

AMERICAN ARBITRATION ASSOCIATION

AIDS HEALTHCARE FOUNDATION and PHARMACY4HUMANITY,	:	
	:	
Claimants,	:	
	:	
v.	:	No. _____
	:	
HUMANA, INC. and	:	
HUMANA PHARMACY SOLUTIONS, INC.,	:	
	:	
Respondents.	:	

STATEMENT OF CLAIMS

Claimants AIDS Healthcare Foundation and Pharmacy4Humanity (collectively, “AHF”), by and through undersigned counsel, respectfully submit this Statement of Claims against Respondents Humana, Inc. and Humana Pharmacy Solutions, Inc. (collectively, “Humana”) to recover fees wrongfully imposed under the Humana Rx Quality Network Program and attendant damages. Humana imposed these unfair and unconscionable fees on AHF’s pharmacies in breach of its contractual obligations, in bad faith, and contrary to applicable law and regulations. AHF seeks to recover these fees, other damages, and any relief deemed necessary and proper. In support of its Statement of Claims, AHF states as follows:

NATURE OF THE CASE

1. Founded in 1987, AHF began as a network of hospices committed to fighting for people living with HIV and AIDS and caring for the dying. Since then, AHF has expanded, turning hospices into healthcare centers and building a new paradigm for HIV and AIDS care.

2. AHF's mission is to provide medical care to people living with HIV regardless of their ability to pay. AHF's patients include people without means of paying for care, as well as people of limited means who rely on government programs such as Medicaid, Medicare, and the Ryan White CARE Act to pay for care. AHF is an essential safety net provider for disenfranchised, high-risk populations.

3. AHF owns and operates specialty pharmacies that focus on serving patients with HIV and AIDS. AHF has 64 retail, accredited, specialty pharmacies in sixteen states, Washington D.C., and Puerto Rico. Many of AHF's pharmacies are located at or near AHF healthcare centers.

4. AHF's pharmacies are accredited as specialty pharmacies by the Accreditation Commission for Health Care for Specialty Pharmacy Services, with Distinction for Infectious Disease Specific to HIV. Accredited specialty pharmacies have demonstrated superior proficiency handling specialty medication which require higher levels of monitoring and patient education.

5. Among other services, AHF's pharmacies fill and dispense prescription drugs to patients, many of whom are beneficiaries of government-sponsored health plans with prescription drug coverage, such as Medicare Part D ("Filling and Dispensing Services"). As such, AHF's pharmacy customers include Medicare patients who are enrolled in the Medicare Part D prescription program. Medicare is the federal health insurance program for people who are 65 and over, as well as younger people with disabilities.

6. Humana, by and through its various subsidiaries and affiliates, is both a health insurer and one of the largest pharmacy benefits managers ("PBMs") in America. PBMs like Humana manage the prescription drug benefits of their clients, which can include for example, insurers, third party administrators, employer sponsors of group health plans, and government prescription drug plan sponsors.

7. Humana in its role as a PBM enters into contracts with pharmacies like AHF, which then provide pharmacy services under those contracts.

8. Since approximately 2004, AHF has contracted with Humana to participate in Humana's provider network and to provide Filling and Dispensing Services to eligible patients, including to Medicare Part D patients. Unfortunately, since that time, AHF has been systematically squeezed over a course of years by predatory and illegal contracts imposed on it by Humana. Humana abuses its market power to force AHF to submit to one-sided contracts. Worse yet, Humana engages in arbitrary, unreasonable, and bad faith interpretations of and conduct under these contracts, all to AHF's detriment.

9. As explained below, the predatory and illegal contracts that Humana imposes (collectively, the "Provider Contract") – and Humana's misconduct in carrying out their terms – maximizes Humana's profits at the expense of AHF and the beneficiaries of Medicare Part D plans. Humana unilaterally modifies its contract terms to make them even more lopsided and then adds insult to injury by, among other things, abusing its power, evading the spirit of the parties' bargain, and interpreting gaps in the agreement to Humana's sole benefit. The result is that AHF has fewer resources to carry out its mission to eradicate AIDS and generate new and innovative means of treatment and prevention, while Humana enjoys billions in profits.

10. One of the most onerous conditions of Humana's Provider Contract has been the imposition of draconian fees under its "Humana Rx Quality Network Program" (the "Quality Network Program" or "Program"). Humana illegally clawed back millions of dollars in payments received by AHF for its Filling and Dispensing Services to Medicare Part D plan beneficiaries ("Program Fees"). Among its other practices, Humana adopted unfair, unreasonable, and unconscionable "performance standards," which purport to measure "performance" based on

factors outside of AHF's control. Because of how Humana interpreted and applied its "performance standards," administered the Program, and assessed Program Fees, Humana has wrongfully withheld more and more of AHF's reimbursements each year.

11. Since 2017, Humana illegally withheld more than \$27 million from AHF under the Program.

12. Additionally, Humana imposed Program Fees not only to the detriment of AHF and Medicare Part D plan beneficiaries, but also in contravention of the law and regulatory scheme governing Medicare Part D. Fees such as the Program Fees imposed by Humana and other PBMs are often identified as "direct and indirect remuneration" ("DIR") fees. This label is based on a perceived loophole in Medicare Part D regulations that PBMs incorrectly argue has permitted them to impose such fees.

13. However, the statute and applicable regulations make clear that DIR fees like the Program Fees charged by Humana were never anticipated by Congress or the Center for Medicare and Medicaid Services ("CMS"), the agency responsible for administering Medicare Part D. The statute calls for all discounts, rebates, and other price concessions from pharmacies to be reflected in the price paid for a drug by the beneficiary at the time it is dispensed. The regulations left a very limited exception to this requirement for the rare situation that a discount or rebate could not be calculated at the point of sale. Humana impermissibly abused the Program and charged fees under the Program that it falsely claimed could not be calculated at the point of sale.

14. Despite guidance from CMS regarding the impropriety and adverse impact of such DIR fees under the regulatory regime, Humana continued to charge Program Fees. Indeed, Humana and other PBMs dramatically increased DIR fees year over year – more than 107,000%

between 2010 and 2020 – until CMS eliminated the exception as of January 1, 2024. In other words, DIR fees grew by more than one thousand times over ten years.

