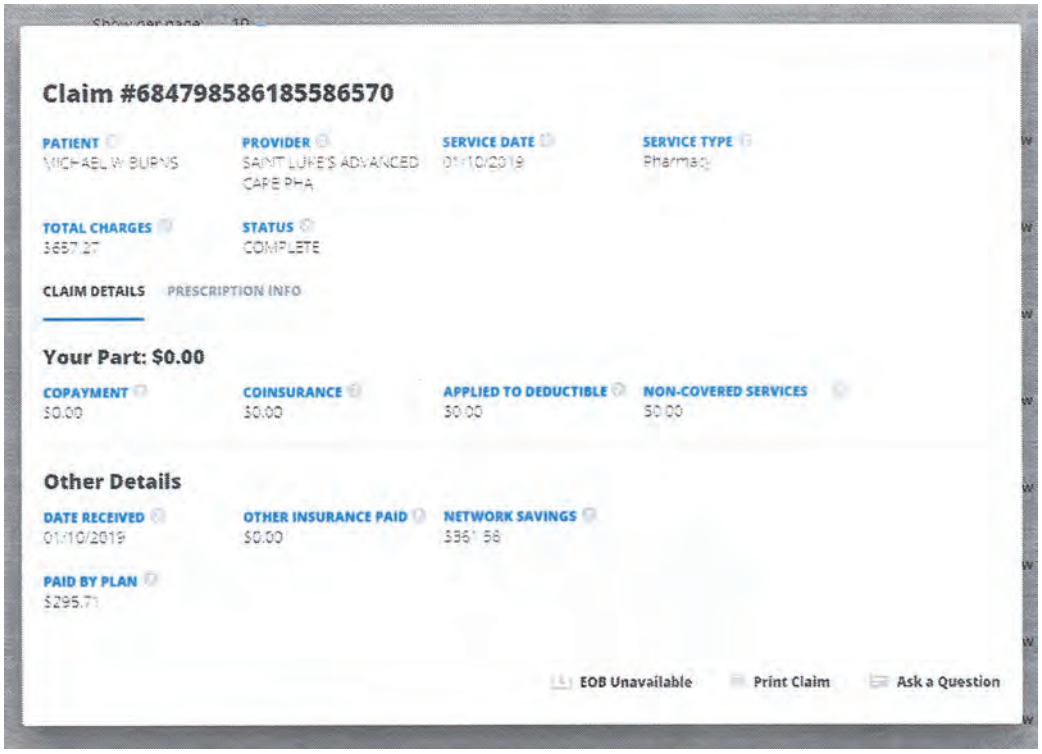

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TOTAL CHARGES
$657.27

STATUS
COMPLETE

CLAIM DETAILS | PRESCRIPTION INFO

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APPLIED TO DEDUCTIBLE
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Other Details

