



STATE OF HAWAII
KA MOKU'ĀINA O HAWAII
DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
KA 'OIHANA PONO LIMAHANA

March 3, 2026

To: The Honorable Karl Rhoads, Chair,
The Honorable Mike Gabbard, Vice Chair, and
Members of the Senate Committee on Judiciary

Date: Tuesday, March 3, 2026
Time: 10:15 a.m.
Place: Conference Room 016, State Capitol

From: Jade T. Butay, Director
Department of Labor and Industrial Relations (DLIR)

Re: S.B. 2751 S.D.1 RELATING TO WORKERS' COMPENSATION

I. OVERVIEW OF PROPOSED LEGISLATION

The DLIR appreciates the intent of SB2751 to improve clarity in compounded prescription drugs to help prevent inflated pricing. However, we respectfully **oppose** the SD1 amendments because they introduce provisions that conflict with the core intent of Hawaii's workers' compensation law to provide individualized, medically necessary care. Specifically, SD1 allows bulk compounding facilities, imposes arbitrary dispensing limits, and mandates Pharmacy Benefit Managers use, all of which creates barriers to timely and patient-specific treatment.

SB2751 SD1 proposes to amend HRS Chapter 386 by:

- Providing a definition of a "compounded prescription drug" that references section 503A of the Federal Food, Drug and Cosmetic Act,
- Limiting the dispensing of prescription drugs by physicians to 30 days following the industrial injury, and requiring all prescription drugs to be obtained through the employer's pharmacy benefit manager (PBM) thereafter; and
- Requiring prescription drugs not approved by the FDA, such as compounds, to be identified as compounds when listed on the treatment plan and when billed, and be supported by medical documentation of the need for a compound drug over any FDA-approved over-the-counter or prescription drug that provides similar therapeutic results.

II. CURRENT LAW

§386-21.7 Prescription drugs and pharmaceuticals:

- Subsection (a) provides that, notwithstanding any other provision to the contrary, immediately after a work injury is sustained by an employee and so long as reasonably needed, the employer shall furnish to the employee all prescription drugs as the nature of the injury requires,
- Subsection (b) pertains to repacked and relabeled drugs,
- Subsection (c) provides that payment for compounded prescription drugs shall be the sum of one hundred forty per cent of the average wholesale price by gram weight of each underlying prescription drug contained in the compounded prescription drug. For compounded prescription drugs, the average wholesale price shall be that set by the original manufacturer of the underlying prescription drug as identified by its National Drug Code and as published in the Red Book: Pharmacy's Fundamental Reference as of the date of compounding, except where the employer or carrier, or any entity acting on behalf of the employer or carrier, directly contracts with the provider or provider's assignee for a lower amount,
- Subsection (d) states that all pharmaceutical claims submitted for repackaged, relabeled, or compounded prescription drugs shall include the National Drug Code of the original manufacturer. If the original manufacturer of the underlying drug product used in repackaged, relabeled, or compounded prescription drugs is not provided or is unknown, then reimbursement shall be one hundred forty per cent of the average wholesale price for the original manufacturer's National Drug Code number as listed in the Red Book: Pharmacy's Fundamental Reference of the prescription drug that is most closely related to the underlying drug product,
- Subsection (e) states that notwithstanding any other provision in this section to the contrary, equivalent generic drug products shall be substituted for brand name pharmaceuticals unless the prescribing physician certifies that no substitution shall be prescribed because the injured employee's condition does not tolerate an equivalent generic drug product, and
- Subsection (f) states that for the purposes of this section, "equivalent generic drug product" has the same meaning as provided in §328-91.

§328-91 "Equivalent generic drug product" means a drug product approved by the director as substitutable by pharmacists and included in the Hawaii list of equivalent generic drug products and interchangeable biological products.

§328-1 "Prescription drug" means: (1) Any drug required by federal or state statutes, regulations, or rules to be dispensed only upon a prescription, including finished dosage forms and active ingredients subject to §328-16 or section 503(b) of the Federal Act; or (2) Any drug product compounded or prepared pursuant to a practitioner's order.

The DLIR's §12-15-55 *Drugs, supplies and materials* subsection (a) provides that charges for prescribed drugs, supplies, or materials for the use of the injured employee shall be separately listed and certified by the provider, or a duly authorized representative, that such charges for drugs, supplies, or materials were required and prescribed for the industrial injury.

III. COMMENTS ON THE SENATE BILL

The fundamental intent of Hawaii's workers' compensation law is to ensure that injured workers receive appropriate, individualized medical care that promotes recovery and safe return to work. Prescription drugs are a critical component of this care, and in certain cases, compounded prescription drugs are essential when FDA-approved medications are not suitable due to patient allergies, dosage requirements, or other clinical concerns.

Patient-specific compounding ensures that medications are tailored to the unique needs of each injured worker, supporting both patient safety and effective treatment outcomes. This individualized approach reflects the original purpose of the law to provide care that is necessary and reasonable for the specific injury and patient.

The lack of clarity in HRS Chapter 386 has led to inconsistent interpretations and inflated billing practices, undermining the law's intent. By adopting the federal definition under section 503A, this bill ensures compounded drugs are prepared only for an identified individual patient based on a valid prescription. As important is the professional oversight by licensed pharmacists and physicians.

DLIR does not support inclusion of 503B outsourcing facilities or similar bulk manufacturing operations. The Department does not support SD1's allowance of "any other type of similar compounding facility". Hawaii's workers' compensation law is intended for patient-specific, individualized care, not mass production which are found in 503B facilities. Bulk compounding models have been associated with inflated costs and lack of cost control.

The SD1 version adds a 30-day limit on physician dispensing, which conflicts with the "so long as reasonably needed" standard set in §386-21.7. Arbitrary time limits undermine access to care, especially for claimants in rural areas with limited pharmacy access.

DLIR recognizes that transparency is important. However, requiring pre-approval for non-FDA-approved drugs could delay medically necessary treatment and contradict the workers' compensation law to provide prompt care based on medical need.

The SD1 version introduces mandatory use of pharmacy benefit managers (PBM), which adds administrative complexity, delays treatments, and increases costs. PBMs impose network restrictions and fees, making it harder for injured workers to access care in an already limited workers' compensation provider market.

For these reasons, the Department **opposes the SD1**. The DLIR continues to **strongly support** the introduced version, with the clarification that the definition of “compounded prescription drug” should reference title 21 United States Code section 353a. This amendment would more accurately align the measure with Hawai‘i’s workers’ compensation law, which is grounded in patient-specific, individualized medical care, services, and supplies.

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STATE OF HAWAII | KA MOKU'ĀINA O HAWAII
DEPARTMENT OF HUMAN RESOURCES DEVELOPMENT
KA 'OIHANA HO'OMŌHALA LIMAHANA
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Statement of
BRENNA H. HASHIMOTO
Director, Department of Human Resources Development

Before the
SENATE COMMITTEE ON JUDICIARY
Tuesday, March 3, 2026
10:15AM
State Capitol, Conference Room 016

In consideration of
SB2751 SD1, RELATING TO WORKERS' COMPENSATION

Chair Rhoads, Vice Chair Gabbard, and members of the committee:

The Department of Human Resources Development (HRD) is in **support** of SB2751 SD1.

The purpose of SB2751 SD1 is to:

- Define compounded prescription drugs for the purposes of the State's Workers' Compensation Law.
- Limit dispensing of prescription drugs by physician to 30 days after the industrial injury and requires all prescription drugs to be obtained through the employer's pharmacy benefit manager thereafter.
- Require prescription drugs not approved by the Food and Drug Administration (FDA), such as compounds, to be identified as compounds when listed on the treatment plan and when billed, and be supported by a statement of medical necessity documenting the case of medical need for a compound drug over an FDA-approved over-the-counter or prescription drug of similar therapeutic effect.

HRD has a fiduciary duty to administer the State Executive Branch's self-insured workers' compensation program using public funds. In our capacity, we have first-hand experience with escalating medical costs. We support the amended measure for the following reasons:

- Limiting physician dispensing of prescription drugs reduces the potential for

conflict of interest. When physicians are able to prescribe and dispense medications throughout the entirety of an injured worker's claim, there can be a financial incentive to prescribe more drugs or higher-priced options. As such, limiting dispensing would maintain evidence-based prescribing, reduce over-prescribing, minimize profit-driven decisions and ensure ethical integrity.

- Separating prescribing and dispensing functions after the first 30 days of injury ensures that medication costs are reasonable and aligned with appropriate formulary or fee schedule. This minimizes employers' exposure to higher expenses that may bypass reasonable reimbursement limits.
- When a prescription drug is dispensed by a Pharmacy Benefit Manager (PBM), medication safety is enhanced since it passes through a double check system. Pharmacists are able to verify dosage and drug interactions, check for allergies, and provide medication counseling. This independent, second safety check reduces medication errors and adverse drug contradictions. Including pharmacists in the dispensing process promotes a team-based approach to healthcare which benefits the injured worker.
- The U.S. Food and Drug Administration (FDA) does not approve compounded drugs, nor does it review compounded drugs for safety, effectiveness, or quality before marketing. As such, when treatment plans clearly identify non-FDA drugs, employers understand what they are funding, carriers can assess risk exposure, and PBM's can track utilization. This enhanced transparency minimizes hidden off-formulary prescribing which often results in higher costs and serves to reduce associated administrative burden of disputes and billing conflicts.
- The requirement that treatment plan requests for non-FDA drugs justify the medical necessity, including why an over the counter or FDA approved prescription drug of similar therapeutic effect is not appropriate, reinforces an evidence-based review and approval process.
- The transparency of identifying non-FDA drugs on treatment plans and bills may allow injured workers to better understand what medications they are receiving, make them aware if a drug is not FDA approved, and promotes informed patient consent. This awareness can also facilitate discussions between the injured worker and their medical providers regarding alternative medications or treatments to aid in their recovery and return to work.

To ensure all non-FDA approved compounds fall under existing cost controls while supporting the intention of measure which is to promote patient safety, regulatory consistency, and cost predictability, HRD recommends the following amendment:

On page 6, line 3, revise the current subsection (h) as follows:

“‘Compounded prescription drug’ means a drug product that is compounded in a

compounding facility in compliance with 503A or **503B** of the Food, Drug, and Cosmetic Act (21 U.S.C. 353a and **353b, respectively**), or any other type of similar compounding facility approved by the Food and Drug Administration.”

We are available to answer any questions or provide further information as needed.

**DEPARTMENT OF HUMAN RESOURCES
KA 'OIHANA HO'OMOHALA LIMAHANA
CITY AND COUNTY OF HONOLULU**

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March 3, 2026

LATE

The Honorable Karl Rhoads, Chair
The Honorable Mike Gabbard, Vice Chair
and Members of the Committee on Judiciary
The Senate
State Capitol, Room 016
415 South Beretania Street
Honolulu, Hawai'i 96813

Dear Chair Rhoads, Vice Chair Gabbard, and Members of the Committee:

SUBJECT: Senate Bill No. 2751 SD1
Relating to Workers' Compensation

The City and County of Honolulu, Department of Human Resources, **strongly supports** this measure and specifically, the 30-day limitation on physician dispensing.

The workers' compensation system should prioritize injured workers receiving safe, effective, **FDA-approved medications** at fair prices – and not at the high markups which are being charged by dispensing physicians and their affiliated companies. Senate Bill No. 2751 SD1 achieves that purpose by limiting physician-dispensed prescription drugs in workers' compensation claims to the first 30-days from the work injury date. During this initial 30-day period, physicians can dispense medication as medically necessary. Following the 30-day period, injured workers would use the employer's Pharmacy Benefit Manager (PBM), which is the method used by all other employees for obtaining prescription drugs under any medical benefit plan in Hawai'i.