15. Humana’s Quality Network Program has been a sham and fraudulent by its very nature. While Humana claimed that the Program was designed to improve the “performance” of AHF and other pharmacies servicing Medicare Part D plans administered by Humana, its real purpose was to increase Humana’s profits at the expense of the pharmacies. For example, the Program purported to assign “performance” scores to pharmacies. Yet in practice, Humana appears to determine “performance” and assign scores primarily on its assessment of medication adherence – the rate at which AHF’s patients fill their prescriptions. Yet AHF pharmacies do not control what medications a physician orders for a patient or more importantly whether and how often the patient picks up the prescriptions. These factors are outside a pharmacy’s control.

16. Over and above its other contractual violations, Humana breached the parties’ contract for this additional reason. In its Provider Contract, Humana expressly agreed to “comply with all applicable federal, state, and CMS laws, rules and regulations to which Humana is subject.” However, Humana has failed to do so. For example, Medicare Part D requires that representatives of Part D plans like Humana contract with any willing pharmacy that meets the plan’s standard terms and conditions. 42 U.S.C. § 1395w-104(b)(1)(A); 42 CFR §423.120(a)(8)(i). These terms and conditions must be both relevant and reasonable. 42 U.S.C. § 1395w-104(b)(1)(A); 42 CFR §423.505(b)(18). Because Humana imposes DIR fees that are neither relevant nor reasonable, Humana is in violation of CMS rules and regulations. Federal law additionally prohibits Humana from requiring pharmacies to accept “insurance risk” of the type commonly assumed only by insurers. 42 U.S.C. § 1395w-104(b)(1)(A, E); 42 U.S.C. § 1395w-151(a)(7). Through its imposition of DIR fees and use of performance-based measures outside the

control of AHF, Humana is requiring AHF to accept risk of the type commonly assumed only by insurers, directly contrary to federal law.

17. The impact of the Quality Network Program and Humana’s bad faith, unfair, and unconscionable actions in administering it have been severe. Humana unreasonably penalizes specialty pharmacies. For example, in its most recent iteration of the Program, Humana slashed AHF’s reimbursement by 10% of a medication’s ingredient cost. Each AHF pharmacy could only recover the amount withheld months later if the pharmacy had a “Specialty Medication Performance Score” of 98%, as determined by Humana. If a pharmacy’s performance score was at least 75% but below 98%, Humana returned a mere 0.5% of the pharmacy’s ingredient cost. If a pharmacy’s performance score was less than 75%, Humana denied the pharmacy the full 10% of its ingredient cost that Humana withheld.

18. The Program has damaged AHF and Medicare Part D beneficiaries. In practice, Humana has calculated Program Fees in a manner making it impossible for AHF to adapt its practices to impact their “performance score” or even predict what their Humana Program Fees will be.

19. In reality, the Quality Network Program has not been a rational means for encouraging pharmacies like AHF to perform sensible tasks or lead to better patient outcomes for Medicare Part D beneficiaries. Rather, it has been a pretext for Humana to interpret the Program in such a way as to impose large, unjustified, after-the-fact fees on AHF’s pharmacies and dramatically and wrongfully increase its own revenue.¹

¹ Specialty pharmacies have long pointed out that they should not be penalized in reimbursements for events over which they have no control, such as when patients may be delayed in picking up or taking medication, or simply choose not to continue due to side effects or contraindications. *See, e.g.,* Medicine Counter Pharmacy, FTC-2022-0015-0443, at 2 (Apr. 14, 2022), <https://www.regulations.gov/comment/FTC-2022-0015-0443> (“Studies have shown [that patients] taking maintenance medicines on time have a better impact on health[;] however, there is little control that pharmacist[s] have on medication adherence. Our pharmacy enrolls patients in auto-refills, refill reminders, offers monthly pill packs, patient education, and free delivery[;] however for those patients who don’t want to we are unable

20. Humana’s Program Fees and contracting practices have seriously harmed AHF. This illegal and unconscionable seizure to pad Humana’s profits cannot be justified. AHF brings this dispute to recover the funds Humana has taken in bad faith and in breach of its contractual obligations.

PARTIES

21. AIDS Healthcare Foundation is a not-for-profit, public benefit, tax exempt, 501(c)(3) corporation domiciled in and with its principal place of business at 6255 Sunset Boulevard, 21st Floor, Los Angeles, California, 90028.

22. Pharmacy4Humanity is a California not-for-profit, public benefit corporation, and 501(c)(3) tax exempt charity, with its principal place of business at 6255 Sunset Boulevard, 21st Floor, Los Angeles, California, 90028.

23. AIDS Healthcare Foundation and Pharmacy4Humanity are affiliate entities that own and operate specialty pharmacies serving patients with HIV and AIDS. For purposes of Humana’s Provider Contract, AIDS Healthcare Foundation and Pharmacy4Humanity are collectively “AHF Pharmacies.” As noted above, for purposes of this Statement of Claims, they are referred to herein collectively as “AHF.”

to force patients to put the medicine in their mouths for those who don’t care about their health. Patients should be incentivized or penalized for picking up their medicines on time, NOT pharmacies.”); Dokimos Nevada City Pharmacy, FTC-2022-0015-0128, at 1 (Feb. 15, 2022), <https://www.regulations.gov/comment/FTC-2022-0015-0128> (“If a patient isn’t on certain medications (often due to a side effect or some contraindication determined by their doctor) we are punished and must pay higher fees. If a patient stops a medication for some reason, is hospitalized and not using their medication from home [and] so is deemed ‘non-compliant,’ we are also punished.”).

In a similar vein, internal PBM documents reviewed by the Federal Trade Commission (“FTC”) have shown PBM staff admitting how certain assessment metrics make no sense in application, such as applying non-specialty metrics to specialty pharmacies like AHF. On July 9, 2024, the FTC released an Interim Staff Report (the “Interim Report”) entitled: Pharmacy Benefit Managers: The Powerful Middlemen Inflating Drug Costs and Squeezing Main Street Pharmacies. The Interim Report describes what FTC staff has uncovered to date during a two-year investigation of the country’s six largest pharmacy benefit managers, including Humana. See <https://www.ftc.gov/reports/pharmacy-benefit-managers-report>.

24. Humana, Inc. is a for-profit corporation organized and existing under the laws of Kentucky, with its principal place of business at 500 West Main Street, Louisville, Kentucky, 40202.

25. Humana Pharmacy Solutions, Inc. is a for-profit corporation organized and existing under the laws of Kentucky, with its principal place of business at 500 West Main Street, Louisville, Kentucky, 40202.