DATE RECEIVED
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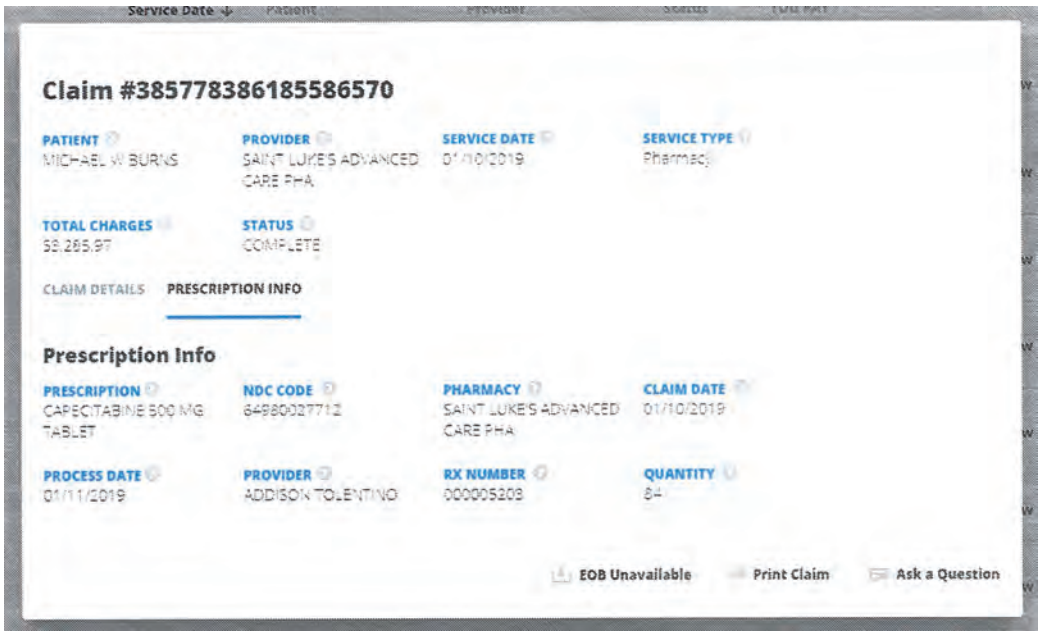
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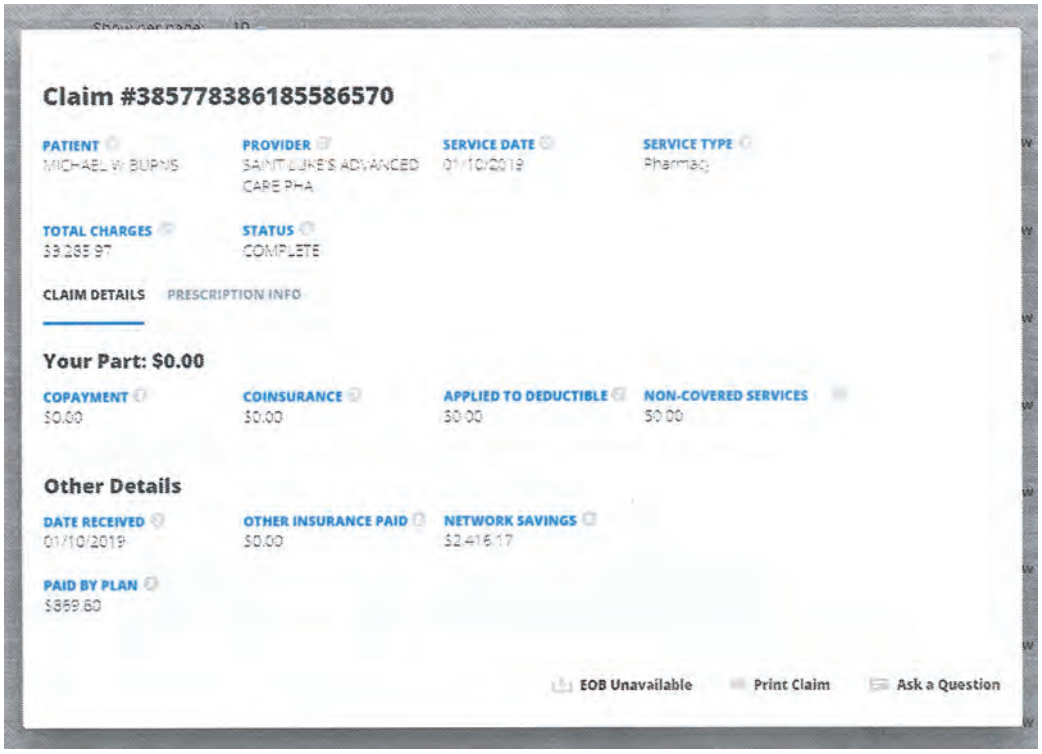
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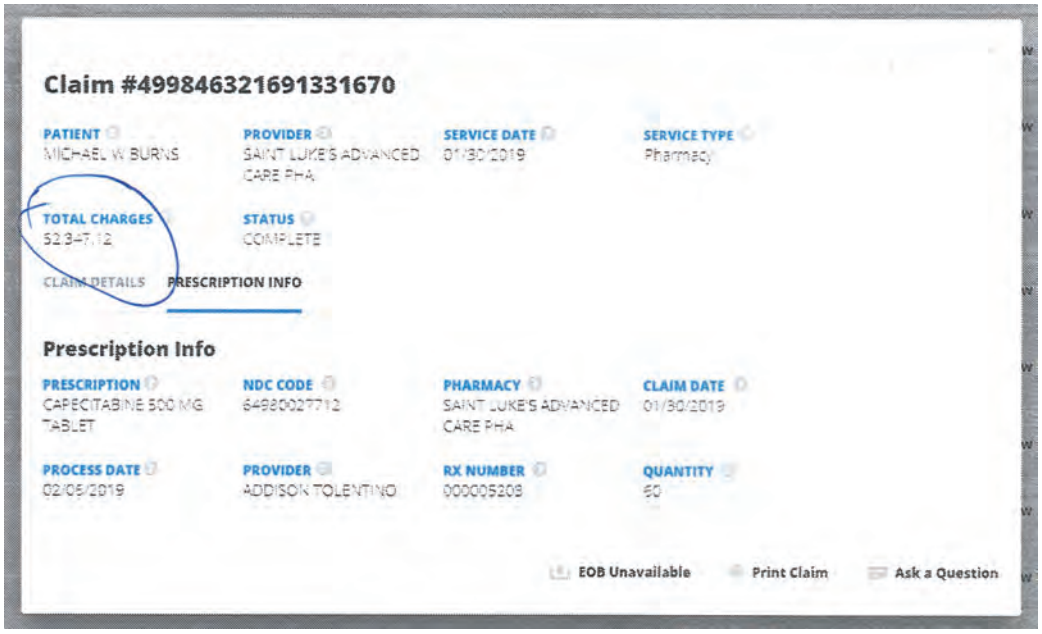
Print Claim
Ask a Question