The City's workers' compensation data supports the urgency of this issue. For example, a claim for medication that normally costs \$951 at a retail/PBM was billed at \$7,816 when physician-dispensed, representing a 8.21X or 821% markup. These practices significantly impact self-insured, taxpayer-funded workers' compensation programs like the City and County of Honolulu from both a cost perspective and the time required to address physician-initiated billing disputes before the State Department of Labor and Industrial Relations (DLIR).

The Honorable Karl Rhoads, Chair
The Honorable Mike Gabbard, Vice Chair
March 3, 2026
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The 30-day limitation on physician dispensing adopted by the Labor/Technology and Health/Human Services committees will:

- Protect injured workers with proven, FDA-approved retail pharmacy options and reduce the costs for employers like the City and County of Honolulu by millions of dollars annually. Of the \$16 million dollars in workers' compensation medication costs incurred by the City and County of Honolulu over the past five years, \$12 million dollars of that was attributable to physician-dispensed medication;
- Reduce bill dispute volume at the DLIR by over 90%;
- Remove financial incentives for physicians to dispense medication at inflated costs rather than prescribe FDA-approved medication to be obtained at the pharmacy.

Based on the foregoing, the City and County of Honolulu respectfully requests that the Judiciary Committee pass Senate Bill No. 2751 SD1 as proposed.

Sincerely,



Nola N. Miyasaki
Director

TESTIMONY OF MILIA LEONG

COMMITTEE ON JUDICIARY
Senator Karl Rhoads, Chair
Senator Mike Gabbard, Vice Chair

Tuesday, March 3, 2026
10:15 a.m.

SB 2751, SD1

Chair Rhoads, Vice Chair Gabbard, and members of the Committee on Judiciary, my name is Milia Leong, Executive Claims Administrator for HEMIC Insurance Managers, Inc., and Chair of the Workers' Compensation Policy Committee for Hawaii Insurers Council. The Hawaii Insurers Council is a non-profit trade association of property and casualty insurance companies licensed to do business in Hawaii. Member companies underwrite approximately forty percent of all property and casualty insurance premiums in the state.

Hawaii Insurers Council submits **comments** on this bill. While we support the intent of this bill as amended in SD1, we ask that the Committee consider replacing the words "compounds", "compound drug", and "compound" as they appear in the bill on Page 5, lines 14, 15, 17, and 20, to "compounded prescription drug" which is defined now in this bill.

Thank you for the opportunity to testify.

SB-2751-SD-1

Submitted on: 3/1/2026 5:07:05 PM

Testimony for JDC on 3/3/2026 10:15:00 AM

Submitted By	Organization	Testifier Position	Testify
Brandon Shirai	Testifying for Hawaii Injury Recovery Center	Oppose	Written Testimony Only

Comments:

To:

Senator Karl Rhoads, Chair

Senator Mike Gabbard, Vice Chair

Members of the Senate Committee on Judiciary

Date: March 3, 2026

Time: 10:15 a.m.

Place: Conference Room 016

Re: SB2751, SD1 – Testimony in Strong Opposition from a Treating Physician

Chair Rhoads, Vice Chair Gabbard, and Members of the Committee:

My name is Brandon Shirai, M.D., and I am a practicing physician in Hawai‘i who regularly treats injured workers. I am submitting this testimony in strong opposition to SB2751, SD1.

I initially supported SB2751 when it was introduced as a narrow measure to align Hawai‘i’s definition of “compounded prescription drug” with the federal 503A standard. That version provided an important clarification. However, the SD1 draft introduces broad policy changes that significantly alter how injured workers receive care. It establishes a 30-day limit on physician dispensing, requires patients to transition to employer-selected PBM channels after that period, and adds new requirements for medications that are not FDA-approved, including compounded medications.

From the perspective of a physician directly caring for injured workers, these changes are impractical and harmful.

Physician Dispensing Is Essential to Maintaining Access to Care

Treating workers’ compensation patients is considerably more administratively demanding than treating non-work-related injuries. The required forms, prior authorizations, treatment plan updates, adjuster communications, and compliance documentation require approximately 2.5 times more staff time and physician involvement, without any corresponding increase in reimbursement.

In-clinic dispensing is not a profit center; it is one of the few mechanisms that helps offset the uncompensated administrative burden associated with these cases. It also allows us to:

- Initiate treatment immediately, without delays caused by pharmacy denials or PBM inquiries.
- Reinforce medication instructions and monitor adherence at each visit.
- Maintain integrated oversight of clinical care and medication management, improving safety and outcomes.

If dispensing is prohibited after 30 days, as proposed in SD1, the already limited margin that allows clinics like mine to continue accepting workers' compensation patients will disappear. Without this support, I would not be able to continue treating these individuals.

The PBM Mandate in SD1 Will Disrupt Care and Delay Treatment

The committee report notes that SD1 was amended to require all prescriptions after the first month to be processed through the employer's PBM. This represents a significant shift in decision-making authority away from treating physicians and toward PBMs and bill review vendors.

This mandate will:

- Fragment care by placing a PBM intermediary between physician and patient.
- Increase delays when prescriptions are questioned, modified, or denied.
- Reduce a physician's ability to verify precisely what medication the patient ultimately receives.

We are already observing concerning practices from certain PBM-linked platforms, including unilateral "adjustments" to treatment plans that do not reflect the prescribing physician's orders. When third-party systems reinterpret or alter a physician's treatment plan, it raises serious clinical, ethical, and legal concerns.

Given these realities—combined with slower and more uncertain reimbursement—my clinic cannot absorb the additional administrative strain. If SB2751, SD1 becomes law, I would be forced to stop accepting workers' compensation patients, as physician dispensing is currently the only mechanism that helps offset the disproportionate workload.

SD1 Goes Well Beyond the Bill's Original Purpose

The original bill focused narrowly on clarifying the definition of compounded prescription drugs by adopting the federal 503A standard. In contrast, SD1:

- Imposes a statutory 30-day cap on physician dispensing and transfers control to PBMs.
- Adds new documentation and labeling requirements for compounded and other non-FDA-approved medications.
- Revises the definition of “compound prescription drug” in ways that depart from the bill’s initial intent.

These are substantial policy shifts that directly affect access to care within the workers’ compensation system. Such changes should not be embedded in what began as a technical definitional measure.

Without Physician Dispensing, Many Clinics Will Stop Treating Injured Workers

The situation is clear:

- Workers’ compensation cases involve significantly more administrative work for equal or lower reimbursement.
- Physician dispensing helps make continued treatment of these patients feasible.
- Eliminating dispensing after 30 days and mandating PBM routing will make it financially unsustainable for many clinics—including mine—to continue accepting workers’ compensation patients.

The likely result will be fewer physicians willing to treat injured workers, increased treatment delays, and poorer outcomes.

For these reasons, I respectfully urge the Committee to:

- Restore SB2751 to its original, limited purpose of adopting the federal 503A definition;
or
- If that is not possible, defer SB2751, SD1 in its entirety.

Thank you for considering the real-world impact this bill will have on injured workers and the physicians who care for them.

Respectfully submitted,
Brandon Shirai, M.D.

To: Senator Karl Rhoads, Chair
Senator Mike Gabbard, Vice Chair
Members of the Senate Committee on Judiciary

Date: March 3, 2026
Time: 10:15 a.m.
Place: Conference Room 016

Re: SB2751, SD1 – Strong Opposition

Dear Chair Rhoads, Vice Chair Gabbard, and Members of the Committee:

My name is Frank Izuta, MD and I am a Board Certified Occupational Medicine physician who only treats patients with work related injuries. I have cared for injured workers in Colorado from 1986 to 1997 then here in Hawaii from 1997 until the present time. I am writing in **strong** opposition to SB2751, SD1.

I supported SB2751 in its original form. It was written based on the collaborative efforts of a committee chaired by State Representative Scott Matayoshi and included physicians, representatives from Work Comp insurers, attorneys and representatives from the repackaging pharmacies. A specific problem was identified that was responsible for excessive charges paid by the Insurers and absorbed by the employers and had no therapeutic or safety advantages over medication that could be bought over the counter. It was clearly a way that certain physicians in our community could take advantage of the system with no cost benefit to the employer and no health or safety benefit to the patient. SB2751 was written based on input by all members of the committee. It addressed a serious loophole in the Worker's Compensation System and was a win win for all parties.

SB2751 SD1 is a very different Bill that includes a blanket 30-day limit on physician dispensing and requires all prescription drugs after that point to be obtained through the employer's pharmacy benefit manager (PBM), along with new hurdles for non-FDA-approved drugs such as compounds.

Clearly, SB2751 SD1 was not written by a group made up of different members of the Worker's Compensation Health System. It does not improve the health and safety of our injured workers. It does not streamline or facilitate treatment by a physician to a patient. And does not make treating injured workers more attractive to new or existing physicians. It appears the only purpose of SB2751 SD1 is to save money however, I am doubtful that will occur.

SB2751 was written to prevent a few irresponsible physicians from taking advantage of the system and charging exorbitant prices for medications that could be obtained over the counter. Most physicians prescribe medications appropriately and responsibly. The ability to dispense medication is an invaluable source of income for any physician with a large workers compensation practice.

The average visit for an injured worker take much longer than the average visit for a non-work related medical visit. The irresponsible physicians will always game the system. Their primary goal is to make money. Appropriate cost effective treatment is not a priority. If the rules of the game change they will change the way they practice. The responsible physicians won't change the way they treat patients, but they will stop taking worker's compensation patients.

It is obvious that SB2751 SD1 was not written based.

From the standpoint of a physician who actually treats injured workers, this is unworkable and unfair.

I originally supported SB2751 when it was a straightforward measure intended to align Hawaii's definition of "compounded prescription drug" with the federal 503A standard. That version addressed a narrow but important clarification. The SD1 draft, however, introduces sweeping policy changes that fundamentally alter how injured workers receive care. It imposes a 30-day limit on physician dispensing, forces patients into employer-selected PBM channels after that point, and adds new requirements for medications that are not FDA-approved, including compounds.

From the perspective of someone who provides hands-on care to injured workers, these changes are unworkable and harmful.

Physician Dispensing Is What Makes Treating Injured Workers Viable

Caring for an injured worker is far more complex, time-consuming, and administratively burdensome than seeing a non-workers' compensation patient. Studies and practice experience show that treating injured workers requires roughly 2.5 times more time, paperwork, and staff effort than comparable non-work-related cases, yet there is no additional reimbursement to cover these costs.

In my practice, dispensing is not a "profit center"; it is how we offset a portion of the uncompensated labor that comes with:

- Extensive forms, treatment plans, and communications with adjusters and case managers.
- Prior authorizations, utilization review responses, and appeals.
- Detailed documentation to meet workers' compensation requirements.

When a clinic dispenses medications directly, we can:

- Start treatment immediately, without sending a worker to an external pharmacy and risking delays or denials.
- Monitor adherence closely, reinforcing medication instructions at each visit.
- Consolidate clinical care and medication management in one setting, which is safer and more efficient for the patient.

Removing physician dispensing after 30 days, as SD1 proposes, strips away the already thin margin that allows clinics like mine to continue accepting workers' compensation patients. Without that ability, my clinic simply could not absorb the additional unreimbursed time and overhead. I would be forced to stop treating injured workers altogether.

