DISCOUNT drug mart FOOD FAIR
AN EMPLOYEE OWNERSHIP COMPANY
www.discount-drugmart.com
The Stores That Save YOU The Runaround!

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May 12, 2025

The Honorable Susan Manchester
Chair- Ohio Senate Government Oversight & Reform Committee
1 Capitol Square – Room 048
Columbus, Ohio 43215

Re: Discount Drug Mart Supports PBM Reform Budget Amendment

Dear Chair Manchester:

On behalf of Discount Drug Mart's 4,700 plus employees- including more than 250 pharmacists- operating 79 pharmacies and stores throughout Ohio- we write this letter to urge Members of the Senate Government Oversight & Reform Committee to support the Pharmacy Benefit Manager (PBM) Reform Amendment in HB 96 as passed by the Ohio House of Representatives earlier this year. We believe the PBM Reform Amendment will result in meaningful pharmacy benefit manager reforms.

Today- just three pharmacy benefit managers **control more than 80% of all pharmacy networks and prescription drug claims in the United States.** Each year- these three largest PBMs appear on the Fortune 25 List of Largest Companies in the United States. These PBMs generated more than **$357.8B in revenues** for 2023- up more than 10% from the previous year. What function does a PBM hold? They sit in the middle of a transaction between a pharmacy and its patient and the patient's insurance company.

In 2022- State of Ohio Medicaid moved to a single PBM contract creating a new system of paying for medications. **The result: a savings to Medicaid and Ohio taxpayers of $140 million over 2 years.** And- dispensing fees and reimbursements paid to pharmacies increased as well. The study was conducted by Milliman- State Medicaid's actuarial firm. Don't believe the hype and misinformation of increased insurance premiums by our opponents. They are only protecting their places on the Fortune 25 lists.

The reforms in the PBM Reform Amendment will result in a more competitive marketplace- and ensure better patient access to medications. The drug cost reimbursement strategies and tactics of the PBMs are resulting in the closure of more than 1 pharmacy each day in the United States. In Ohio- we have **lost more than 173 pharmacies over the last 12 months** year alone creating pharmacy deserts throughout Ohio. Our own Ohio Attorney General Dave Yost has filed a lawsuit accusing the PBMs of illegally driving up the cost of medications. In many instances- **prescriptions we fill today are below our cost to purchase**.

Discount Drug Mart is an employee owned company with locations only in Ohio. Founded by Parviz Boodjeh- a pharmacist in 1969- our pharmacists fill over 8,400,000 prescriptions yearly. We help patients use medicines correctly and safely- while offering innovative services that improve patient health and healthcare affordability.

We would urge you and the Members of the Senate Government Oversight & Reform Committee to support the PBM Reform Budget Amendment in HB 96 as passed the Ohio House of Representatives.

Respectfully,

Don Boodjeh
Chief Executive Officer

John Gans
President

Steve Ferris
Government Affairs Director

Attachments (2)

Please Contact Steve Ferris if you have any questions or if you need any additional information. Steve can be reached by telephone (330-725-2340) or by email: sferris@discount-drugmart.com

Biz & Labor
Civil Rights
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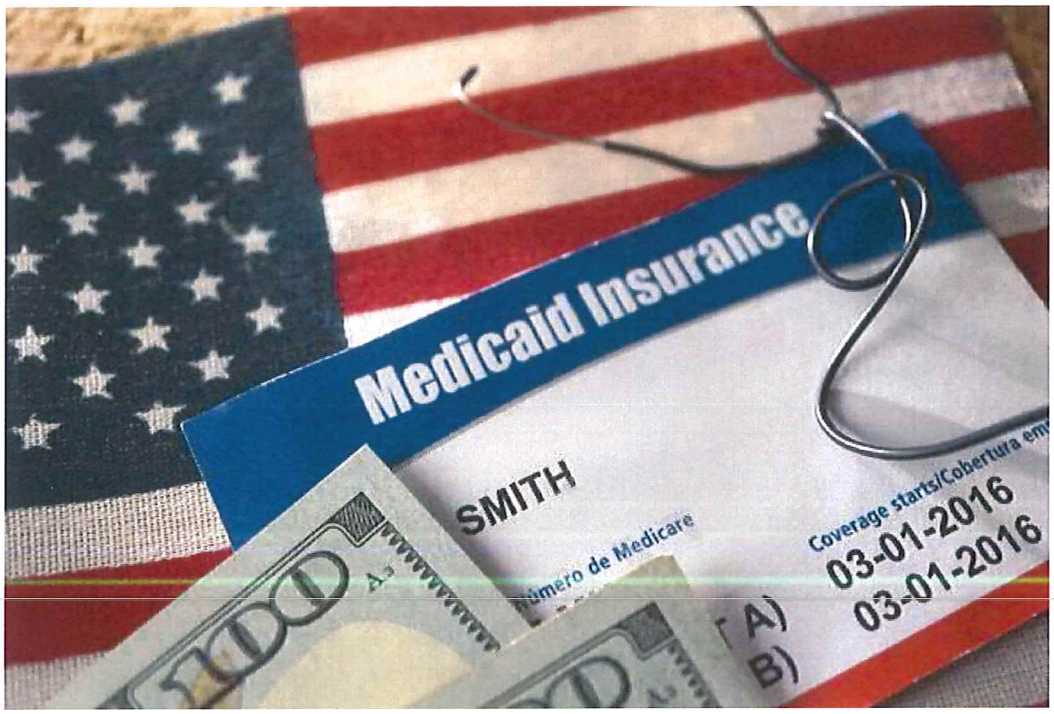
Ohio Medicaid got rid of big middlemen, paid pharmacies more and saved $140 million, report says