Claim #499846321691331670

PATIENT
MICHAEL W BURNS

PROVIDER
SAINT LUKE'S ADVANCED CARE PHA

SERVICE DATE
01/30/2019

SERVICE TYPE
Pharmacy

TOTAL CHARGES
$2,847.12

STATUS
COMPLETE

CLAIM DETAILS | PRESCRIPTION INFO

Prescription Info

PRESCRIPTION
CAPECITABINE 500 MG TABLET

NDC CODE
64980027712

PHARMACY
SAINT LUKE'S ADVANCED CARE PHA

CLAIM DATE
01/30/2019

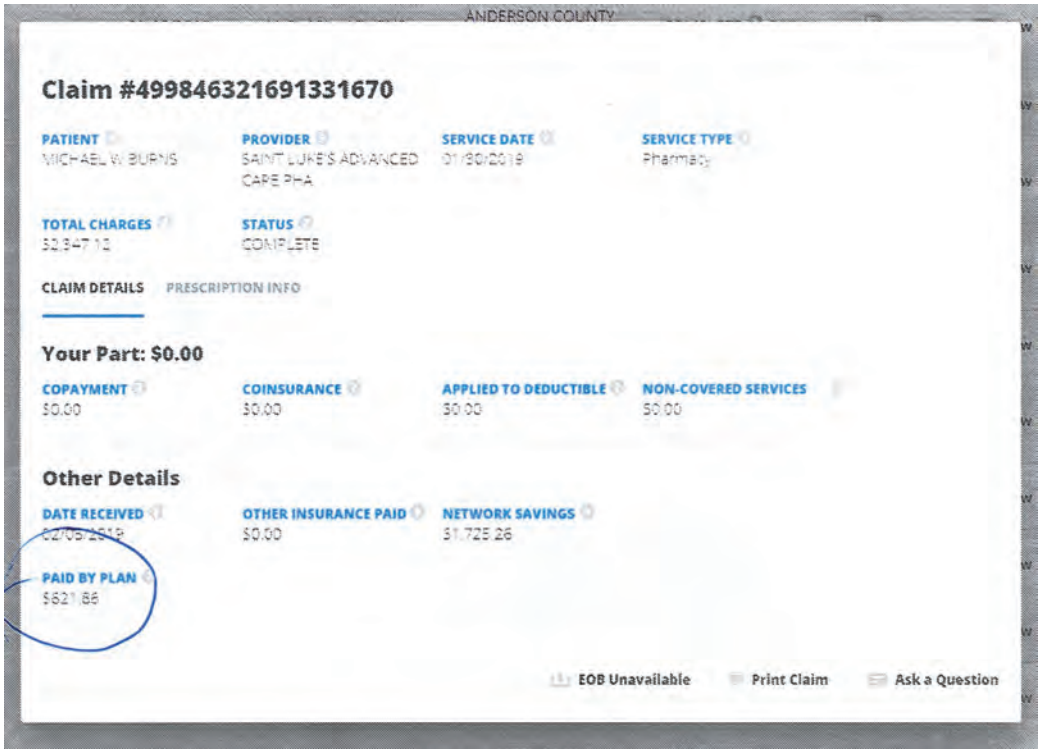
PROCESS DATE
02/05/2019

PROVIDER
ADDISON TOLENTINO

RX NUMBER
000005208

QUANTITY
60

EOB Unavailable | Print Claim | Ask a Question



Claim #499846321691331670

PATIENT
MICHAEL W BURNS

PROVIDER
SAINT LUKE'S ADVANCED CARE PHA

SERVICE DATE
01/30/2019

SERVICE TYPE
Pharmacy

TOTAL CHARGES
$2,847.12

STATUS
COMPLETE

CLAIM DETAILS | PRESCRIPTION INFO

Your Part: $0.00

COPAYMENT
$0.00

COINSURANCE
$0.00

APPLIED TO DEDUCTIBLE
$0.00

NON-COVERED SERVICES
$0.00