26. Upon information and belief, Humana Pharmacy Solutions, Inc. is a subsidiary of Humana, Inc.

JURISDICTION

27. Under the terms of Humana's Provider Contract, any dispute between the parties must be arbitrated and administered by the American Arbitration Association under its then-applicable Commercial Arbitration Rules and Procedures.

28. AHF has exhausted all internal Humana administrative appeal, grievance, or other dispute resolution mechanisms prior to the submission of its Demand for Arbitration and this Statement of Claims. Specifically, on February 5, 2024, AHF wrote to Humana to object to the inequitable operation of the Quality Network Program, invoking the dispute-resolution procedures in the Provider Contract. Humana responded on March 7, 2024, disagreeing with AHF's positions but agreeing that AHF had exhausted Humana's internal dispute process and that the parties were at an impasse.

FACTUAL BACKGROUND

Specialty Pharmacies Like AHF Are Vital to Vulnerable Patient Populations

29. Pharmacists and pharmacies are integral to the American health care system. Many pharmacies play an outsized role in their communities, particularly with vulnerable segments of

the population. Many of their customers are of limited means and rely on pharmacists to understand their medical conditions and medications.

30. The National Association of Specialty Pharmacy defines “specialty pharmacy” as a pharmacy that solely or largely provides medications for people with serious health conditions requiring complex therapies. Specialty pharmacies focus on high-cost medication for patients with complex disease states.

31. Specialty pharmacies, among other things, connect patients who are severely ill with medications that are prescribed for their conditions, provide counseling on how to use these medications, and communicate as appropriate with caregivers and the patient’s physician or other health care providers. Specialty medications often have a complex profile that requires intensive patient management and, in some cases, special handling.

32. The American Pharmacists Association describes specialty medications as having some or all of the following key characteristics: treatment of complex, chronic, and/or rare conditions; high cost, often exceeding \$10,000, with some costing more than \$100,000 annually; availability through exclusive, restricted, or limited distribution; special storage, handling, and/or administration requirement; ongoing monitoring for safety and/or efficacy; and risk evaluation mitigation strategy.

33. As previously stated herein, AHF is a specialty pharmacy that focuses on serving patients that with HIV and AIDS.

34. A significant percentage of the medications provided by AHF are oral antiretrovirals (“ARVs”). ARVs have transformed disease management for people living with HIV, enabling people to have a lifespan comparable to the general population.

35. The U.S. pharmacy market was valued at approximately \$618 billion in 2023 and is projected to continue to grow as the number of prescribed medications increases annually.² The market is dominated by national retail chains, mass retail pharmacies, and mail-order pharmacies owned by Humana and the other PBMs. The market share of non-corporate-affiliated pharmacies has shrunk by 50% over the last couple of decades.³ As a result, as recent Congressional hearings found, independent pharmacies, including specialty pharmacies, are struggling because they cannot negotiate their contracts with PBMs in any meaningful type of fashion.⁴

36. Some pharmacies like AHF have held on despite growing challenges, especially from DIR fees. But that has not been true of all independent pharmacies. As stated by the New York Times, “[t]he disappearance of local pharmacies limits health care access for poorer communities but ultimately enriches P.B.M.’s parent companies, which own drug stores or mail-order pharmacies.”⁵

Medicare Part D

37. The vast majority of prescription drugs are not paid for directly by patients. Rather, they are paid for by insurance plans or other entities that pay for the drugs dispensed to patients on their behalf. A portion of the payment for the prescribed drug is usually made by the patient

² According to IBISWorld, the U.S. pharmacy market was valued at \$618.2 billion in 2023, which was a 5.6% increase from the previous year.

³ See <https://www.mckinsey.com/industries/healthcare/our-insights/meeting-changing-consumer-needs-the-us-retail-pharmacy-of-the-future>.

⁴ See *The Role of Pharmacy Benefit Managers in Prescription Drug Markets Part I: Self-Interest of Healthcare?: Hearing Before H. Comm. on Oversight & Accountability*, 118th Cong. (May 23, 2023); *The Role of Pharmacy Benefit Managers in Prescription Drug Markets Part II: Not What the Doctor Ordered: Hearing Before H. Comm. on Oversight & Accountability*, 118th Cong. (Sept. 19, 2023).

⁵ See Rebecca Robbins & Reed Abelson, *The Opaque Industry Secretly Inflating Prices for Drug Prescription*, New York Times (June 21, 2024), available at <https://www.nytimes.com/2024/06/21/business/prescription-drug-costs-pbm/html>.

under the conditions of a plan as a “co-pay,” “co-insurance,” or “deductible” while the rest is covered by the plan.

38. Medicare Part D is a voluntary outpatient prescription drug benefit for Medicare beneficiaries. Its enrollees constitute a large percentage of the prescriptions filled each year in the United States. Although funded by the federal government, the benefits are administered through private plans that contract with the federal government. Medicare beneficiaries have access to prescription drug coverage through these Part D plans.

39. Beneficiaries of Medicare Part D can choose to enroll in a stand-alone prescription plan (“PDP”) to supplement traditional Medicare or as part of a Medicare Advantage plan that provides all Medicare-covered benefits including prescription drugs. These plans pay for beneficiaries’ prescription drugs, with the beneficiary paying a portion of the expense.

40. In 2023, approximately 50 million of the 65 million people covered by Medicare were enrolled in Part D plans.⁶ Because Medicare recipients are prescribed more drugs on average than the population as a whole, Medicare beneficiaries constitute an even more outsized percentage of filled prescriptions than their already large numbers would indicate.

41. Medicare Part D enrollment is concentrated in three national firms – UnitedHealth, CVS Health, and Humana – with a combined 57% of all Part D enrollees in 2023.⁷

As a PBM, Humana Stands Between Patients and Their Medication

42. As noted above, Humana is one of the largest PBMs, existing the center of the pharmaceutical industry.

⁶ See <https://www.kff.org/medicare/fact-sheet/an-overview-of-the-medicare-part-d-prescription-drug-benefit/>.

⁷ See <https://www.kff.org/medicare/issue-brief/key-facts-about-medicare-part-d-enrollment-and-costs-in-2023/>.