SD1 Goes Far Beyond the Bill's Original Purpose

The original bill was narrowly focused on clarifying the definition of compounded prescription drugs by adopting the federal 503A standard. SD1, however:

- Imposes a statutory 30-day cap on physician dispensing and shifts control to PBMs.
- Adds new documentation and labeling requirements for compounds and other non-FDA-approved medications.
- Alters the definition of "compound prescription drug" in ways that undermine the bill's original intent.

These are major policy changes that reshape access to care in the workers' compensation system. They should not be inserted into what began as a technical definitional bill.

Without Physician Dispensing, Many Clinics Will Stop Treating Injured Workers

The reality is straightforward:

- Workers' compensation cases require significantly more administrative work for the same or lower reimbursement.
- Physician dispensing is what allows clinics to continue treating these patients despite that imbalance.
- Removing dispensing after 30 days and forcing prescriptions through PBMs will make it financially impossible for many clinics—including mine—to continue accepting workers' compensation patients.

Physician Dispensing Is Essential to Maintaining Access to Care

Treating a workers' compensation patient is significantly more labor-intensive than treating a non-work-related injury. The administrative burden—forms, authorizations, treatment plan updates, communication with adjusters, and compliance documentation—requires roughly 2.5 times more staff time and physician involvement, with no additional reimbursement to offset that workload.

Dispensing medications in the clinic is not a financial windfall; it is one of the few mechanisms that helps cover the uncompensated administrative demands of workers' compensation cases. It also allows us to:

- Begin treatment immediately, without delays caused by pharmacy denials or PBM questioning.
- Reinforce medication instructions and monitor adherence at each visit.
- Keep clinical care and medication management integrated, which improves safety and outcomes.

If dispensing is cut off after 30 days, as SD1 proposes, the already thin margin that allows clinics like mine to continue accepting workers' compensation patients disappears. Without that support, I would not be able to continue treating these patients.

SD1's 30-Day PBM Mandate Hurts Patients and Undermines Care

The committee report on SB2751, SD1 explains that the bill was amended to limit physician dispensing to thirty days after the injury and then require all prescriptions to be obtained through the employer's PBM. This change is not about clarifying compounding definitions; it is about shifting control from treating physicians to PBMs and bill-review vendors.

This mandate will:

- Fragment care by inserting a PBM between me and my patient after the crucial first month of treatment.
- Delay medication access when PBMs deny, question, or alter prescriptions written by the treating physician.
- Make it harder to monitor adherence, as I will no longer see directly what the patient actually receives.

In addition, with certain PBM-linked platforms such as IMS/MediHawaii, we are already seeing practices that I view as deeply problematic—such as unilateral “amendments” to treatment plans that do not reflect what I actually ordered. When a third-party system can alter or reinterpret a physician's treatment plan, it is not just a billing issue; it becomes a clinical and legal concern.

Under these conditions, and with slower, more uncertain reimbursement, my clinic cannot sustain the extra staff time and administrative load that workers' compensation demands. If SB2751, SD1 becomes law, I will have no choice but to stop accepting workers' compensation patients, because physician dispensing is the only mechanism that currently helps offset the 2.5-fold increase in workload without any corresponding increase in reimbursement.

The PBM Mandate in SD1 Will Disrupt Care and Delay Treatment

The committee report explains that SD1 was amended to require all prescriptions after the first month to be routed through the employer's PBM. This is a dramatic shift in control away from treating physicians and toward PBMs and bill-review vendors.

This mandate will:

- Fragment care by inserting a PBM between the physician and the patient.
- Increase delays when PBMs question, modify, or deny prescriptions.
- Reduce the physician's ability to verify what medication the patient actually receives.

We are already seeing troubling practices from certain PBM-linked platforms, including unilateral “adjustments” to treatment plans that do not reflect what I ordered. When a third-party system can reinterpret or alter a physician's plan, it raises clinical, ethical, and legal concerns.

Under these conditions—and with slower, more uncertain reimbursement—my clinic cannot sustain the additional administrative load. If SB2751, SD1 becomes law, I would be forced to stop accepting workers' compensation patients because dispensing is the only mechanism that currently offsets the disproportionate workload.

SD1 Moves Far Beyond the Original Purpose of the Bill

Your own standing committee report acknowledges that the original purpose of this bill was to define compounded prescription drugs for workers' compensation purposes by adopting the federal 503A definition, to address inconsistent interpretations and billing issues. The new language in SD1 goes far beyond that limited purpose. It:

- Imposes a statutory 30-day cap on physician dispensing and forces patients into PBM-controlled channels thereafter.
- Adds new documentation and labeling requirements for non-FDA-approved drugs such as compounds, on top of existing utilization and medical-necessity review.
- Changes the definition of “compound prescription drug” in a way that undermines the bill's original intent to bring clarity and alignment with federal law.

These are major policy changes that fundamentally affect the doctor–patient relationship and access to care in the workers' compensation system. They should not be tucked into what began as a technical definitional bill.

If Physician Dispensing Ends, So Does My Ability to Treat Injured Workers

For my clinic, the reality is simple:

- Treating workers' compensation patients requires about 2.5 times the administrative work for the same or lower net reimbursement than non-work-related care.
- Physician dispensing is what makes it possible to keep our doors open to injured workers in spite of that imbalance.

- If SB2751, SD1 eliminates physician dispensing after 30 days and pushes all prescriptions into PBM-controlled systems that can delay, alter, or deny care, I cannot continue to see these patients and remain financially viable.

That means fewer physicians willing to treat injured workers, longer delays in care, and worse outcomes—exactly the opposite of the Legislature’s stated goal of promoting recovery and safe return to work.

For these reasons, I respectfully but firmly urge you to:

- Amend SB2751 back to its original, limited form focused on defining “compounded prescription drug” in line with federal law; or
- If that cannot be done, defer SB2751, SD1 entirely.

PBMs do not examine patients, yet they routinely delay, alter, or deny medications that I prescribe. Their platforms sometimes reinterpret treatment plans in ways that do not match my clinical orders. When a third-party entity can override or modify a physician’s plan, it compromises both safety and accountability.

Physician dispensing ensures immediate access to medications, reduces delays, and allows me to verify adherence at every visit. Removing this ability after 30 days fragments care and increases the risk of complications, prolonged disability, and inconsistent treatment.

Workers’ compensation cases require significantly more administrative work than standard care, with no additional reimbursement. Dispensing is the only mechanism that offsets this imbalance. Without it, my clinic—and many others—cannot continue treating injured workers.

Thank you for the opportunity to submit written testimony.

Frank Izuta, MD



TESTIMONY IN STRONG OPPOSITION TO SB2751, SD1

TO: Senator Karl Rhoads, Chair
Senator Mike Gabbard, Vice Chair
Members of the Committee on Judiciary

DATE: Tuesday, March 3, 2026

TIME: 10:15 a.m.

PLACE: Conference Room 016

RE: SB2751, SD1 – Relating to Workers' Compensation

Position: STRONG OPPOSITION to SB2751, SD1

Honorable Chair Rhoads, Vice Chair Gabbard, and Members of the Committee:

My name is Gary Okamura and I am the President of Work Injury Medical Association of Hawaii, representing Work Comp treating physicians and providers in Hawaii. I submit this testimony in **strong opposition** to SB2751, SD1, and urge this Committee to **defer this bill** unless it is amended back to its original form. While I strongly supported the original SB2751, which sought to align Hawaii law with federal FDA standards by defining compounded prescription drugs under 21 U.S.C. § 353a (Section 503A of the Federal Food, Drug, and Cosmetic Act), the SD1 amendments have **completely perverted the bill's intent** and would inflict devastating harm on Hawaii's workers' compensation system.

The Original Bill Was Sound Policy

The original SB2751 addressed a legitimate need: clarifying the statutory definition of "compounded prescription drug" to align Hawaii law with federal FDA regulations distinguishing between:

- **503A compounds:** Patient-specific medications compounded by pharmacists under state Board of Pharmacy oversight, never assigned their own NDC or AWP
- **503B compounds:** FDA-manufactured drug products made in registered Outsourcing Facilities under FDA Good Manufacturing Practices, assigned unique NDCs and AWP, listed in Redbook

This distinction matters. Under current law (HRS §386-21.7), reimbursement for compounded drugs is calculated based on 140% of the AWP of the "underlying prescription drug." The ambiguity about whether 503B products—which have their own NDCs and AWP—fall under this provision has created confusion and enabled bad-faith denials by bill review companies like Solera Integrated Medical Solutions (Solera-IMS).

The original bill would have brought clarity and protected legitimate medical care. **The SD1 amendments destroyed that purpose.**

The SD1 Amendments Serve One Master: Solera-IMS's Financial Interests

The Senate Labor and Technology Committee inserted three devastating amendments into SD1—amendments that **track word-for-word the testimony submitted by Solera-IMS in opposition to the original bill**. These amendments do not serve injured workers, physicians, or employers. They serve to **increase revenue for Pharmacy Benefit Managers (PBMs) and their affiliate companies**, including MediHawaii (owned by Solera-IMS), while inserting barriers to timely medical care.

Amendment #1: Mandatory PBM Routing After 30 Days



SD1 Amendment (1): "Limiting the dispensing of prescription drugs by physicians to thirty days following the industrial injury and requiring all prescription drugs to be obtained through the employer's pharmacy benefit manager thereafter."

This amendment is devastating for multiple reasons:

1. **It mandates directing of care, which Hawaii law prohibits.** Employers have a legal obligation under HRS §386-21 to furnish medical care "as the nature of the injury requires"—as determined by the treating physician, not a PBM. This amendment strips physicians of their statutory authority to manage their patients' medication needs.
2. **It creates a financial windfall for PBMs without improving care.** PBMs make money by inserting themselves into the drug supply chain in ways physicians and pharmacies cannot access:
 - **Rebates from manufacturers:** PBMs negotiate rebates for formulary placement, which are not passed to patients or providers
 - **Spread pricing:** PBMs charge insurers more than they reimburse pharmacies, pocketing the difference
 - **Administrative fees:** PBMs collect fees from manufacturers and insurers for managing formularies and processing claims
 - **Click fees:** When prescriptions route through PBM software like MediHawaii, Solera-IMS collects transaction fees
3. **PBMs cannot profit from physician dispensing because those claims bypass PBM software.** When physicians dispense directly, pharmacy claims go straight to the carrier/employer without flowing through PBM systems. This amendment forces all prescriptions through PBM infrastructure so PBMs can extract their fees—fees that add zero clinical value.
4. **The 30-day limit has no basis in workers' compensation best practices.** No other state uses this arbitrary cutoff. The amendment was crafted solely to funnel prescriptions into PBM systems, not to improve patient outcomes.
5. **This flies in the face of the Hawaii Attorney General's active lawsuit against the three dominant PBMs,** alleging price inflation, rebate manipulation, and anticompetitive practices. Why would the Legislature mandate routing injured workers' prescriptions through entities currently sued for fraudulent pricing schemes?
6. **Physician dispensing enhances compliance and recovery.** When physicians can monitor medication compliance directly, they can adjust treatment plans in real time, promoting faster return to work—the core goal of workers' compensation. Forcing workers to obtain medications elsewhere fragments care and delays recovery.

The former Committee Chair appears unaware that this amendment was designed to enrich PBMs, not protect injured workers. This is not a policy improvement—it is regulatory capture.