Other Details

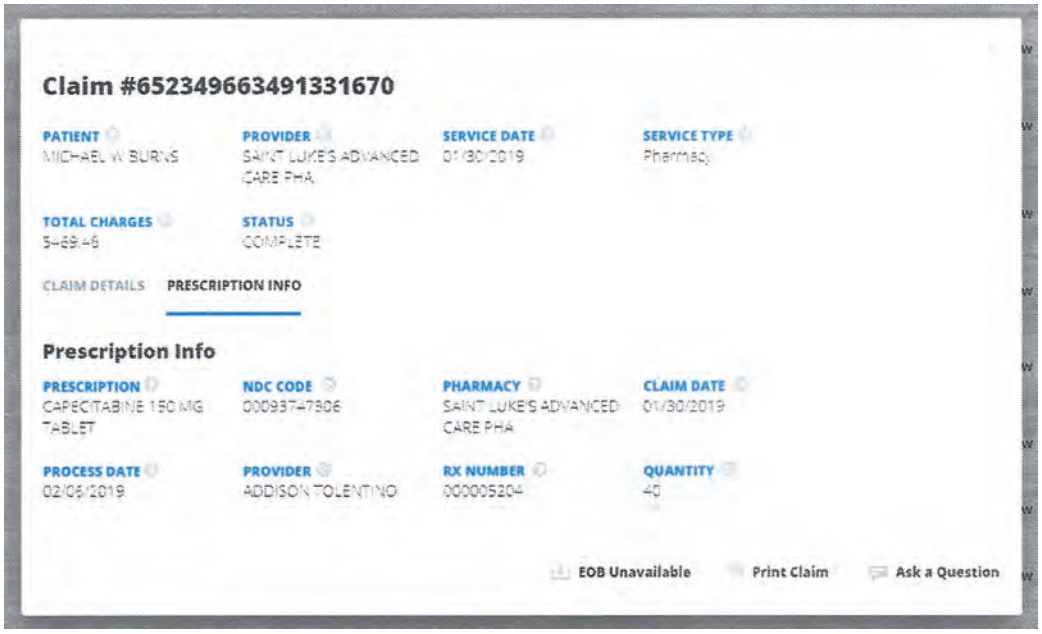
DATE RECEIVED
02/05/2019

OTHER INSURANCE PAID
$0.00

NETWORK SAVINGS
$1,725.26

PAID BY PLAN
$621.86

EOB Unavailable | Print Claim | Ask a Question



Claim #652349663491331670

PATIENT
MICHAEL W BURNS

PROVIDER
SAINT LUKE'S ADVANCED CARE PHA

SERVICE DATE
01/30/2019

SERVICE TYPE
Pharmacy

TOTAL CHARGES
$469.48

STATUS
COMPLETE

CLAIM DETAILS | **PRESCRIPTION INFO**

Prescription Info

PRESCRIPTION
CAPECITABINE 150 MG TABLET

NDC CODE
00093747906

PHARMACY
SAINT LUKE'S ADVANCED CARE PHA

CLAIM DATE
01/30/2019

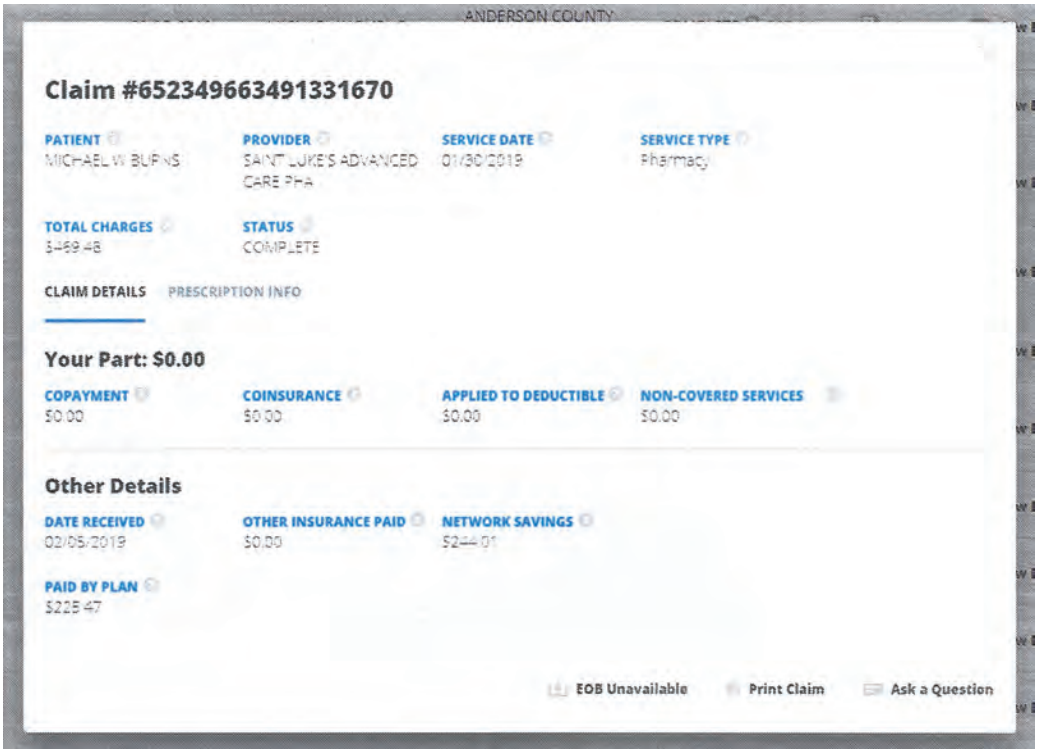
PROCESS DATE
02/05/2019

PROVIDER
ADDISON TOLENTINO

RX NUMBER
000005204

QUANTITY
40

EOB Unavailable | Print Claim | Ask a Question



ANDERSON COUNTY

Claim #652349663491331670

PATIENT
MICHAEL W BURNS

PROVIDER
SAINT LUKE'S ADVANCED CARE PHA

