Date: June 10, 2025

To: Chair Sharon Ray, Members of House General Government Committee

From: Sean Stephenson, Senior Director of State Affairs for the Pharmaceutical Care Management Association (PCMA)

RE: Testimony in opposition to House Bill 229

Chair Ray, Vice Chair LaRe, Ranking Member Brent, and members of the House General Government Committee, my name is Sean Stephenson, and I am the Senior Director of State Affairs for the Pharmaceutical Care Management Association (PCMA), here to testify in opposition to House Bill 229. I appreciate the opportunity to provide testimony to you today.

PCMA is the national association representing America's pharmacy benefit managers also known as PBMs. PBMs administer prescription drug plans and operate mail-order and specialty pharmacies for more than 289 million Americans with health coverage through large employers, health insurers, labor unions, and federal and state-sponsored health programs.

PBMs exist to reduce prescription drug costs for employers, governments and union health plans to provide their employees affordable access to needed prescription drugs. PBMs help employers and government programs design affordable, sustainable pharmacy benefits using a range of tools that improve adherence, reduce errors, and prevent unnecessary costs. In doing so, PBMs execute, not dictate, the terms set by our clients. Employers choose what works best for their workforce, and PBMs help them implement it.

House Bill 229 is a Well-Intentioned Bill with Significant Consequences

Most significantly, HB 229 would enact a fiduciary mandate that could cost the state of Ohio $228 million in excess drug spending in the first year alone, and more than $2.8 billion over the next 10 years.[1]

Federal Law (Department of Labor and Courts) Clearly State PBMs are not Fiduciaries

PBMs follow the instructions of their clients and do not control plan assets, which, according to federal law, means PBMs are not fiduciaries. Creating fiduciary duties where they don't belong would turn a contractual relationship into a trustee-style arrangement, introducing legal conflicts, expanding liability, and ultimately requiring PBMs to purchase expensive insurance that drives up costs for everyone. According to the Department of Labor (DOL), PBMs "who have no power to make any decisions as to plan policy, interpretations, practices or procedures, but who perform [certain] administrative functions for an employee benefit plan…are not fiduciaries of the plan."[2] Likewise, PBMs have no "discretionary authority" over plan assets as defined by the DOL, which is an essential threshold requirement for fiduciary status under federal law. Moreover, federal courts have struck down state PBM fiduciary mandates as being preempted by the Employee Retirement Income Security Act (ERISA).[3]

Fiduciary mandates would subject PBMs to broader legal liabilities than under current law because they would transform an arm's length contractual relationship into one where one party is responsible for assets that belong to another, such as a trustee relationship. Increased legal risk

[1] Increased-Costs-Associated-With-Proposed-State-Legislation-Impacting-PBM-Tools.pdf
[2] 13 29 CFR 2509.75-8 - Questions and answers relating to fiduciary responsibility under the Employee Retirement Income Security Act of 1974.
[3] Pharm. Care Mgt Ass'n v. District of Columbia, 613 F.3d 179 (D.C. Cir. 2010)

Pharmaceutical Care Management Association
325 7th Street, NW, 9th Floor
Washington, DC 20004
www.pcmanet.org

could result in PBMs needing to purchase additional liability insurance. The added cost of this insurance would then drive prescription drug benefit costs higher for both PBM clients and the individuals enrolled in their plans.

Fiduciary Strips Employers of Flexibility and Innovation in Drug Benefit Design

Perhaps the most troubling aspect of this bill is how it would tie the hands of private employers and public purchasers who want to design benefits that meet their unique needs. Ohio businesses, governments, and labor unions each serve distinct populations. A one-size-fits-all fiduciary model would eliminate the ability to tailor plans—blocking benefit designs that rely on cost-saving tools like formularies, step therapy, and prior authorization. Without these tools, costs go up, choices go down, and adherence suffers.