Amendment #2: Burdensome Medical Necessity Documentation

SD1 Amendment (2): "Requires non-FDA-approved prescription drugs, such as compounds, to be identified as compounds when listed on the treatment plan and when billed, and be supported by a statement of medical necessity documenting the case of medical need for a compound drug over an FDA-approved over-the-counter or prescription drug of similar therapeutic effect."

This amendment insults physicians and obstructs timely care:



1. **Every prescription a physician writes is a statement of medical necessity.** When a physician prescribes a compound, they have already diagnosed the patient, evaluated treatment options, and determined medical necessity. This amendment demands that physicians justify their clinical judgment to insurance adjusters and PBM reviewers who lack the treating relationship and clinical context.
2. **It adds bureaucratic layers that delay treatment.** Injured workers need timely access to medication to control pain, reduce inflammation, and facilitate healing. Requiring additional documentation and pre-approval creates delays that prolong suffering and delay return to work.
3. **It presumes physician malfeasance without evidence.** The amendment treats all physicians as if they are profiteering from compound prescriptions, when in reality the vast majority are providing individualized care to patients with allergies, dosage requirements, or therapeutic needs that FDA-approved drugs cannot meet.
4. **Existing law already addresses inappropriate prescribing.** Physicians who prescribe medically unnecessary drugs can be disciplined by the state medical board and face denial of reimbursement through existing dispute processes. This amendment solves no problem that current law doesn't already address.

This is not patient protection—it is harassment of treating physicians and empowerment of bill review companies to deny legitimate claims.

Amendment #3: Broadening the Definition to Include 503B Products

SD1 Amendment (3): "Changing the definition of 'compound prescription drug' to be 'a drug product that is compounded in a compounding facility in compliance with section 503A of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 353a) or any other type of similar compounding facility approved by the Federal Drug Administration.'"

This amendment destroys the bill's original purpose:

1. **It deliberately reintroduces the ambiguity the bill was meant to eliminate.** The original bill sought to define compounds as 503A products only, which would clarify that 503B products—FDA-manufactured drugs with NDCs and AWP—should be reimbursed at their listed AWP, not calculated using an "underlying drug" formula that doesn't apply.
2. **503B products are not traditional compounds—they are FDA-manufactured drugs.** They are made in registered FDA Outsourcing Facilities under Good Manufacturing Practices, assigned National Drug Codes, listed in Redbook with established AWP, and sold to healthcare providers as finished drug products. They are fundamentally different from patient-specific 503A compounds.
3. **Solera-IMS benefits financially from this ambiguity.** By keeping the law vague, Solera-IMS can continue to deny reimbursement for 503B products using flawed calculations, forcing providers into lengthy disputes. Solera-IMS's business model depends on denying claims—they earn 20-30% of the "savings" generated from denials. The more they deny, the more they profit.
4. **The Department of Labor and Industrial Relations (DLIR) has repeatedly ruled that 503B products must be reimbursed at their AWP,** yet Solera-IMS continues to deny these claims, exploiting the current statutory ambiguity to generate dispute revenue.
5. **The phrase "or any other type of similar compounding facility" is deliberately vague,** allowing future manipulation and ensuring continued confusion. If the Legislature wanted to include 503B facilities, it should say so explicitly—but that would contradict federal law, which distinguishes 503A from 503B precisely because they are different regulatory categories.



This amendment ensures that Solera-IMS can continue its profitable denial practices while wrapping itself in the false flag of "cost containment."

Solera-IMS's Testimony: Smoke, Mirrors, and Conflicts of Interest

Solera-IMS testified in opposition to the original bill and proposed amendments that became SD1. Their testimony is riddled with:

- **False claims that physician dispensing drives costs**, ignoring that PBMs add layers of profit without clinical value
- **Conflating 503A and 503B products** to obscure the fact that 503B drugs are FDA-manufactured and should be reimbursed at AWP
- **Accusing physicians of fraud based on the actions of "a couple of bad actors"**, while tarring the entire medical community
- **Projecting costs the "State will save"** if physician dispensing is curtailed—savings that actually represent revenue transferred to PBMs
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Solera-IMS's business model depends on claim denials. They do not earn money when claims are paid fairly and promptly. They earn money by creating disputes, delays, and denials—and by positioning themselves as gatekeepers in the prescription drug supply chain.

The Core Problem: PBM Profit Extraction vs. Clinical Care

The fundamental issue is this: **PBMs make money by controlling the financial architecture of the drug benefit, not by providing clinical care.**

PBMs	Physicians & Pharmacists
Negotiate rebates from manufacturers	Paid for clinical services
Set formulary placement	Follow medical necessity
Control reimbursement rates	Operate within rates set by PBMs
Use spread pricing to capture margins	Cannot access rebates or spreads
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Table 1: How PBMs profit vs. how providers are compensated

Doctors do not negotiate manufacturer rebates. Pharmacies do not set spread pricing. Neither group controls formularies or reimbursement terms. PBMs do—and that control generates billions in revenue nationally while adding little to no clinical value.

When Hawaii's Legislature mandates routing through PBMs, it is not improving care—it is **mandating profit extraction by middlemen.**



This Bill Should Be Rejected

SB2751, SD1, as currently written, should **not pass** out of the Senate Judiciary Committee. It represents:

- Regulatory capture by a bill review company with financial conflicts of interest
- Directing of care in violation of Hawaii workers' compensation principles
- Barriers to timely medical treatment that will delay recovery and return to work
- Enrichment of PBMs at the expense of injured workers, physicians, and employers
- Perpetuation of statutory ambiguity that enables bad-faith claim denials

If this Committee wishes to preserve the integrity of Hawaii's workers' compensation system, it must either:

1. **Amend the bill back to its original form**, defining compounded prescription drugs as 503A products only,
OR
2. **Defer the bill entirely** to prevent the harm SD1 would inflict.

Conclusion

The original SB2751 was good policy. It would have aligned Hawaii law with federal FDA standards, eliminated ambiguity, and ensured that 503B FDA-manufactured drugs are reimbursed fairly at their established AWP.

The SD1 amendments hijacked that purpose to serve Solera-IMS's financial interests. They mandate PBM routing, create bureaucratic barriers to physician treatment decisions, and perpetuate the very ambiguity the bill was meant to solve.

I urge this Committee to recognize that **the goal of workers' compensation is to help injured workers recover and return to work—not to enrich PBMs and bill review companies.** Physicians, not insurance adjusters or software vendors, should determine what medications their patients need.

Please defer SB2751, SD1, or amend it back to its original form. Do not allow this bill to pass in its current state.

Respectfully submitted,

Gary Okamura, MD
President – WIMAH
Orthopedic Surgeon



TESTIMONY IN STRONG OPPOSITION TO SB2751, SD1

TO: Senator Karl Rhoads, Chair
Senator Mike Gabbard, Vice Chair
Members of the Committee on Judiciary

DATE: Tuesday, March 3, 2026

TIME: 10:15 a.m.

PLACE: Conference Room 016

RE: SB2751, SD1 – Relating to Workers' Compensation

Position: **STRONG OPPOSITION to SB2751, SD1**

Honorable Chair Rhoads, Vice Chair Gabbard, and Members of the Committee:

My name is Cathy Wilson, and I have been supporting injured workers in Hawaii for over 16 years. I submit this testimony in **strong opposition** to SB2751, SD1, and urge this Committee to **defer this bill** unless it is amended back to its original form. While I strongly supported the original SB2751, which sought to align Hawaii law with federal FDA standards by defining compounded prescription drugs under 21 U.S.C. § 353a (Section 503A of the Federal Food, Drug, and Cosmetic Act), the SD1 amendments have **completely perverted the bill's intent** and would inflict devastating harm on Hawaii's workers' compensation system.

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If this Committee wishes to preserve the integrity of Hawaii's workers' compensation system, it must either:

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OR
2. **Defer the bill entirely** to prevent the harm SD1 would inflict.

Conclusion

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The SD1 amendments hijacked that purpose to serve Solera-IMS's financial interests. They mandate PBM routing, create bureaucratic barriers to physician treatment decisions, and perpetuate the very ambiguity the bill was meant to solve.

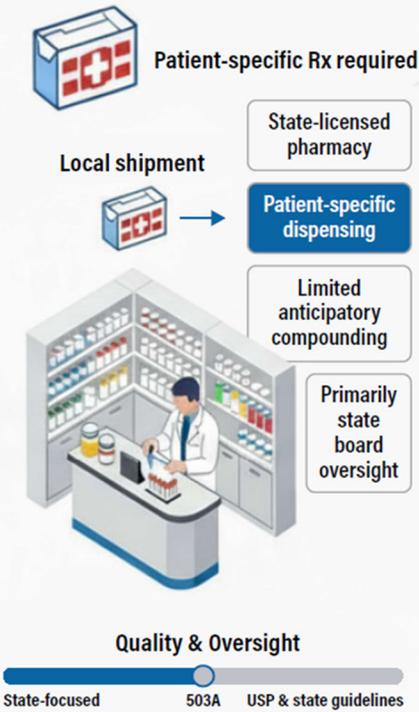
I urge this Committee to recognize that **the goal of workers' compensation is to help injured workers recover and return to work—not to enrich PBMs and bill review companies.** Physicians, not insurance adjusters or software vendors, should determine what medications their patients need.

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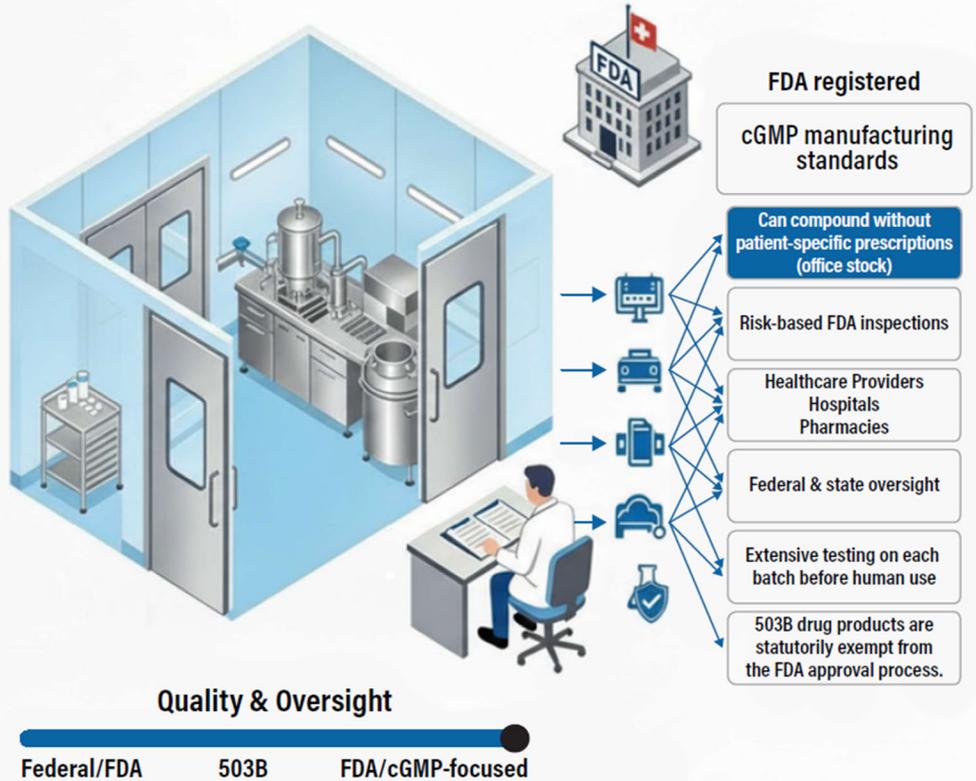
Respectfully submitted,

Cathy Wilson
President
Hawaii Repack, LLC

(503A)



(503B)



LATE



841 Bishop Street, Suite 2250 | Honolulu, Hawaii 96813

Statement of

KRIS KADZIELAWA

Managing Director, Solera Integrated Medical Solutions

Before the

COMMITTEE ON JUDICIARY

Senator Karl Rhoads, Chair Senator Mike Gabbard, Vice Chair

Tuesday, March 3, 2026

10:15AM

State Capitol, Conference Room 016

In consideration of:

SB2751 SD1 RELATING TO WORKERS' COMPENSATION

TESTIMONY IN STRONG SUPPORT FOR SB2751 SD1

Aloha Chair Rhoads, Vice Chair Gabbard, and Members of the Committee:

My name is Kris Kadzielawa, Managing Director of Solera Integrated Medical Solutions. For 33 years we have audited Hawaii workers' compensation claims for carriers, self-insured employers, and the State, fighting the waste, fraud, and abuse that drives up workers' compensation costs and potentially compromises the safety of injured workers.