SERVICE DATE
01/30/2019

SERVICE TYPE
Pharmacy

TOTAL CHARGES
$469.48

STATUS
COMPLETE

CLAIM DETAILS | PRESCRIPTION INFO

Your Part: $0.00

COPAYMENT
$0.00

COINSURANCE
$0.00

APPLIED TO DEDUCTIBLE
$0.00

NON-COVERED SERVICES
$0.00

Other Details

DATE RECEIVED
02/05/2019

OTHER INSURANCE PAID
$0.00

NETWORK SAVINGS
$244.01

PAID BY PLAN
$225.47

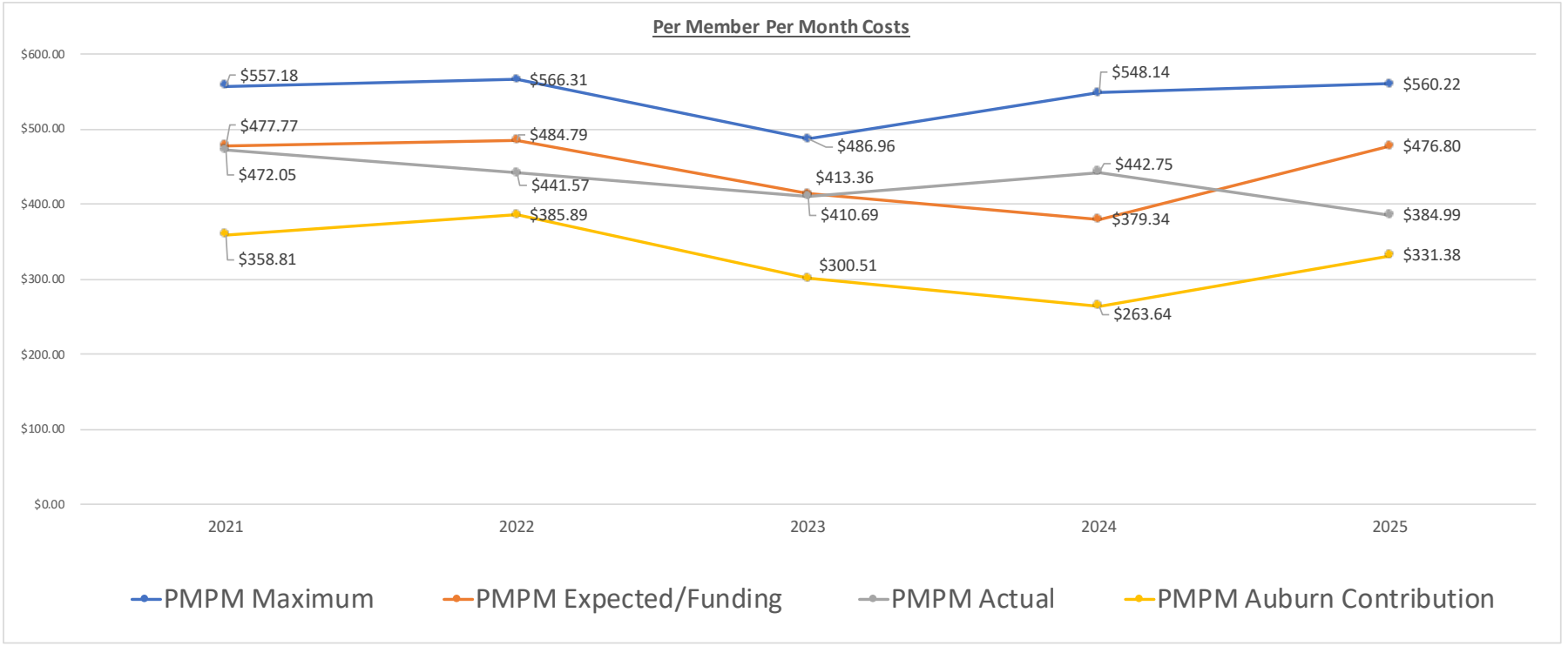
EOB Unavailable | Print Claim | Ask a Question

ALT	QTY	STOCK	CIN NDC/UPC	TRADE NAME MFR	STRENGTH	FORM	SIZE	TYPE	NET COST	INVOICE COST	NET UOI COST	RETAIL PRICE	CONTRACT	NOTES
	0		5116280 16729-0072-12	CAPECITABINE ACCORD	150MG	TABS	1x60 EA	Rx	$35.72	$64.94	$0.5953		1-SOURCE	

ALT	QTY	STOCK	CIN NDC/UPC	TRADE NAME MFR	STRENGTH	FORM	SIZE	TYPE	NET COST	INVOICE COST	NET UOI COST	RETAIL PRICE	CONTRACT	NOTES
	0		5116306 16729-0073-29	CAPECITABINE ACCORD	500MG	TABS	1x120 EA	Rx	$203.57	$370.13	$1.6964		1-CHOSRC	

Quantity	Capecitabine 150mg #120 (Month Supply)	Capecitabine 150mg #120 (Month Supply)	Monthly Total (both Strengths)	6 Month Treatment (Both Strengths)
Billed Amount	$1,408.44	$7,041.36	$8,449.80	$50,698.80
Allowed Amount	$633.66	$1,863.86	$2,497.52	$14,985.12
Cost	$129.88	$305.35	$435.23	***$2,611.38***
Profit				***$12,373.74***

	Maximum	Expected/Funding	PMPM Actual	Auburn Contribution
2021	$557.18	$477.77	$472.05	$358.81
2022	$566.31	$484.79	$441.57	$385.89
2023	$486.96	$413.36	$410.69	$300.51
2024	$548.14	$379.34	$442.75	$263.64
2025	$560.22	$476.80	$384.99	$331.38



	PEPM Maximum	PEPM Expected/Funding	PEPM Actual	PEPM Auburn Contribution
2021	$697.37	$597.98	$590.83	$449.09
2022	$716.10	$613.03	$558.38	$487.97
2023	$725.85	$616.14	$612.17	$447.94
2024	$797.57	$551.95	$644.22	$383.61
2025	$772.11	$657.15	$530.61	$456.72