By: Marty Schladen - April 17, 2025 5:00 am



(Stock photo via Getty Images)

Pharmacy middlemen working in Ohio on behalf of huge health conglomerates have long claimed they keep down drug costs. But a report released last week calls that into question.

The Ohio Department of Medicaid had been burned in the past by the big middlemen. And pharmacies across the state for years had said their Medicaid reimbursements were so scant that it was hard to stay in business. So the Medicaid department in 2022 gave the big pharmacy benefit managers — or PBMs — the boot and created a new system of paying for drugs.

The result: Dispensing fees paid to pharmacies were boosted more than 1,200% on average — and the new setup still achieved savings of $140 million over a two-year period, according to a study done by Milliman, the Medicaid department's actuarial firm.

At the same time, the system managed to sign up nearly every pharmacy in the state, the report said. That makes medicine more accessible to Medicaid patients, who often lack access to reliable transportation.

"Bottom Line: The (new system) delivers on its goals of accountability, transparency, and fairness – While doing so at a significantly lower administrative overhead cost to taxpayers," the Medicaid department said in a cover letter to lawmakers that accompanies the study.

The three biggest PBMs in the United States are each owned by one of the 15 largest companies — UnitedHealth Group, CVS Health and Cigna-Express Scripts. The conglomerates own major insurers and myriad other health businesses, such as doctors' offices and pharmacies.

Their pharmacy benefit managers work on behalf of those and competing insurers to facilitate drug transactions that run through their own and competing pharmacies. They decide which drugs are covered by insurance and which get preferential treatment.

Combined, the big-three PBMs control nearly 80% of the insured drug transactions in the United States. That gives them great leverage to negotiate huge rebates and fees from drugmakers and to impose opaque contracts on pharmacies.

The big PBMs have long claimed they use their size to squeeze savings from drugmakers and pharmacies that they pass along to the insurers they represent. The conglomerates that own them also say that strict firewalls stand between their business units to keep their middlemen from providing unfair advantages to

insurers and pharmacies owned by the same corporation.

But there are widespread complaints that the PBMs' dealings are far from transparent, making it impossible for outsiders to know whether they're getting a good deal. In 2018, the Ohio Department of Medicaid learned that it wasn't.

Independent and small-chain pharmacies across Ohio had been complaining that they were getting killed in the Medicaid program. The reimbursements and dispensing fees they got from CVS Caremark and OptumRx were so low that it was making it hard for them to stay in business, they said.

The Columbus Dispatch in 2018 undertook an investigation. It gathered confidential reimbursement data from dozens of pharmacies, compared them to Medicaid claims data and determined that the two PBMs were charging the state a lot more for drugs than they were paying the pharmacies that had bought and dispensed them.

That prompted the Department of Medicaid to get the PBMs to turn over all their data. It commissioned a study showing that in 2017 alone, the two PBMs servicing the program charged taxpayers $224 million more for drugs than they paid out to pharmacists.

Those and other revelations prompted Ohio Attorney General Dave Yost to file several lawsuits against the PBMs on behalf of state agencies. In addition, state lawmakers in Ohio and elsewhere have passed a raft of laws aimed at reigning them in, and the Federal Trade Commission is investigating and suing the companies.

For its part, the Ohio Department of Medicaid fired CVS Caremark and OptumRx and devised its own PBM.

Launched in October 2022, it unbundled the services that had been provided by the big PBMs to create transparency and ensure contractors weren't imposing huge markups as they had in 2017.