43. Decades ago, PBMs began as administrative service providers working to validate and process pharmacy benefits provided by separate insurance plans. They then expanded into negotiating with pharmaceutical manufacturers on behalf of those plans, developing reimbursement terms and conditions for pharmacies, and developing formularies (i.e., lists of drugs a health plan will cover and reimburse for). Now, after years of acquisitions, the leading PBMs, including Humana, are each part of massive healthcare conglomerates that are often comprised of a health insurer, pharmacies, and the PBM negotiator between health insurers and pharmacies – all rolled into one. The result is that Humana can often exercise significant control over which drugs are available, at what price, and which pharmacies patients can use to access their prescribed medications.

44. Today, the six largest PBMs – CVS Caremark, Express Scripts, OptumRx, Humana, MedImpact, and Prime – manage 94 percent of prescription drug claims in the United States. Four of the largest PBMs are part of publicly traded healthcare conglomerates: UnitedHealth Group Inc., CVS Health Corp. (“CVS”), The Cigna Group, and Humana Inc. In 2016, the combined revenue of these four conglomerates totaled \$456 billion and equaled 14 percent of national health expenditures in the United States. Today, their combined revenue exceeds \$1 trillion and equals 22 percent of national health expenditures.⁸

45. According to the FTC, vertical integration in PBM business structures, particularly with respect to integrated health insurers and specialty and mail order pharmacies like Humana, creates the ability and incentive to increase the use of certain drug products at affiliated pharmacies to generate the greatest revenue and profits for their respective conglomerates. Indeed, Humana’s

⁸ See U.S. Federal Trade Commission, *Pharmacy Benefit Managers: The Powerful Middlemen Inflating Drug Costs and Squeezing Main Street Pharmacies*, Interim Staff Report, p. 6 (July 2024).

affiliated pharmacies operate in direct competition with unaffiliated pharmacies to distribute medications to patients.⁹

46. Pharmacies do not have the option to choose one PBM over another. Each plan is administered by a single PBM, so a pharmacy cannot shop different PBMs to serve the same patients. If the pharmacy does not contract with Humana, its patients must fill their prescriptions at a different pharmacy – one that does contract with Humana – to use their Medicare Part D coverage. To serve the millions of beneficiaries in Medicare Part D plans affiliated with Humana, pharmacies like AHF have no practical choice but to participate in the Humana network.

47. Humana’s vertical integration and the concentrated market enable it to abuse its resulting market power. Humana can interpret the Quality Network Program and coerce pharmacies like AHF to pay exorbitant DIR fees. If the pharmacies survive, Humana obtains inflated profits. If the DIR fees drive independent pharmacies out of business, Humana then benefits from eliminating rivals and steering their customers toward its mail-order pharmacies. Either way, Humana wins, and pharmacies and patients lose.

48. In bringing a recent lawsuit against Express Scripts, Ohio Attorney General Dave Yost described the impact of PBMs as follows:

PBMs are modern gangsters They were designed to protect and negotiate on behalf of employers and consumers after Big Pharma was criticized for overpricing medications, but instead they have absolutely destroyed transparency, scheming in the shadows to control drug prices on all sides of the market.

⁹ See U.S. Federal Trade Commission, Pharmacy Benefit Managers: The Powerful Middlemen Inflating Drug Costs and Squeezing Main Street Pharmacies, Interim Staff Report, p. 5 (July 2024). According to the report, PBMs are steering patients to their affiliated pharmacies and away from unaffiliated pharmacies. *Id.*

In the context of Medicare Part D, PBMs have acted just as Attorney General Yost criticized. As discussed below, their conduct has resulted in massive profits for PBMs generally, and Humana in particular, at the expense of not only pharmacies, but Medicare and its beneficiaries as well.¹⁰

Humana's Contracting Practices and Contracts With AHF

49. The Humana "Provider Contract" is not the subject of competitive arms-length negotiations between Humana and AHF. Humana leverages its market power to force pharmacies to accept the Quality Network Program on a "take it or leave it" basis. Pharmacies like AHF must operate under these terms or be denied access to the millions of beneficiaries covered by Medicare Part D plans serviced by Humana.

50. In the Provider Contract, Humana reserves the right to unilaterally amend the Quality Network Program at any time. Humana further reserves the right to interpret the terms and provisions of the Program and to otherwise supervise the administration of the Program, declaring that all decisions made by Humana are final and binding.

51. The provisions of the Quality Network Program are non-negotiable, and Humana imposed them with no prior review or discussion with AHF. AHF is forced to either accept and labor under unfair, unreasonable, and unconscionable terms, or members of their vulnerable patient population covered by plans represented by Humana, including Part Medicare D plans, cannot fill their prescriptions at AHF pharmacies.

52. Notably, AHF cannot turn to the federal government for assistance with respect to the Quality Network Program, despite the fact that Medicare Part D is a federally-funded program, and Humana nominally represents Part D plans contracting with AHF on their behalf. CMS

¹⁰ See Rebecca Robbins & Reed Abelson, *The Opaque Industry Secretly Inflating Prices for Prescription Drugs*, New York Times, June 21, 2024 (describing the PBM industry and its detrimental impact on pharmacies, plans, and patients), available at <https://www.nytimes.com/2024/06/21/business/prescription-drug-costs-pbm/html>.

follows a policy of “noninterference” and does not police PBMs in their negotiations with pharmacies. The applicable statute states, in relevant part, that “[i]n order to promote competition under this part and in carrying out this part, the Secretary (1) may not interfere with the negotiations between drug manufacturers and pharmacies and PDP sponsors.” 42 U.S.C. § 1395w-111(i). CMS has even added that it “generally do[es] not interfere in plan-pharmacy contract negotiations or opine on the reasonableness or relevancy of specific contractual terms.” 74 Fed. Reg. 1,494, 1510 (Jan. 12, 2009); *see also* 70 Fed. Reg. 4,194, 4255 (Jan. 28, 2005).

53. Notably, however, Humana specifically agreed in its Provider Contract with AHF to abide by federal and state laws and regulations. Section 3.2 of the Provider Contract states that “Humana shall comply with all applicable federal, state, and CMS laws, rules and regulations to which Humana is subject.” Yet despite this express promise to adhere to applicable laws, which AHF relied upon to its detriment, Humana does not do so. Taking full advantage of CMS’s noninterference policy, and despite Section 3.2 of the Provider Contract, Humana regularly and flagrantly violates applicable laws and regulations, including rules and regulations issued by CMS.