We are grateful to the Committees on Labor & Technology and Health & Human Services for their thoughtful work on S.B. 2751, S.D. 1 (Stand. Com. Rep. No. 2217). You listened to our concerns and adopted the exact amendments we recommended:

- A clear **30-day limit** on physician dispensing of **all** prescription drugs, after which injured workers must use the employer’s Pharmacy Benefit Manager;
- Mandatory identification of compounds on treatment plans and bills, plus a statement of medical necessity showing why a non-FDA-approved compound is required over an equally effective, far-less-expensive FDA-approved option; and
- Failure to comply makes the bill non-reimbursable.

These changes protect patients, restore fairness, and relieve employers and the Department of Labor from the disputes generated when current cost controls are constantly challenged with novel attempts at circumvention by physician dispensers.

Why the 30-day limit is essential – real Hawaii data

Physician dispensing is the #1 cost driver in Hawaii workers’ compensation. Here is an example of what actually happens in a **single office visit** on a Hawaii claim:

Drug (one month supply)	Retail Pharmacy PBM Cost	Physician-Dispensed Billed	PD vs. PBM Cost Multiple
Diclofenac Sodium 2% gel	\$30.79	\$3,760.93	122×
Pregabalin 100 mg	\$490.57	\$1,415.79	3×
Lidothol Gel	\$30.00	\$1,326.43	44×
Rabeprazole 20 mg #30	\$340.00	\$481.25	1.4×
Lidocaine Patch 5%	\$60.00	\$431.58	7×
TOTAL – single visit	\$951	\$7,416	7.8×

The physician keeps ~\$4,450; the dispensing company keeps ~\$2,966 less the deducted cost of the dispensed medication which is usually small to negligible relative to the billed amount. Multiply by hundreds or thousands of claims and you see why this practice has become the top cost driver while exhausting claims and the State’s Administrative teams for 20 years.

Even more egregious:

- **LidoRX** – lidocaine 3% cream billed as a prescription drug at **\$520 for 2 oz.** It is actually OTC (<4% lidocaine) and is reimbursed at **\$14.**
- **SpeedGel RX** – homeopathic cream with colchicine (a gout drug unrelated to most workplace injuries) billed at **\$734 for 2 oz** – not reimbursable at all.
- **Methacarbamol 500** – oral dose, generic medication billed at **\$1,379 for 60 pills** – with a cost of less than \$10 and the most common PBM charge of \$30.

These are not isolated; they are the business model.

Proven results of a 30-day limit Many states have enacted similar limits. In Hawaii the impact would be immediate and dramatic:

- **\$3–5 million annual savings** to the State budget alone.
- Another **\$8–10 million** in system-wide savings to insurers and employers.
- **More than 90% reduction** in the bill-dispute volume that swamps the Department of Labor.

After the first 30 days, injured workers simply fill prescriptions at a retail pharmacy or through the PBM – exactly as they do for every other type of insurance such as prepaid health. Access to care is preserved; profiteering ends.

In my 33 years of auditing medical bills in Hawaii, **my company has never had a single dispute over prescription drugs that did not involve physician dispensing.** The current statute works perfectly for everyone except those who keep inventing novel ways around it.

Finally, we respectfully request one minor but important clarification to the definition of “compounded prescription drug” in S.D. 1. Because 503B outsourcing facilities produce compounds in bulk (not strictly patient-specific), we recommend either explicitly including 503B in the definition — consistent with federal law treating 503B facilities as compounders — or clearly excluding non-patient-specific 503B products from workers’ compensation coverage, as they do not meet the patient-specific standard. This simple adjustment, consistent with the points we raised in testimony for the companion measure H.B. 2164, will prevent future circumvention while maintaining the patient-safety focus of the bill.

In EXHIBIT A attached to my testimony, please see a product label from one such bulk manufactured 503B compound labeled by the manufacturer in compliance with FDA requirements as a “COMPOUND,” referencing a “COMPOUND DATE,” and identifying the name of the company that it was “COMPOUNDED BY.” If 503B facility compounds

are not included in the definition of compounds, then how are they to be treated under Hawaii Law? Currently these bulk manufactured compounds (as all other compounds) must be deconstructed and reimbursed per §386-21.7(c), based on the underlying prescription ingredient with which it was compounded. This is clear in the current statute.

Mahalo for the opportunity to testify. I am happy to answer any questions and remain committed to working with all stakeholders to protect injured workers while controlling costs.

Respectfully submitted,

Kris Kadzielawa

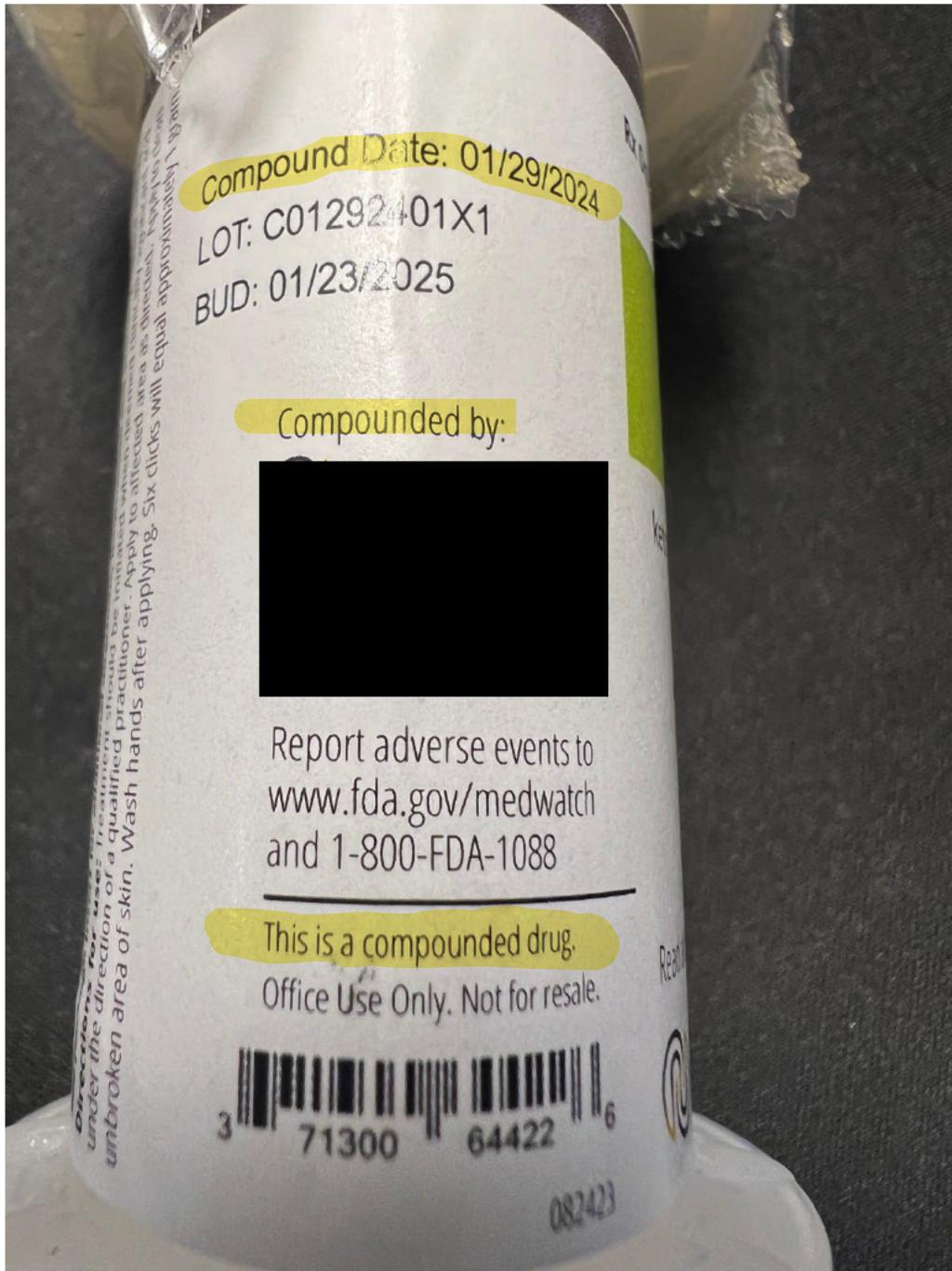
Co-Founder, Managing Director | Solera IMS | MediHawaii.com

O: +1 808 531 2273 ext. 25 | kris.kadzielawa@solera.com

Solera IMS | 841 Bishop Street, Suite 2250 | Honolulu, Hawaii 96813



EXHIBIT A – 503B Manufactured Compound Product Label identifying it as a Compound Medication.



LATE

SB-2751-SD-1

Submitted on: 3/2/2026 1:02:31 PM

Testimony for JDC on 3/3/2026 10:15:00 AM

Submitted By	Organization	Testifier Position	Testify
Carol Ann Orr MD	Testifying for Carol A Orr MD LLC	Oppose	Written Testimony Only

Comments:

To:
 Senator Karl Rhoads, Chair
 Senator Mike Gabbard, Vice Chair
 Members of the Senate Committee on Judiciary

Date: March 3, 2026
 Time: 10:15 a.m.
 Place: Conference Room 016

Re: SB2751, SD1 – Testimony in Strong Opposition from a Treating Physician

Chair Rhoads, Vice Chair Gabbard, and Members of the Committee:

My name is Carol Ann Orr MD, and I am a practicing physician in Hawai‘i who regularly treats injured workers. I am submitting testimony in strong opposition to SB2751, SD1.

I originally supported SB2751 when it was a straightforward measure intended to align Hawai‘i’s definition of “compounded prescription drug” with the federal 503A standard. That version addressed a narrow but important clarification. The SD1 draft, however, introduces sweeping policy changes that fundamentally alter how injured workers receive care. It imposes a 30day limit on physician dispensing, forces patients into employerselected PBM channels after that point, and adds new requirements for medications that are not FDAapproved, including compounds.

From the perspective of someone who provides hands on care to injured workers, these changes are unworkable and harmful to both the patient and provider.