In the interest of keeping pharmacies whole, it also mandated a huge increase on dispensing fees paid to them — from an average of just 73 cents per prescription under the old system to $9 under the new one, the report said. Partly as a result of that, the Medicaid department was able to get almost every pharmacy in Ohio to join its network and thus maximize accessibility for recipients.

The single PBM "pharmacy network is the largest, most inclusive in-state pharmacy network ever, with over 99% of Ohio pharmacies contracted as in-network providers, the Medicaid department said. "In addition to standard retail pharmacies, Ohio Medicaid beneficiaries also have access to specialized compounding pharmacies, mail-order pharmacies, home delivery pharmacies, and specialty pharmacies. In total, over 2,600 unique pharmacy locations are contracted with (the single PBM), including nearly 250 accredited specialty pharmacies."

The Medicaid department also boasted that recipients enjoy "complete freedom of choice with respect to their pharmacy selection" because Gainwell, the company that runs its PBM, doesn't own a pharmacy.

Ohio attorney general and 38 others call on Congress to stop middlemen from owning pharmacies

This story has been updated to include a response provided by OptumRx after it published. Ohio Attorney General Dave Yost on Monday joined the vast majority of state attorneys general in demanding that Congress make a major change in the business of selling drugs. They want to prohibit giant health conglomerates from owning both powerful ...
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OCJ Ohio Capital Journal

CVS Caremark and OptumRx are part of giant health conglomerates that also own pharmacies. Yost and 38 other state attorneys general on Monday accused the conglomerates of using their middlemen to favor their own pharmacies over their competitors. In a letter, they called on Congress to prohibit the health care giants from owning both PBMs and pharmacies.

The Medicaid department said it avoided such conflicts under its new arrangement.

"Under the (former arrangement), members were often steered to PBM-owned or affiliated specialty pharmacies; today, members are provided their options and are free to select the pharmacy provider that best meets their needs," the department said.

In addition, the new, single PBM eliminated duplicative administrative costs. That measure saved $333 million over two years when compared to what they would have cost under the old system, according to models created by the Medicaid department's actuaries.

If you deduct increased dispensing fees and other new expenses from those savings, the new system created net savings of $140 million over a two-year period, the actuaries said.

The new system "has delivered much needed accountability and price transparency for Ohio taxpayers and Ohio pharmacies, providing assurance that Ohio's tax dollars are spent appropriately," the Medicaid department said.

HC2053

. B. No.

I_136_0001-4

_____moved to amend as follows:

After line 70964, insert:

"Sec. 3959.01. As used in this chapter:

(A) "Administration fees" means any amount charged a covered person for services rendered. "Administration fees" includes commissions earned or paid by any person relative to services performed by an administrator.

(B) "Administrator" means any person who adjusts or settles claims on, residents of this state in connection with life, dental, health, prescription drugs, or disability insurance or self-insurance programs. "Administrator" includes a pharmacy benefit manager. "Administrator" does not include any of the following:

(1) An insurance agent or solicitor licensed in this state whose activities are limited exclusively to the sale of insurance and who does not provide any administrative services;

(2) Any person who administers or operates the workers' compensation program of a self-insuring employer under Chapter 4123. of the Revised Code;

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(3) Any person who administers pension plans for the benefit of the person's own members or employees or administers pension plans for the benefit of the members or employees of any other person;

(4) Any person that administers an insured plan or a self-insured plan that provides life, dental, health, or disability benefits exclusively for the person's own members or employees;

(5) Any health insuring corporation holding a certificate of authority under Chapter 1751. of the Revised Code or an insurance company that is authorized to write life or sickness and accident insurance in this state.

(C) "Actual acquisition cost" means the amount that a drug wholesaler charges a pharmacy for a drug product as listed on the pharmacy's billing invoice.

(D) "Aggregate excess insurance" means that type of coverage whereby the insurer agrees to reimburse the insured employer or trust for all benefits or claims paid during an agreement period on behalf of all covered persons under the plan or trust which exceed a stated deductible amount and subject to a stated maximum.

~~(D)~~ (E) "Contracted pharmacy" or "pharmacy" means a pharmacy located in this state participating in either the network of a pharmacy benefit manager or in a health care or pharmacy benefit plan through a direct contract or through a contract with a pharmacy services administration organization, group purchasing organization, or another contracting agent.

~~(E)~~ (F) "Contributions" means any amount collected from a covered person to fund the self-insured portion of any plan in accordance with the plan's provisions, summary plan

descriptions, and contracts of insurance.