54. For example, Medicare Part D requires that its Part D plans (and their representatives like Humana and other PBMs) must contract with any willing pharmacy that meets the plan’s standard terms and conditions. *See* 42 U.S.C. § 1395w-104(b)(1)(A); 42 CFR § 423.120(a)(8)(i). These terms and conditions must be both relevant and reasonable and allow any willing pharmacy to participate. *See* 42 U.S.C. § 1395w-104(b)(1)(A); 42 CFR § 423.505(b)(18). However, the Quality Network Program and other conditions of the Humana Provider Contract contain terms that are neither relevant nor reasonable, withholding “fees” as explained below on bases that are irrelevant and unreasonable, as well as unconscionable.

55. Medicare Part D also prohibits Humana and other PBMs from requiring pharmacies to accept “insurance risk.” 42 U.S.C. § 1395w-104(b)(1)(E); 42 CFR § 423.120(a)(8)(ii). “Insurance risk” is defined as “risk of the type commonly assumed only by insurers licensed by a State and does not include payment variations designed to reflect performance-based measures of activities within the control of the pharmacy, such as formulary compliance and generic drug substitution.” 42 U.S.C. § 1395w-151(a)(7); *see also* 42 CFR § 423.4. The prohibited insurance risk therefore includes performance-based measures outside the control of the pharmacy. *Id.* But the Quality Network Program and other conditions of the Humana Provider Contract force insurance risk on pharmacies in direct contravention to the regulatory scheme.

56. The impact of draconian contracting practices by Humana and other PBMs has been felt by AHF and other specialty pharmacies across the country. As described above and discussed in the recent report prepared by the House Committee on Oversight and Accountability, the “fees” imposed by PBMs are “an avenue . . . to claw back or charge back pharmacies” and “are being manipulated by PBMs to increase profits and introduce vast uncertainty for pharmacies that are hit with unpredictable fees that result in negative reimbursement rates.” The PBMs “penalize” specialty pharmacies and assess higher fees on them. *See* House Committee on Oversight and Accountability, *The Role of Pharmacy Benefit Managers in Prescription Drug Markets*, July 23, 2024, available at: <https://oversight.house.gov/wp-content/uploads/2024/07/PBM-Report-FINAL-with-Redactions.pdf>.

Direct and Indirect Remuneration Fees

57. Congress anticipated and required that Medicare Part D beneficiaries receive the full benefit of any discounting when they pay for a drug at the time it is dispensed to them. The statute requires that beneficiaries be provided with access to “negotiated prices” for payment for drugs covered under Medicare Part D. 42 U.S.C. § 1395w-102(d)(1)(A). The statute further states

that “negotiated prices shall take into account negotiated price concessions, such as discounts or indirect subsidies, rebates, and direct or indirect remunerations, for covered Part D drugs, and include any dispensing fees for such drugs.” *Id.* at §1395w-102(d)(1)(B).

58. The Conference Report to the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 stated the following: “Qualified drug plans would be required to provide beneficiaries with access to negotiated prices (including all discounts, direct or indirect subsidies, rebates, other price concessions, or direct or indirect remunerations), regardless of the fact that no benefits may be payable.” H.R. Rep. No 108-391, at 438 (2003) (Conf. Rep.). The legislative history further added that “all PDP plans will be required to make available to their enrollees the benefit of all price discounts.” H.R. Rep. No. 108-178, pt. 1, at 184 (2003) (emphasis added).

59. CMS enacted regulations that defined “negotiated prices” under Medicare Part D as prices for covered drugs that are “reduced by those discounts, direct or indirect subsidies, rebates, other price concessions, and direct or indirect remuneration that the Part D sponsor has elected to pass through to Part D enrollees at the point of sale.” 42 C.F.R. §423.100.

60. In 2014 rulemaking, CMS declared that “we believe that the best interpretation of statutory intent is that all pharmacy price concessions must be reflected in the negotiated price.” CMS drafted a regulation that was intended to further clarify Congressional intent regarding “negotiated prices” under the Medicare Part D program. In the rulemaking process, CMS stated the following:

[W]hen price concessions from pharmacies are reflected in forms other than the negotiated price, the degree of price concession that the pharmacy has agreed to is no longer reflected in the negotiated prices available at point of sale or reflected on the Medicare Prescription Drug Plan Finder (Plan Finder) tool. Thus, the true price of drugs at individual pharmacies is no longer transparent to the market. Consequently, consumers cannot efficiently minimize both their costs (cost

sharing) and costs to the taxpayers by seeking and finding the lowest-cost drug/pharmacy combination. Moreover, as the coverage gap closes, there are fewer and fewer beneficiaries who are exposed to the full cost of drug products, either at the point of sale or as reflected in Plan Finder estimates. When this occurs, the basis of competition shifts from prices to cost sharing, and the pricing signals available to the market can be distorted when lower cost sharing is not aligned with lower prices. Thus, we believe the exclusion of pharmacy price concessions from the negotiated price thwarts the very price competition that the Congress intended when it said that private plans would compete with other plans on both premiums and negotiated prices.

61. The proposed rules went into effect on January 1, 2016, and required all price concessions from network pharmacies to be included in the “negotiated prices” established between the pharmacy and the PBMs, except for what the agency deemed a “narrow” exception. This narrow exception to the general rule excluded from the negotiated price “those contingent price concessions that cannot reasonably be determined at the point-of-sale.”

62. This narrow exception galvanized Humana and other PBMs to illegally exploit “performance based” direct and indirect remuneration (“DIR”) fees that were purportedly unable to be calculated at the time the beneficiary paid for his or her prescription. In making these rules, CMS did not anticipate the PBMs’ illegal exploitation of the exception and the subsequent and dramatic increase in DIR fees that would be imposed by the PBMs, and CMS’s rulemaking reflected its belief that the amount of money that could not be determined at the point of sale to be minimal.

63. The PBMs justified these fees by claiming that they were based on “performance” standards (although those standards were a sham, as explained herein with respect to the Humana “performance” standards). In so doing, the PBMs falsely claimed that these fees were not able to be calculated at the point of sale and therefore did not need to be accounted for in the price paid by the Medicare Part D plans and their beneficiaries at the point of sale.

64. DIR fees imposed on pharmacies by PBMs exploded in volume. From 2010 to 2020, DIR fees charged by PBMs increased by 107,400%, which means that these fees grew 1000 times larger. Pharmacy price concessions in the form of DIR fees increased from less than \$9 million in 2010 to **\$12.6 billion** in 2021. DIR fees increased by another 36% from 2021 to 2022. In 2022, pharmacies paid a total of **\$17.1 billion** in DIR fees, or approximately 7% of gross expenditure for Medicare Part D.