Physician Dispensing Is Essential to Maintaining Access to Care to prevent delay in patients receiving their medication's on the date of service. Geographically, patients have difficulty on the Big Island of Hawaii to drive to employer/ insurance selected pharmacies, imposing a hardship. Also, there is delay in approvals by the insurance carrier when patient medication is sent outside as the pharmacies defer obtaining the authorization to our clinic and send the

authorization request back to our clinic to do the work for them to get the prior authorization to have the medication filled outside.

Treating a workers' compensation patient is significantly more laborintensive than treating a nonworkrelated injury. The administrative burden—forms, authorizations, treatment plan updates, communication with adjusters, and compliance documentation—requires roughly 2.5 times more staff time and physician involvement, with no additional reimbursement to offset that workload.

Dispensing medications in the clinic is not a financial windfall; it is one of the few mechanisms that helps cover the uncompensated administrative demands of workers' compensation cases. It also allows us to:

- Begin treatment immediately, without delays caused by pharmacy denials or PBM questioning.
- Reinforce medication instructions and monitor adherence at each visit.
- Keep clinical care and medication management integrated, which improves safety and outcomes.

If dispensing is cut off after 30 days, as SD1 proposes, the already thin margin that allows clinics like mine to continue accepting workers' compensation patients disappears. Without that support, I would not be able to continue treating these patients, and I will retire and close my clinic early leaving a void in an already underserved area of East Hawaii.

The PBM Mandate in SD1 Will Disrupt Care and Delay Treatment

The committee report explains that SD1 was amended to require all prescriptions after the first month to be routed through the employer's PBM. This is a dramatic shift in control away from treating physicians and toward PBMs and billreview vendors.

This mandate will:

- Fragment care by inserting a PBM between the physician and the patient.
- Increase delays when PBMs question, modify, or deny prescriptions.
- Reduce the physician's ability to verify what medication the patient actually receives. Bill reviewers will be making medical decisions on what medications are medically necessary, not the physician.

We are already seeing troubling practices from certain PBMLinked platforms, including unilateral “adjustments” to treatment plans that do not reflect what I ordered. When a thirdparty system can reinterpret or alter a physician’s plan, it raises clinical, ethical, and legal concerns.

Under these conditions—and with slower, more uncertain reimbursement—my clinic cannot sustain the additional administrative load. If SB2751, SD1 becomes law, I would be forced to stop accepting workers’ compensation patients because dispensing is the only mechanism that currently offsets the disproportionate workload.

SD1 Goes Far Beyond the Bill’s Original Purpose

The original bill was narrowly focused on clarifying the definition of compounded prescription drugs by adopting the federal 503A standard. SD1, however:

- Imposes a statutory 30day cap on physician dispensing and shifts control to PBMs.
- Adds new documentation and labeling requirements for compounds and other nonFDAapproved medications.
- Alters the definition of “compound prescription drug” in ways that undermine the bill’s original intent.

These are major policy changes that reshape access to care in the workers’ compensation system. They should not be inserted into what began as a technical definitional bill.

Without Physician Dispensing, Many Clinics Will Stop Treating Injured Workers, including my practice, which will be forced to shut down.

The reality is straightforward:

- Workers’ compensation cases require significantly more administrative work for the same or lower reimbursement.
- Physician dispensing is what allows clinics to continue treating these patients despite that imbalance.
- Removing dispensing after 30 days and forcing prescriptions through PBMs will make it financially impossible for many clinics—including mine—to continue accepting workers’ compensation patients.

The result will be fewer physicians willing to treat injured workers, longer delays, and poorer outcomes.

For these reasons, I respectfully urge the Committee to:

- Restore SB2751 to its original, limited purpose of adopting the federal 503A definition; or
- If that is not possible, defer SB2751, SD1 entirely.

Thank you for considering the realworld impact this bill will have on injured workers and the physicians who care for them.

sincerely, Carol Ann Orr MD

LATE

SB-2751-SD-1

Submitted on: 3/2/2026 1:36:34 PM

Testimony for JDC on 3/3/2026 10:15:00 AM

Submitted By	Organization	Testifier Position	Testify
Gabe Merrill	Testifying for Hawaii Injured Workers Association	Oppose	Written Testimony Only

Comments:

To: Senator Karl Rhoads, Chair
Senator Mike Gabbard, Vice Chair
Members of the Senate Committee on Judiciary

Date: March 3, 2026
Time: 10:15 a.m.
Place: Conference Room 016

Re: SB2751, SD1 – Strong Opposition Due to PBM Interference and Patient Safety Risks

Chair Rhoads, Vice Chair Gabbard, and Members of the Committee:

My name is Gabe Merrill and I am President of the Hawaii Injured Worker’s Association. I have cared for injured workers for 20+ years in Hawaii. I strongly oppose SB2751, SD1.

The SD1 draft fundamentally changes the bill’s purpose. Instead of clarifying the definition of compounded medications, it now restricts physician dispensing to 30 days and shifts control of ongoing treatment to employer-selected PBMs. This raises serious concerns about patient safety and clinical integrity.

PBMs do not examine patients, yet they routinely delay, alter, or deny medications that I prescribe. Their platforms sometimes reinterpret treatment plans in ways that do not match my clinical orders. When a third-party entity can override or modify a physician’s plan, it compromises both safety and accountability.

Physician dispensing ensures immediate access to medications, reduces delays, and allows me to verify adherence at every visit. Removing this ability after 30 days fragments care and increases the risk of complications, prolonged disability, and inconsistent treatment.

Workers’ compensation cases require significantly more administrative work than standard care, with no additional reimbursement. Dispensing is the only mechanism that offsets this imbalance. Without it, my clinic—and many others—cannot continue treating injured workers.

For the safety of patients and the integrity of medical decision-making, I urge the Committee to restore SB2751 to its original, limited purpose or defer SB2751, SD1.

Thank you for your consideration.

-Gabe Merrill, MS, Hawaii Injured Worker's Association

PS it's a huge drag and emotionally defeating for an injured worker to not get their FDA approved prescription specific to their injury on time or in some cases not at all. There are only so many tools in the tool kit to help Hawaii's injured workers and being able to get them their prescribed medications on time without denial or delay is super important.

It's like going to the market to pick up the groceries to make dinner and being told you can't have the necessary ingredients until the manager approves it. "Unfortunately," the manager states "I am not available to take your call...please leave a message."

Finally, contacting the Manager and they say, "sorry; please go to our affiliated store and see whether or not they have the ingredient – but they are only open on Tuesdays at 330 pm-4:15pm and the item you may not be in stock. Dinner will not be made.

Then injured workers wonder, why am I being treated like this?

To: Senator Karl Rhoads, Chair
Senator Mike Gabbard, Vice Chair
Members of the Senate Committee on Judiciary
Date: March 3, 2026
Time: 10:15 a.m.
Place: Conference Room 016

Re: SB2751, SD1 – Strong Opposition (Testimony of a 503B Outsourcing Facility CEO)

Chair Rhoads, Vice Chair Gabbard, and Members of the Committee:

Aloha, my name is Robert P Nickell, Pharmacist, and the CEO of a FDA-registered 503B Outsourcing Facility that manufactures compounded drug products under current Good Manufacturing Practice (cGMP) and ships drugs into Hawaii for hospitals, clinics, and pharmacies that treat Hawaii patients. I am submitting this testimony in **strong** opposition to SB2751, SD1. Please refer to the Slide Deck attachments in addition to my testimony on SB2751 SD1.

I strongly support SB2751 in its original form because it did one important and overdue thing: it updated Hawaii's workers' compensation statute to align the definition of "compounded prescription drug" with federal law and FDA terminology, clarifying the role of traditional 503A compounding. This definition is needed to help payers, providers, and DLIR when comprehending the reimbursement schedule for HRS386-21.7(c)(d). The latest amended SD1 version has stripped out that much needed, narrow, technical clarification and replaced it with sweeping policy changes unrelated to the original purpose of the bill, and at the same time, greatly narrowing the drug product tools for the healthcare provider to treat the injured worker in Hawaii. This hardly seems fair to the injured worker, and actually takes away their rights they have today, and makes it more difficult for them to heal and return to work. As you know, HRS states, and for good reason, "**all prescription drugs as the nature of the injury requires**". With all due respect, adding in non-related amendments that completely alter the landscape for drug treatment services to the injured worker, without going through conferences, settlements, and meetings between the stakeholders, does not make sense. Unless this Committee restores the bill to its original, targeted form, I respectfully urge you to delete the amendments, or defer SB2751, SD1.

What is a 503B FDA Outsource Facility?

Congress created the 503B outsourcing facility category for drug products, in the Drug Quality and Security Act (DQSA) of 2013 to fill the gap between Traditional 503A compounding pharmacies and large-scale pharmaceutical compounded manufacturing. Thus, the creation and establishment of 503B Outsourcing Facilities registered with the FDA.

FDA Outsourcing Facilities:

- Operate only in FDA-registered facilities under full cGMP standards, the same quality system that applies to major pharmaceutical manufacturers such as Pfizer and Lilly.
- Manufacture finished, non-patient-specific drug products, commonly known as, "manufactured compounds". These drug products are then dispensed or administered by pharmacies, hospitals, and healthcare providers to their patients, when deemed clinically necessary by their health care provider.
- They use only active pharmaceutical ingredients (APIs), excipients, and appropriate bases; they cannot legally compound/manufacture, with an "underlying prescription drug or drug product, as outlined for traditional compounding in HRS386-21.7 (c)(d) and is a distinct difference between traditional and manufactured compounding.
- They are assigned a manufacturer labeler code in order to register a National Drug Code (NDC) for each drug product, and those products are listed in Redbook, which is the established, standard pharmaceutical reference compendium, used by Hawaii Statute for determining workers' compensation reimbursement under HRS 386-21.7. As well, the Average Wholesale Pricing (AWP) for all 503B drugs are found in Redbook.

By contrast, 503A Traditional Compounding pharmacies:

- Create only patient-specific preparations dispensed pursuant to an individual prescription for a specific patient.
- Are regulated under USP standards and by state boards of pharmacy, including the Hawaii State Board of Pharmacy and not under annual FDA cGMP compliance.
- They are never listed in Redbook and do not have registered listings with the FDA for NDCs or AWP.

The original SB2751 appropriately focused on clarifying the definition of a compounded prescription drug in state workers' compensation law so that 503A Traditional compounding is treated consistently with federal definitions, while recognizing that 503B drug products are already treated as reimbursable drug products with their own NDC and AWP under Hawaii law, under section HRS386-21.7(a)(b). That is sound policy, consistent with Hawaii law, DQSA, and the FDA to promote clarity, safety, and predictable reimbursement.

How SD1 Destroys the Original Intent

SB2751, SD1 fundamentally rewrites the bill. Instead of cleanly updating state law to mirror federal definitions around 503A Traditional compounding.

SD1 instead:

1. Grafts in a controversial 30-day limit on physician dispensing and forces all subsequent prescriptions through a pharmacy benefit manager (PBM). This has nothing to do with compounding drug products, and is NOT in the best interest of the injured worker, the treating healthcare provider, or the local community pharmacy.
2. Imposes additional preapproval, labeling, and documentation requirements on non-FDA-approved drugs such as compounds, inviting interference in clinical decision-making. I believe there is no one more qualified to render a clinical decision than the treating provider. Please refer to the attachment, Slide Deck "What is FDA Approval".
3. Rewrites the definition of "compound prescription drug" to sweep in not only, 503B Outsourcing Facilities but "any other type of similar or dissimilar, compounding facility approved by the Federal Drug Administration," effectively erasing the very 503A/503B distinction that federal law and the original bill were designed to clarify. As well, with such broad wording to include any drug, drug product, prescription drug, or compounded drug over the next 50 years is disingenuous at best.