~~(F)~~ (G) "Drug product reimbursement" means the amount paid by a pharmacy benefit manager to a contracted pharmacy for the cost of the drug dispensed to a patient and does not include a dispensing or professional fee.

~~(G)~~ (H) "Drug wholesaler" means a wholesale drug distributor accredited by a nationally recognized nonprofit organization that represents the interests of state boards of pharmacy and to which the state board of pharmacy is a member.

(I) "Fiduciary" has the meaning set forth in section 1002(21)(A) of the "Employee Retirement Income Security Act of 1974," 88 Stat. 829, 29 U.S.C. 1001, as amended.

~~(H)~~ (J) "Fiscal year" means the twelve-month accounting period commencing on the date the plan is established and ending twelve months following that date, and each corresponding twelve-month accounting period thereafter as provided for in the summary plan description.

~~(I)~~ (K) "Insurer" means an entity authorized to do the business of insurance in this state or, for the purposes of this section, a health insuring corporation authorized to issue health care plans in this state.

~~(J)~~ (L) "Managed care organization" means an entity that provides medical management and cost containment services and includes a medicaid managed care organization, as defined in section 5167.01 of the Revised Code.

~~(K)~~ (M) "Maximum allowable cost" means a maximum drug product reimbursement for an individual drug or for a group of therapeutically and pharmaceutically equivalent multiple source

drugs that are listed in the United States food and drug administration's approved drug products with therapeutic equivalence evaluations, commonly referred to as the orange book.

~~(L)~~ (N) "Maximum allowable cost list" means a list of the drugs for which a pharmacy benefit manager imposes a maximum allowable cost, either directly or by setting forth a method for how the maximum allowable cost is calculated.

~~(M)~~ (O) "Multiple employer welfare arrangement" has the same meaning as in section 1739.01 of the Revised Code.

~~(N)~~ (P) "National drug code number" or "national drug code" means the number registered for a drug pursuant to the listing system established by the United States food and drug administration under the "Drug Listing Act of 1972," 21 U.S.C. 360.

(Q) "Ohio pharmacy" means a pharmacy, including an independent pharmacy, ~~that is incorporated or organized in this state under Title XVII of the Revised Code.~~that is located in the state and is licensed by the Ohio Board of Pharmacy.

(R) "Pharmacy benefit manager" means an entity that contracts with pharmacies on behalf of an employer, a multiple employer welfare arrangement, public employee benefit plan, state agency, insurer, managed care organization, or other third-party payer to provide pharmacy health benefit services or administration. "Pharmacy benefit manager" includes the state pharmacy benefit manager selected under section 5167.24 of the Revised Code.

~~(O)~~ (S) "Plan" means any arrangement in written form for the payment of life, dental, health, or disability benefits to covered persons defined by the summary plan description and

includes a drug benefit plan administered by a pharmacy benefit manager.

~~(P)~~ (T) "Plan sponsor" means the person who establishes the plan.

~~(Q)~~ (U) "Self-insurance program" means a program whereby an employer provides a plan of benefits for its employees without involving an intermediate insurance carrier to assume risk or pay claims. "Self-insurance program" includes but is not limited to employer programs that pay claims up to a prearranged limit beyond which they purchase insurance coverage to protect against unpredictable or catastrophic losses.

~~(R)~~ (V) "Specific excess insurance" means that type of coverage whereby the insurer agrees to reimburse the insured employer or trust for all benefits or claims paid during an agreement period on behalf of a covered person in excess of a stated deductible amount and subject to a stated maximum.

~~(S)~~ (W) "Summary plan description" means the written document adopted by the plan sponsor which outlines the plan of benefits, conditions, limitations, exclusions, and other pertinent details relative to the benefits provided to covered persons thereunder.

~~(T)~~ (X) "Third-party payer" has the same meaning as in section 3901.38 of the Revised Code.

Sec. 3959.111. (A)(1)(a) In each contract between a pharmacy benefit manager and a pharmacy, the pharmacy shall be given the right to obtain from the pharmacy benefit manager, within ten days after any request, a current list of the sources used to determine maximum allowable cost pricing. In each contract between a pharmacy benefit manager and a pharmacy, the

pharmacy benefit manager shall be obligated to update and implement the pricing information at least every seven days and provide a means by which contracted pharmacies may promptly review maximum allowable cost pricing updates in an electronic format that is readily available, accessible, and secure and that can be easily searched.

Subject to division (A)(1) of this section, a pharmacy benefit manager shall utilize the most up-to-date pricing data when calculating drug product reimbursements for all contracting pharmacies within one business day of any price update or modification.