65. In 2018, CMS informed PBMs and Part D sponsors that their manipulation of post point-of-sale pharmacy price concessions after the point of sale was anti-competitive. As part of proposed rulemaking CMS stated: “The one-sided nature of the pharmacy payment arrangements that currently exist also creates competition concerns by discouraging independent pharmacies from participating in a plan’s network and thereby increasing market share for the sponsors’ or PBMs’ own pharmacies. Part D is a market-based approach to delivery of prescription drug benefits and relies on healthy market competition. Thus, adopting policies that promote competition is an important and relevant consideration in protecting Medicare beneficiaries and the Medicare trust fund from unwarranted costs. Market competition is best achieved when a wide variety of pharmacies are able to compete in the market for selective contracting with plan sponsors and PBMs.” 83 Fed. Reg. 62,176.

66. The DIR fees being charged by the PBMs became so overwhelming to AHF and other specialty and independent pharmacies that CMS was forced to completely change the rules regarding DIR fees to end this wrongful practice. In 2022, CMS finalized a rule that eliminated the narrow exception for contingent price concessions that cannot reasonably be determined at the point of sale, as it was clearly not being used narrowly and legally by PBMs, effective January 1, 2024. 87 Fed. Reg. 27,704, 27,839 (May 9, 2022).

67. Yet in the meantime, AHF has been significantly harmed by Humana’s punitive and predatory conduct. Humana has wrongfully assessed DIR fees in violation of longstanding CMS rules and regulations that Humana agreed to abide by in its Provider Contract, as well as contrary to its legal obligations under other applicable federal and state laws. From 2017 through 2023, AHF lost more than \$27 million in revenue to Humana DIR fees – monies that otherwise would have gone into services and advocacy for people impacted by HIV, consistent with AHF’s nonprofit mission.

Humana Rx Quality Network Program

68. In or around 2016, Humana established the Quality Network Program, which is incorporated into the Provider Contract and is mandatory for pharmacies that contract with Humana. The Program imposed DIR fees that are clawed back from the ingredient cost paid to pharmacies on a per prescription basis. The Program fees were nominally based on the “performance” of the pharmacy over a designated period, though as explained herein, that notion is a fiction. Humana determines “performance” based on “quality measures” it establishes and applies in an unjustifiable, bad faith, and wrongful manner.

69. Humana has administered the Quality Network Program so as to unfairly penalize specialty pharmacies like AHF and to ensure that specialty pharmacies will fail to achieve the performance standards. Humana’s 10% penalty on ingredient costs is especially punitive because of the fact that ARVs and other specialty medications are expensive. In this way, Humana disproportionately impacts AHF and its patients with chronic health issues.

70. Additionally, Humana has used medication adherence standards, which are based on whether patients timely pick up their prescriptions from the pharmacy, in a manner that has unfairly, unreasonably, and unconscionably penalized AHF and other pharmacies. What a

physician prescribes and whether the patient picks up a prescription are factors outside the pharmacies' control. It is a physician – not a pharmacist – who is responsible for the clinical judgment as to what medication to prescribe. And it is the patient – not the pharmacist – who decides whether to pick up his or her prescription. Worse yet, this case concerns AHF's Medicare Part D patient population, meaning that the patients are either age 65 or older or have qualifying disabilities, in addition to having HIV. As Humana well knows, these patients struggle with adherence challenges, including significant comorbidities, stigma, and social determinants.

71. Humana has continually changed the Quality Network Program to withhold more and more revenue from participating pharmacies like AHF. For example, prior to 2019, under the Program, Humana's holdback amount was \$5.00 per eligible claim from the amount due to the pharmacy. Effective as of January 1, 2019, Humana adopted a new methodology, withholding 8% of the total ingredient cost per eligible claim, and for specialty pharmacies like AHF, only allowing pharmacies that have a "performance score" of 98%¹¹ recover that 8% back. By contrast, if a pharmacy's "performance score" was 75%, Humana would repay a meager 0.5% of the amount previously withheld. If a pharmacy's "performance score" was less than 75%, Humana would not repay anything. (In contrast, for traditional pharmacies, Humana allowed pharmacies that performed at least in the 75% percentile to recover 120% of the amount withheld. Humana thus unfairly penalizes specialty pharmacies, which typically dispense more expensive medications.) Even more egregious, the 98% performance score set by Humana means that a specialty pharmacy will only recover the amount withheld if 98% of their patients achieve a record of near-perfect medication adherence over the course of a year. Effective as of January 1, 2023, Humana made

¹¹ Moreover, as noted above, the notion of a performance metric is taken from the CMS Star Ratings, which apply to health plans, not pharmacies. But CMS's passing threshold is that 75% of patients must be at least 90% adherent to their medications. Thus, not only does Humana use a metric or standard that does not make sense to apply to a pharmacy, but by setting the performance metric at 98%, Humana also has distorted it to make it virtually unattainable.

things even worse, raising the percentage of ingredient cost withheld from 8% to a whopping 10%. In addition to these already punitive and detrimental conditions of the Program, if a pharmacy does not have 10 patients to be tracked, regardless of that pharmacy’s performance score, that pharmacy has no ability to receive back the 10% of ingredient cost improperly withheld by Humana.

72. The combination of Humana’s withholding 10% of ingredient cost plus the 98% performance score has damaged AHF and its pharmacies. For example, if as few as 3 of 100 patients of a pharmacy or 2 of 50 patients of a pharmacy fail to pick up their prescriptions on what Humana determines to be a timely basis, Humana will not return 9.5% of the 10% of the ingredient cost withheld. Humana thus imposes an egregious 10% penalty on every prescription, which is compounded with an illusory promise to return those funds based on AHF’s meeting a 98% “performance standard” based on factors outside the control of the pharmacy. Humana’s Program is unfair, unreasonable, and unconscionable.

73. The amounts Humana has withheld from AHF over the past several years have been significant. The following chart illustrates the drastic impact on AHF’s revenue, meaning that AHF has a diminished ability to carry out its mission of providing health care to the HIV and AIDS patient population:

Year	Amount of Net DIR Fees Withheld by Humana Since 2017
2017	\$44,612
2018	\$364,838
2019	\$3,754,238
2020	\$4,812,480
2021	\$4,652,328
2022	\$7,031,635

2023	\$6,762,768
TOTAL	\$27,422,889

As a result of Humana’s illegal withholding of revenue from AHF, AHF has been unable to use monies that otherwise would have gone into services and advocacy for people impacted by HIV, consistent with AHF’s nonprofit mission.