These amendments do not "improve" the underlying measure; they convert a technical definitional bill into a vehicle for shifting control of injured workers' medications away from treating physicians and FDA-regulated manufacturers and toward PBMs and bill-review vendors with clear financial incentives. As a 503B owner who invests heavily in rigorous FDA oversight, batch testing, and cGMP compliance, I can say unequivocally that SD1 moves Hawaii in the wrong direction on safety, transparency, and fairness for the injured worker.

Why the 503A / 503B Distinction Matters

From a manufacturing and regulatory perspective, section 503A and 503B are not interchangeable; they are distinct legal frameworks with very different safeguards and reimbursement implications. In the giant book of CFR / FDA Guidelines, 503A and 503B are just section numbers, however, with major differences in drug safety, marketing categories, and FDA oversight. Please refer to the attachment for Slide Deck "SB2751 503A and 503B comparisons".

- 503A Traditional Compounding Pharmacies and their drugs are patient-specific, and not FDA-inspected annually under cGMP. Traditional Compounds do not have NDC, nor are they listed in Redbook with an AWP.
- 503B Outsourcing Facility Drug Products are produced under FDA cGMP. These FDA-registered facilities, are assigned manufacturer labeler codes and NDCs, and are listed in Redbook with an AWP used by Hawaii for workers' compensation reimbursement under section HRS386-21.7(a)(b).

The original bill appropriately used this structure to bring clarity to how a “compounded prescription drug” should be understood in workers’ compensation law, and recognizing that 503B drug products are already treated as reimbursable drug products for purposes of the Hawaii Revised Statutes.

By redefining “compound prescription drug” to include “a drug product that is made in a FDA Outsource Facility in compliance with section 503B... or any other type of similar or dissimilar, facility to be discovered in the next 50 years regardless of FDA approval, non-approval, or even EXEMPT from approval by the [FDA],” SD1 deliberately blurs the lines that federal law and FDA guidance have drawn.

Specifically:

- Interferes with 503B manufactured compounds, and places them into an ambiguous, undefined Statute designed for Traditional compounded drugs. This further undermines the fact that 503B FDA Drug Products are recognized in Red Book and fully reimbursable under HRS 386-21.7(a)(b).
- This amendment is designed to take away patient care from the health care provider on the front lines in Hawaii, and damage the ability of the injured to get “back to work”. Even DLIR has ruled that 503B FDA Outsource Facility Drug Products are fully recognized in Redbook and Hawaii Statute and are properly recognized under HRS386-21.7(a)(b).

In short, SD1 protects the business model of those who profit from confusion, rather than patients, physicians, pharmacies, and manufacturers who follow the law.

The 30-Day PBM Mandate Harms Patients and Distorts the Bill

The new language in SD1 that limits physician dispensing to 30 days post-injury and then requires all prescriptions to go through the employer’s PBM is completely self-serving and unrelated to the original technical purpose of this measure. It is also bad policy:

- It effectively directs care to a PBM, contrary to Hawaii’s longstanding principle that the treating physician—not a distant benefit manager—controls clinical decisions and access to needed drugs.
- It fragments care and complicates adherence, especially in workers’ compensation cases where continuity between the physician and the medication supply is critical to safe recovery and timely return to work.
- It privileges the financial interests of PBMs, which are privately owned, and bill-review vendors, who earn revenue from rebates, spread pricing, and administrative fees tied to their control over the drug benefit, not from providing direct clinical services to injured workers. The amendment as I see it, takes away from the health care provider and the patient, and turns the injured worker into a commodity for the financial pleasure of those controlling the purse strings.

As a 503B manufacturer, there are higher costs to absorb into the price of cGMP compliant drug products, such as, environmental monitoring, stability testing, and batch release testing required by the FDA for every lot of drug product produced, just like any other drug manufacturer. When PBMs or bill-review companies use ambiguous definitions or arbitrary limits to deny or underpay claims for potential life altering drug products used by hospitals, pharmacies, and healthcare providers, it directly undermines the spirit of HRS386-21 to treat the injured worker in Hawaii with **all prescription drugs as the nature of the injury requires**.

If the Legislature wants to have a policy debate about PBMs, physician dispensing, drug formularies, and injured worker benefit design, that should be done in a bill that is honestly labeled and thoroughly vetted on those issues—not buried in a definitional workers’ compensation bill that was originally about aligning Hawaii law with federal compounding standards.

Why SB2751 Should Be Restored or Deferred

As the CEO of a 503B outsourcing facility, I supported SB2751 as introduced because it was a focused, technical correction:

- It clarified the definition of compounded prescription drugs in the Hawaii state workers' compensation law in a way that is consistent with DQSA, CFR Section 503A, and current FDA guidance.
- It implicitly acknowledged that 503B drug products, "manufactured compounds", with their own NDC and AWP, are already treated as reimbursable drug products under Hawaii's existing fee schedule framework, just like any other prescription drug product listed in Redbook.

The SD1 amendments, by contrast, are a step backward for the injured patient and the health care provider:

- They erase the critical Federal distinction between 503A and 503B, inviting more confusion and more disputes over otherwise legitimate 503B drug product claims.
- They insert a sweeping PBM mandate and new hurdles on non-FDA-approved drugs that were never part of the original bill's rationale and that interfere with clinical care for injured workers.
- They shift the bill from a neutral technical fix into a vehicle that disproportionately benefits PBMs and bill-review vendors who in my opinion, already profit from ambiguity, denials, and delay.
- The amendment effectively wipes out the independent pharmacy and any pharmacy for that matter from participating in the healthcare delivery system for the injured worker.

For these reasons, I respectfully request that the Committee either:

1. Amend SB2751 back to its original form, restoring the narrow definition tied to section 503A and leaving out the PBM and expanded definition language; or
2. If that is not possible, defer SB2751, SD1 indefinitely and in its entirety.

The damage created by this amendment in my humble opinion is a false flag against the healthcare providers and their ability to treat patients within the State of Hawaii, and is really an attack on the injured worker, taking their rights to drugs that can help them get back to work, and further eliminating direct care by their local physicians, and the ability to visit their local pharmacy to get their medications on a timely basis.

Hawaii's workers' compensation system deserves clear, federally aligned definitions that reward compliance with FDA standards and support safe, reliable access to needed medications for injured workers. Currently, the State of Hawaii law does not properly define "Traditional Compounding Pharmacy" and the SD1 amendments have nothing to do with the intent of the original bill.

Thank you for the opportunity to testify. I am available to answer any questions and to work with legislators and stakeholders on language that truly aligns Hawaii law with federal compounding standards without sacrificing patient care or inviting further abuse of the system.

Mahalo and with respect,

Robert Nickell, CEO 
Nubtratori RX – 503B FDA Outsourcing Facility

Testimony includes attachments:
Slide Deck SB2751 SD1 503A and 503B comparison
Slide Deck What is FDA Approval SB2751



FDA Outsourcing Facility

NUBRATORI RX™

Quality Innovation Patient Safety

LATE

SB-2751-SD-1

Submitted on: 3/2/2026 8:12:17 PM

Testimony for JDC on 3/3/2026 10:15:00 AM

Submitted By	Organization	Testifier Position	Testify
Scott Morioka	Testifying for Hawaii Injury Recovery Center, Inc.	Oppose	Written Testimony Only

Comments:

To: Senator Karl Rhoads, Chair Senator Mike Gabbard, Vice Chair
Members of the Senate Committee on Judiciary

Date: March 3, 2026

Time: 10:15 a.m.

Place: Conference Room 016

Re: SB2751, SD1 – Strong Opposition

Dear Chair Rhoads, Vice Chair Gabbard, and Members of the Committee:

My name is Scott Morioka, MD, and I am a treating physician who cares for injured workers in Hawai‘i. I am also the President/Owner of Hawaii Injury Recover Center, a small group of three physicians who treat injured workers at two locations (Kuakini and Waikele). I oppose SB2751, SD1.

The original bill was a narrow clarification aligning Hawai‘i’s definition of compounded medications with federal 503A standards. SD1 goes far beyond that purpose. It imposes a 30 day limit on physician dispensing and forces all prescriptions after that point through the employer’s PBM. It also adds new requirements for compounds and other non-FDA approved medications.

Treating workers’ compensation patients requires significantly more administrative time—often more than double that of nonworkrelated care—with no additional reimbursement. Physician dispensing is what allows clinics like mine to absorb that workload while ensuring patients receive timely treatment.

A 30 day cutoff will fragment care, delay medications, and reduce adherence. PBM systems frequently question or alter prescriptions, creating barriers that directly affect recovery. If this mandate becomes law, my clinics will no longer be able to sustain workers’ compensation care. I

respectfully urge the Committee to restore the bill to its original, limited purpose—or defer SB2751, SD1 entirely.

Thank you for the opportunity to testify.

Albion Yi

Persistent Billing

714-206-6844

Albion@mypbrx.com



Date: 3/3/2026

Rebuttal to Proposed 30-Day Physician Dispensing Limitation in SB2751

Patient Access Will Be Severely Compromised

The proposed 30-day limitation on physician dispensing will create dangerous barriers to care for Hawaii's injured workers. The ability to leave the medical practice with medications in hand is an essential service that combines compliance, access and reduces risk of further injury due to additional travel. This arbitrary cutoff forces patients to navigate complex pharmacy benefit manager (PBM) networks precisely when they need immediate, uninterrupted access to medications. For patients with work-related injuries who may have limited mobility, transportation challenges, or live in remote areas, this creates an unnecessary and potentially harmful disruption in their treatment continuity.

Rural and Neighbor Island Patients Face Disproportionate Impact

Hawaii's unique geography makes this limitation particularly problematic for patients on neighbor islands and in rural communities. Many injured workers already face significant challenges accessing healthcare services, and forcing them to find alternative pharmacy sources after 30 days will exacerbate these access problems. Patients may be forced to:

- Unnecessarily suffer in pain due to medication delays and PBM denials that directly compromise their recovery
- Travel between islands or long distances to find participating pharmacies
- Face interruptions in specialized compounded medications that may not be available through standard pharmacy networks
- Experience gaps in pain management during critical recovery periods

Limited Pharmacy Network Acceptance of Workers' Compensation

A significant barrier that legislators have overlooked is that many local pharmacies, particularly in rural areas and neighbor islands, do not accept workers' compensation insurance. This creates a perfect storm of access problems:

- Complex billing requirements deter pharmacy participation

- Delayed reimbursements from workers' compensation insurers make it financially challenging for pharmacies
- Limited pharmacy networks mean patients may have to travel significant distances, when their injury may limit their ability to retrieve medications.
- Specialized medications may not be available through participating pharmacies

Physicians Will Abandon Workers' Compensation Practice

The proposed limitations, combined with existing administrative burdens and delayed payments by insurers, will drive physicians away from treating workers' compensation patients. A majority of providers do not accept workers compensation cases due to existing documentation compliance, complex billing issues and lack of payment. Healthcare providers already face:

- Extensive documentation requirements that consume valuable clinical time
- Significant delays in payment from workers' compensation insurers
- Complex prior authorization processes that delay patient care
- Administrative costs that often exceed reimbursement rates

Limiting physician dispensing to 30 days will make participation in the workers' compensation system financially unsustainable for many physicians. As a result, a significant number of physicians—particularly those in rural or underserved areas—will be forced to stop treating workers' compensation patients altogether, leading to decreased access to timely medical care for injured workers.