Fiduciary Mandates Would Decrease the Use of Cost-Savings and Drug Adherence Tools

Increased legal liability and conflicting obligations between fiduciary duties and client contracts would result in PBMs adopting defensive business strategies to mitigate the risk of lawsuits. By reducing the use of evidence-based tools like prior authorization (PA), step therapy (ST), and drug utilization reviews, all tools that have been proven to generate savings of up to 50% in some categories while ensuring patients get the right drug at the right time, means higher costs and less appropriate care.

Performance-Based Contracting Would Be Undermined by Fiduciary Mandates

HB 229 would also disrupt performance-based contracting, a growing and bipartisan-supported innovation in health care. By tying fees to measurable outcomes like improved adherence or fewer gaps in care, PBMs can reward high-performing pharmacies and negotiate stronger deals with drug manufacturers. Fiduciary obligations, however, could effectively ban this, disallowing one of the most promising ways to align payment with patient value.

Fiduciary Mandates Would Increase Administrative Costs

A state fiduciary mandate would increase costs as PBMs would be forced to redesign administrative and contractual processes unique to Ohio. Specifically, PBMs would have to revise contracts with other supply chain entities to comply with a state's new requirements, which would be completely different than other states' and at odds with ERISA's goals of a "uniform administrative scheme" for processing claims and distributing benefits.

PBMs Committed to Transparency

PCMA is committed to continuing to work with policymakers to engage on policies that enhance actionable transparency. House Bill 229 allows the superintendent of insurance to examine the books of PBMs to determine various metrics, including information relating to rebates.
The choice of information always belongs to the client (business, government, union), and PBMs work to provide whatever level of data and information the client puts in their contract.

PBMs are doubling down on their work to support transparency and provide actionable information to our clients. The market is demanding it, and our companies are responding. Many PBMs are offering new programs that make pharmacy benefits easier for employers and unions and their plan participants to understand. Efforts are underway to bring more detailed visibility to employers through additional options for reporting mechanisms. PBMs are also providing tools that offer patients more transparency to help facilitate convenient access to information that empowers patient savings and improves adherence. PBMs have online web portals and digital apps for patients that provide real-time, actionable information, allowing them to search for the lowest-cost prescription alternatives, find or compare across pharmacies, or access their prescription histories.

Affiliate Reimbursement

House Bill 229 prohibits PBMs from reimbursing a pharmacy less than the amount the PBM reimburses an affiliate for providing the same product. These provisions interfere with value-based, pay-for-performance models that reward pharmacies for improving outcomes like ensuring adherence or reducing hospitalizations. These innovations benefit patients and payers alike and should be encouraged, not penalized.

Moreover, as currently worded, the bill would require PBMs to reimburse independent pharmacies at the same rate as affiliated pharmacies, but it does not specify that the comparison must be limited to Ohio-based reimbursement rates. This opens the door to cherry-picking reimbursement benchmarks from high-cost states like California or New York, which would dramatically inflate drug costs for all Ohio patients and purchasers.

In addition, we want to correct a misstatement made during proponent testimony which claimed that PBMs determine both the cost and reimbursement of prescription drugs. It is wholly inaccurate to state PBMs set and reimburse cost and important to correct as this body considers regulation of PBMs. Pharmacies purchase drugs from wholesalers, not PBMs. And it is drug manufacturers—not PBMs—who set the list prices of medications. PBMs do not sell drugs to pharmacies, nor do we dictate wholesale acquisition costs.

The drug supply chain includes:

- Manufacturer sets the price
- Wholesaler purchases from the manufacturer
- Pharmacy purchases from the wholesaler
- PBM administers the benefit and reimburses the pharmacy based on plan design that employers dictate
- Patient receives the drug

PBMs work for the plan sponsor (employer, union, or government) to help manage costs and ensure appropriate use. We are administrators, not price setters or drug suppliers.

Finally, I want to acknowledge and thank Rep. Deeter for her hard and thoughtful work on this bill and willingness to engage stakeholders as she continues to perfect House Bill 229 to achieve the legislative objective of regulating PBMs. Chair Ray, members, thank you for your time today, and I am happy to take any questions you have at this time.

Pharmaceutical Care Management Association
325 7th Street, NW, 9th Floor
Washington, DC 20004
www.pcmanet.org