74. It is important to note that the injurious effect of Humana’s Quality Network Program on AHF and its pharmacies is particularly detrimental given the nature of the medications that AHF pharmacies dispense and the types of patients that AHF serves. The specialty drugs that AHF pharmacies dispense for their HIV and AIDS patients are very expensive. Because Humana’s Program penalizes pharmacies based on a percentage of drug ingredient cost, the Program has a disproportionately harsh impact on drugs that cost more, like antiretroviral medications, which are a critical part of treating and preventing HIV infection and the care of patients living with HIV. Furthermore, many of AHF’s Medicare Part D patients with HIV and AIDS have serious comorbidities, are elderly, and/or are impacted by social determinants including homeless, substance abuse, or incarceration.

75. AHF engages in significant efforts on outreach and case management, including working with physicians and others involved in patients’ overall healthcare; monthly calls to patients to remind them that their refills are due; asking whether patients would like to pick their prescriptions up, have them delivered, or request some other method of receiving their monthly medications; synchronizing routine medications so that refills are all due at the same time; and reviewing medications with patients during monthly calls to make sure know what medications they are supposed to be taking. Yet regardless of what AHF pharmacies do to assist patients in

adhering to their medications, it is ultimately the patient who determines medication adherence.¹² AHF cannot force its patients to refill their prescriptions.

76. In sum and effect, the Quality Network Program reduces the reimbursement level received by AHF for filling prescriptions for Medicare Part D beneficiaries, and AHF's pharmacies do not receive the bargained-for reimbursement. As is the case with many specialty pharmacies, AHF has been significantly harmed by Humana. Humana required AHF to pay millions of dollars in improper and unlawful DIR fees.

CLAIMS FOR RELIEF

Count I (Breach of Duty of Good Faith and Fair Dealing)

77. AHF hereby incorporates by reference paragraphs 1 through 84 herein.

78. AHF agreed to provide prescription drug services to patients administered by Humana in good faith and with the full expectation that Humana would act in good faith in its conduct.

79. AHF fully performed its obligations, including dispensing medications to eligible patients and timely submitting claims for reimbursement in compliance with the requirements of the Provider Contract.

80. The above-described conduct of Humana violated the implied covenant of good faith and fair dealing. Humana exercised its discretion under the Quality Network Program and performed its contractual obligations under the Provider Contract in bad faith, unfairly, and unconscionably. In so doing, Humana denied AHF the benefit of its bargains.

¹² Medication adherence usually refers to whether patients take their medications as prescribed (*e.g.*, twice daily), as well as whether they continue to take a prescribed medication. Proportion of Days covered while framed as an adherence measure, does not actually indicate whether the patient is "taking his or her medication." It is more reflective of a pharmacy dispensing metric or a measure of how often a patient picks up a medication refill. A patient can do as he or she pleases with that medication once it is dispensed by the pharmacy, which may or may not include taking the medication.

81. Humana has acted in bad faith and breached the implied covenant of good faith and fair dealing in its performance of the contract generally.

82. In addition, Humana has wrongfully exercised its discretion in how it has interpreted and carried out the Program, which has no relation to the “performance” of AHF pharmacies and is merely a means for Humana to increase its profits and deprive AHF of its bargained-for reimbursement.

83. Among other things, Humana abused its discretion in assessing Program Fees by relying on factors outside of AHF’s control and setting “performance” standards that were unattainable and, in practice, a sham.

84. Humana’s repeated breaches of the implied covenant in connection with the Provider Contract caused harm to AHF in an amount in excess of \$27 million.

Count II (Unconscionability)

85. AHF hereby incorporates by reference paragraphs 1 through 92 herein.

86. The Provider Contract is an adhesive contract.

87. Certain terms of the Provider Contract do not fall within the reasonable expectations of AHF, the adhering party.

88. Certain terms of the Provider Contract are both substantively and procedurally unconscionable.

89. The Provider Contract contains terms, such as the Quality Network Program, that are so one-sided that they illustrate the imbalance in the obligations and rights between Humana and AHF, particularly the profit that Humana gains to AHF’s expense. The Program Fees exemplify the significant cost-price disparity resulting from the unconscionable terms of the Quality Network Program.

90. At the time of contract, AHF was at a severe bargaining power disadvantage as Humana had exclusive control over access to all beneficiaries of insurance plans administered by Humana, including Medicare Part D plans. The burgeoning Program Fees levied by Humana demonstrate that bargaining did not proceed as it should have.

91. AHF is entitled to a ruling that the portions of the Humana Provider Contract and the ways that Humana has interpreted and carried out the Quality Network Program do not fall within AHF's reasonable expectations and/or are substantively and/or procedurally unconscionable and unenforceable.

**Count III (Claim of Breach of Contract Based on Humana's
Violations of CMS Regulations and Federal Law)**

92. AHF hereby incorporates by reference paragraphs 1 through 99 herein.

93. In Section 3.2 of the Provider Contract, Humana agreed to "comply with all applicable federal, state, and CMS laws, rules and regulations to which Humana is subject."

94. However, Humana has failed to comply with "applicable federal, state, and CMS laws, rules and regulations," including federal law and CMS regulations.

95. Contrary to applicable rules and regulations that require all price concessions, except those that cannot be reasonably determined at the point of sale, to be reflected at the point of sale, Humana levied Program Fees post-point of sale, despite being able to determine a minimum Program fee in every instance at the point of sale, all in direct contravention of Medicare Act rules and regulations, including 42 U.S.C. 423.100.

96. The terms of Humana contracts imposing and improper Program fees post-point of sale on AHF violate the law, are contrary to public policy, and are unenforceable.

97. Humana’s imposition of improper Program fees post-point of sale in violation of, inter alia, 42 U.S.C. 423.100, is detrimental to AHF and has damaged AHF, requiring AHF to pay Humana at least \$27 million in improper fees.

98. AHF is entitled to damages caused by Humana’s breaches of the Provider Contract arising out of Humana’s violations of federal law.

Count IV (Claim of Breach of Contract Based on Humana’s

Violations of the Any Willing Provider Law)

99. AHF hereby incorporates by reference paragraphs 1 through 106 herein.

100. As stated above, in Section 3.2 of the Provider Contract, Humana agreed to “comply with all applicable federal, state, and CMS laws, rules and regulations to which Humana is subject.”