Treatment Continuity Will Be Disrupted

Patient-specific compounding and immediate medication access are essential when FDA-approved medications are not suitable due to patient allergies, dosage requirements, or other clinical concerns. The 30-day cutoff:

- Arbitrarily disrupts physician-directed treatment plans
- Forces patients into standardized PBM formularies that may not address their specific medical needs
- Creates gaps in specialized pain management protocols
- May result in patients being switched to less effective alternatives

Administrative Burden Will Increase, Not Decrease

Contrary to claims of reduced administrative burden, the proposed limitation will create additional complexity as physicians must:

- Coordinate with multiple PBM networks with varying formularies and requirements
- Justify continued medication needs through prior authorization processes
- Manage patient complaints about pharmacy access issues
- Handle treatment disruptions when PBMs deny or delay medications

- Spend additional time on documentation and appeals processes

Patient Safety and Recovery Concerns

Work-injured patients often have limited mobility and transportation challenges. Forcing them to obtain medications through distant pharmacies after 30 days creates safety risks and may result in:

- Medication non-compliance due to access barriers
- Worsening of conditions due to treatment interruptions
- Extended disability periods and delayed return to work
- Increased risk of chronic pain conditions
- Higher overall healthcare costs due to complications

Economic Impact on Healthcare System

The limitation will likely result in:

- Increased Patient safety and recovery concerns
- Reduced physician participation in workers' compensation programs
- Increased emergency department visits when patients cannot access medications
- Higher long-term disability costs due to delayed or interrupted treatment
- Increased administrative costs for all stakeholders
- Potential legal challenges and disputes over medication access

Recommendations

Instead of implementing this arbitrary 30-day limitation, legislators should focus on:

- Improving payment timelines for workers' compensation providers
- Streamlining administrative processes to reduce provider burden
- Expanding pharmacy networks that accept workers' compensation insurance

Excluding 503B and any other compounding facilities in the definition.

- Not allowing medications from 503B outsourcing facilities to be reimbursed would harm patients, providers, and the overall drug supply chain.
- Impact on patient access and safety
 - 503B facilities supply many sterile and ready-to-use products that hospitals, ASCs, and clinics rely on, especially injectables and infusions used in-office.
 - They play a key role in filling gaps during drug shortages, including drugs that may be unavailable from traditional manufacturers; blocking reimbursement would make these alternatives financially inaccessible for many patients.

- Because 503B facilities must follow cGMP and undergo FDA inspection, their compounded drugs often have higher, more standardized quality controls than in-house compounding in small facilities.
- Financial and operational impact on providers
 - If payers refuse reimbursement for 503B products, hospitals and physician offices would have to absorb the cost or stop using them, which would push them back to more labor-intensive in-house compounding or to less ideal alternatives.
 - In-house compounding often requires more staff time, specialized equipment, and waste management, increasing operating costs and risk of error, especially for high-volume or complex sterile preparations.
 - Smaller or rural facilities that depend on outsourced ready-to-use products might simply not be able to offer certain therapies at all if they cannot be reimbursed.
- System-level consequences
 - Removing reimbursement effectively disincentivizes use of a segment that was specifically created after DQSA to improve quality and reliability of compounded medications at scale.
 - It could worsen drug shortage impacts, because 503B facilities currently help stabilize supply when manufacturers discontinue or cannot meet demand for particular products.
 - Overall, such a policy would likely reduce access to needed medications, increase workflow and safety burdens on providers, and undermine a key safety- and quality-focused part of the supply chain, without a corresponding patient safety benefit.

Thanks,



Albon Yi
Medical Billing

LATE

SB-2751-SD-1

Submitted on: 3/2/2026 10:18:45 PM

Testimony for JDC on 3/3/2026 10:15:00 AM

Submitted By	Organization	Testifier Position	Testify
Marshall Orr, Jr.	Testifying for Carol A Orr MD LLC	Oppose	Written Testimony Only

Comments:

To: Senator Karl Rhoads, Chair
Senator Mike Gabbard, Vice Chair
Members of the Senate Committee on Judiciary

Date: March 3, 2026

Time: 10:15 a.m.

Place: Conference Room 016

Re: SB2751, SD1 – Opposition from a NeighborIsland Treating Provider/Small Business Owner

Chair Rhoads, Vice Chair Gabbard, and Members of the Committee:

My name is Marshall H Orr Jr DPT, and I practice physical therapy and own a physician practice on Hawaii Island, where access to timely care is already a challenge for injured workers. I strongly oppose SB2751, SD1.

The original bill simply aligned Hawai‘i’s definition of compounded medications with federal 503A standards. SD1 now adds a 30day limit on physician dispensing and requires all prescriptions after that point to be routed through the employer’s PBM. For neighborisland communities, this is especially harmful.

Many of my patients cannot easily reach a PBMcontracted pharmacy. Some must travel long distances, rely on limited public transportation, or wait days for mailorder medications. When Dr. Orr dispenses in the clinic, treatment begins immediately, and she can monitor adherence closely—critical for safe recovery and return to work.

Workers’ compensation cases require far more administrative time than standard visits, yet reimbursement is the same or lower. Physician dispensing is what allows clinics like ours to continue accepting these patients. Removing that ability after 30 days would make it financially impossible to maintain this service.

If SB2751, SD1 passes, many neighborisland physicians will be forced to stop treating injured workers, worsening access in communities that already face shortages.

I respectfully ask the Committee to return the bill to its original, narrow purpose or defer SB2751, SD1.

Mahalo for considering the realities faced by neighborislandproviders and patients.

SB-2751-SD-1

Submitted on: 2/26/2026 3:58:14 PM

Testimony for JDC on 3/3/2026 10:15:00 AM

Submitted By	Organization	Testifier Position	Testify
Nancy Monden	Individual	Comments	Written Testimony Only

Comments:

Testimony Regarding SB2751

I appreciate the opportunity to provide testimony on SB2751. There are both advantages and concerns associated with this measure.

Opiate medications have become increasingly difficult for providers to prescribe due to stricter oversight and regulatory requirements from the U.S. Food and Drug Administration and other governing bodies. While this oversight is understandable given the opioid crisis, it has created challenges for providers attempting to manage patients with legitimate pain needs. In some cases, compounded medications serve as appropriate alternatives; however, these compounds are often expensive and may not be affordable for many patients. In Hawaii there are very few pharmacies that provide compound medications. The price may be high but may be worth providing relief to pain.

Additionally, nonprescription drugs dispensed directly by providers may at times be medically necessary. However, the markup on these medications can be significant. Employers and insurance carriers often face difficulty challenging or denying these charges due to limited pricing transparency.

There have been prior situations that highlight these concerns. For example, a pain clinic on the Big Island dispensed morphine, hydrocodone, and other narcotics directly from the clinic at what were reported to be excessive prices. Such practices raise concerns about cost control and oversight.

I believe a balanced approach would allow providers to dispense a limited supply of medications—perhaps two to four weeks—when clinically appropriate. However, the prescription should also be transmitted to a licensed pharmacy to ensure proper documentation, transparency, and accountability. When medications are dispensed directly by a provider without pharmacy oversight, it can be difficult to independently verify exactly what was dispensed.

Thank you for considering these comments on SB2751.

To whom it may concern,

As a physician treating injured workers, I am writing to express my strong support for HB2164 in its original form. This bill provides essential clarity by aligning Hawaii's definitions with federal standards, ensuring that reimbursement for compounded medications is transparent and consistent.

However, I am deeply concerned by the "poison pill" amendments introduced by Pharmacy Benefit Managers (PBMs). These amendments serve only to create confusion and obstruct direct patient care. I urge you to reject these changes for the following reasons:

- **Protecting the Physician-Patient Relationship:** Restricting physician dispensing to only 30 days and forcing patients into PBM-controlled networks interferes with my ability to monitor compliance and adjust treatment in real-time. A PBM is not a substitute for a treating physician. I have personally tried to use PBMs. The result has been 90 percent failure, with patients not being able to get their medications at all due to refusal of outside pharmacies to accept the workers' compensation insurance or pharmacies' inability to confirm the approval from the adjuster due to lack of response from the adjusters. Plus, it is a well-known fact that physician dispensing significantly increases patient compliance, and results in improved clinical outcomes.
- **Preventing Administrative Collapse:** We are already facing a shortage of providers willing to treat injured workers. Adding layers of "medical necessity" statements for compounds, which are already prescribed based on clinical judgment, imposes an undue administrative burden that delays recovery.
- **Avoiding "Penny Wise, Pound Foolish" Outcomes:** By allowing PBMs to delay or deny necessary medications, the system will see an increase in untreated patients and longer "lost time" from work. While carriers may seek to save pennies on drug costs, they will ultimately pay pounds in increased indemnity claims and permanent disability costs.
- **Restoring Federal Alignment:** The proposed changes to the definition of "compounded prescription drug" deliberately blur the line between 503A and 503B facilities. This ambiguity allows bill review companies to ignore DLIR rulings and delay proper payment, further disincentivizing physicians from participating in the workers' compensation system.

The goal of this system is to help injured workers recover and return to the workforce. These amendments do the opposite, they prioritize PBM profits over patient health.

Please pass HB2164 as originally intended and remove the negative amendments noted.

Thank you for your time and for supporting Hawaii's physicians and injured workers.

Sincerely,

Mankwan Wong MD



Pacific Medical Group, LLC

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LATE

March 02, 2026

Dr. Eric Wruck, DC FNP
Pacific Medical Group, LLC
808-873-0733
info@pacmedgroup.com

To: Committee on Judiciary (JDC), Hawai'i State Legislature

Subject: Strong Opposition to SB2751 SD1

Dear Chair and Committee Members,

I am a worker's compensation provider in Kahului, Maui and have served our community for 30 years. I strongly oppose SB2751 SD1, particularly the 30-day dispensing limit, which is a severe departure from the original House bill.

First, many providers already hesitate to handle workers' compensation due to administrative burdens. If this passes, even more providers will step away, flooding the system with injured workers who have no access to care.

Second, in-office dispensing guarantees continuity and immediate access for patients who need timely treatment.

Third, our practice is part of the local economy, and our viability matters. Our practice supports local staff who have been with us for years, contributing to the community.

Finally, carriers have the option to negotiate with dispensing companies—many do—ensuring fair, cost-conscious arrangements.

I urge you to reject this extreme measure. Balanced reform is possible—one that preserves access, continuity, and provider participation.

Sincerely,

Dr. Eric Wruck, DC FNP

LATE

SB-2751-SD-1

Submitted on: 3/3/2026 5:41:43 AM

Testimony for JDC on 3/3/2026 10:15:00 AM

Submitted By	Organization	Testifier Position	Testify
Kara Bernal Jolley	Individual	Oppose	Written Testimony Only

Comments:

Dear Chair and Committee Members,

I respectfully urge you to **oppose SB2751 SD1**.

For the past 11 years, I have worked directly with physicians and injured workers, helping coordinate care and navigate the workers' compensation system.

Please keep injured workers at the center of this decision:

- They are already navigating pain and a complex system.
- Many rely on rides and coordinated visits.
- Adding new restrictions creates new barriers during recovery.
- There are already too few physicians willing to treat workers' compensation patients.
- Additional limitations will push more providers away.
- When providers leave, injured workers are left without care.

This system is already strained. Significant new restrictions risk narrowing access when stability is what patients need most.

Please do not pass SB2751 SD1 in its current form.

Respectfully,

Kara Bernal Jolley