101. Humana has failed to comply with all “applicable federal, state, and CMS laws, rules and regulations,” including federal law and CMS regulations.

102. The applicable federal laws include 42 U.S.C. § 1395w-104(b)(1)(A), the “any willing provider” law. Medicare Part D requires that its Part D plans (and their representatives such as Humana) contract with any willing pharmacy that meets the plan’s standard terms and conditions. 42 U.S.C. § 1395w-104(b)(1)(A); 42 CFR §423.120(a)(8)(i). These terms and conditions must be both relevant and reasonable and allow any willing pharmacy to participate. 42 U.S.C. § 1395w-104(b)(1)(A); 42 CFR §423.505(b)(18). In other words, the any willing provider law applies directly to Medicare programs and requires a prescription drug plan or its

contracted pharmacy benefit manager to permit the participation of any pharmacy that meets the terms and conditions of participation under the plan.

103. The any willing provider law is further codified in 42 C.F.R. § 423.505(b)(18), which states that a Plan D plan sponsor, and all related downstream entities such as PBMs, must agree to have “a standard contract with reasonable and relevant terms and conditions of participation whereby any willing pharmacy may access the standard contract and participate as a network pharmacy.”

104. Humana’s imposition of improper Program fees post-point of sale is unreasonable.

105. Humana’s imposition of the performance standards is unreasonable.

106. AHF is entitled to damages caused by Humana’s breaches of the Provider Contract arising out of Humana’s violations of the any willing provider law.

Count V (Claim of Breach of Contract Based on Humana’s

Violations of Insurance Risk Law)

107. AHF hereby incorporates by reference paragraphs 1 through 114 herein.

108. In Section 3.2 of the Provider Contract, Humana agreed to “comply with all applicable federal, state, and CMS laws, rules and regulations to which Humana is subject.”

109. Humana has failed to comply with “applicable federal, state, and CMS laws, rules and regulations,” including federal law and CMS regulations.

110. As described above, Medicare Part D prohibits Humana from requiring pharmacies to accept “insurance risk.” 42 U.S.C. § 1395w-104(b)(1)(A, E); 42 CFR § 423.120(a)(8)(ii). “Insurance risk” is defined as “risk of the type commonly assumed only by insurers licensed by a State and does not include payment variations designed to reflect performance-based measures of activities within the control of the pharmacy, such as formulary compliance and generic drug

substitution.” 42 U.S.C. § 1395w-151(a)(7); *see also* 42 CFR § 423.4. The prohibited insurance risk includes performance-based measures outside the control of the pharmacy. Humana’s Program creates unfair and detrimental negative variations in payment based upon factors outside the control of AHF, thereby imposing, as a condition of participation in Humana’s contracted pharmacy network, a requirement that AHF accept risk of the type commonly assumed only by licensed insurers, in direct contravention of Medicare Act rules and regulations, including 42 U.S.C. 423.120.

111. The terms of Humana contracts imposing insurance risk on AHF violate the law, are contrary to public policy, and are unenforceable.

112. Humana’s requirement that AHF accept insurance risk in violation of, *inter alia*, 42 U.S.C. 423.120, is detrimental to AHF and has damaged AHF, causing a loss to AHF of at least \$27 million.

113. AHF is entitled to damages caused by Humana’s breaches of the Provider Contract arising out of Humana’s violations of federal law.

Count VI (Alternative Claim of Unjust Enrichment)

114. AHF hereby incorporates by reference paragraphs 1 through 121 herein.

115. Humana’s collection of unconscionable and unlawful DIR Fees from AHF unjustly enriched Humana, and AHF is entitled to disgorgement of those improperly extorted fees.

116. In particular: a) Humana has been unjustly enriched by its collection of improper and unlawful Program Fees from AHF; b) AHF has been impoverished by and to the extent of Humana’s collection of improper Program Fees; c) Humana’s enrichment was directly connected to AHF’s impoverishment; d) there is no valid justification for Humana’s enrichment and AHF’s subsequent impoverishment; and e) AHF has not received the reasonable benefit of its contractual

bargain with Humana, and has been forced to pay DIR fees based on unlawful and unenforceable contractual provisions, thus there has been no showing that there is an available contractual remedy provided by law.

117. Humana is therefore liable to AHF to the extent it was unjustly enriched by AHF's payment of improper, unconscionable, and unlawful fees.

118. Humana should be ordered to return to AHF the money it took in enforcing its improper, unconscionable, and unlawful contract provisions.

Count VII (Alternative Claim of Quantum Merit)

119. AHF hereby incorporates by reference paragraphs 1 through 126 herein.

120. AHF conferred benefits on Humana by providing Filling and Dispensing Services to beneficiaries covered by Medicare Part D plans it administered.

121. Humana accepted the services and other benefits conferred by AHF.

122. The unconscionability and unlawfulness of Humana's actions renders the contracts between AHF and Humana unenforceable as they relate to Program Fees assessed pursuant to the Quality Network Program.

123. Humana was under reasonable notice that AHF expected to be paid.

124. Humana should compensate AHF for the fair value of its services.

REQUEST FOR RELIEF

WHEREFORE, AHF respectfully requests that the Arbitrator:

- a) Award AHF general damages, according to proof at arbitration, in excess of \$27 million;
- b) Award punitive and/or exemplary damages for Humana's oppressive, fraudulent, and/or malicious conduct;
- c) Award pre- and post-judgment interest at the applicable legal rate;

- d) Award expenses and costs of arbitration, including all costs and fees and attorneys' fees;
- e) In the alternative, award AHF the amount to which Humana has been unjustly enriched and AHF unfairly impoverished;
- f) In the alternative, award AHF the funds paid by it in connection with the unconscionable provisions of its contracts with Humana; and
- g) For all other such relief as the Arbitrator may deem just, proper, and equitable.

Respectfully submitted,

BAKER, DONELSON, BEARMAN
CALDWELL & BERKOWITZ, P.C.

Kristine L. Roberts (TN BPR No. 23856)
Jerrick D. Murrell (TN BPR No. 34368)
165 Madison Avenue, Suite 2000
Memphis, TN 38103
Telephone: (901) 577-2000
klroberts@bakerdonelson.com
jmurrell@bakerdonelson.com

Andrew Hurst (DC BPR No. 455471)
901 K Street, NW, Suite 900
Washington, DC 20001
Telephone: (202) 326-5016
ahurst@bakerdonelson.com