(b) A pharmacy benefit manager shall maintain a written procedure to eliminate products from the list of drugs subject to maximum allowable cost pricing in a timely manner. The written procedure, and any updates, shall promptly be made available to a pharmacy upon request.

(2) In each contract between a pharmacy benefit manager and a pharmacy, a pharmacy benefit manager shall be obligated to ensure that all of the following conditions are met prior to placing a prescription drug on a maximum allowable cost list:

(a) The drug is listed as "A" or "B" rated in the most recent version of the United States food and drug administration's approved drug products with therapeutic equivalence evaluations, or has an "NR" or "NA" rating or similar rating by nationally recognized reference.

(b) The drug is generally available for purchase by pharmacies in this state from a national or regional wholesaler and is not obsolete.

(3) Each contract between a pharmacy benefit manager and a

pharmacy shall include an electronic process to appeal, investigate, and resolve disputes regarding maximum allowable cost pricing that includes all of the following:

(a) A twenty-one-day limit on the right to appeal following the initial claim;

(b) A requirement that the appeal be investigated and resolved within twenty-one days after the appeal;

(c) A telephone number at which the pharmacy may contact the pharmacy benefit manager to speak to a person responsible for processing appeals;

(d) A requirement that a pharmacy benefit manager provide a reason for any appeal denial, including the national drug code and the identity of the national or regional wholesalers from whom the drug was generally available for purchase at or below the benchmark price determined by the pharmacy benefit manager;

(e) A requirement that if the appeal is upheld or granted, then the pharmacy benefit manager shall adjust the drug product reimbursement to the pharmacy's upheld appeal price;

(f) A requirement that a pharmacy benefit manager make an adjustment not later than one day after the date of determination of the appeal. The adjustment shall be retroactive to the date the appeal was made and shall apply to all situated pharmacies as determined by the pharmacy benefit manager. This requirement does not prohibit a pharmacy benefit manager from retroactively adjusting a claim for the appealing pharmacy or for any other similarly situated pharmacies.

(B)(1)(a) A pharmacy benefit manager shall disclose to the plan sponsor whether or not the pharmacy benefit manager uses

the same maximum allowable cost list when billing a plan sponsor as it does when reimbursing a pharmacy.

(b) If a pharmacy benefit manager uses multiple maximum allowable cost lists, the pharmacy benefit manager shall disclose in the aggregate to a plan sponsor any differences between the amount paid to a pharmacy and the amount charged to a plan sponsor.

(2) The disclosures required under division (B)(1) of this section shall be made within ten days of a pharmacy benefit manager and a plan sponsor signing a contract or on a quarterly basis.

(3)(a) Division (B) of this section does not apply to plans governed by the "Employee Retirement Income Security Act of 1974," 29 U.S.C. 1001, et seq. or medicare part D.

(b) As used in this division, "medicare part D" means the voluntary prescription drug benefit program established under Part D of Title XVIII of the "Social Security Act," 42 U.S.C. 1395w-101, et seq.

(C) Except as otherwise provided in division (F) of this section, a pharmacy benefit manager shall reimburse an Ohio pharmacy for drug products dispensed on or after the ninety-first day following the effective date of the amendment an amount that is not less than either of the following:

(1) The amount that the pharmacy benefit manager reimburses an affiliated pharmacy for providing the same drug product;

(2) The sum of the following:

(a) A drug product reimbursement not less than the Ohio

pharmacy's actual acquisition cost for the drug dispensed;

(b) A dispensing fee not less than the minimum dispensing reimbursement in effect for the date the drug is dispensed, as determined by the superintendent of insurance under this section.

(D) An Ohio pharmacy may decline to provide a drug product to an individual or pharmacy benefit manager if the Ohio pharmacy would be paid less than the amount required by division (C) of this section.

(E)(1) Not later than ninety days after the effective date of this amendment, the superintendent of insurance shall determine a minimum dispensing reimbursement to be paid for each drug product based on data collected by the department of medicaid through the survey conducted pursuant to section 5164.752 of the Revised Code.

(2) The superintendent shall publish the amount of the minimum dispensing reimbursement and the dates to which it applies on a publicly accessible web site maintained by the department of insurance.

(3) The superintendent shall update the minimum dispensing reimbursement each time the department of medicaid publishes the survey conducted pursuant to section 5164.752 of the Revised Code.

(F)(1) Division (C) of this section does not apply to the extent that it conflicts with a contract or agreement entered into before the effective date of this amendment except that, if such a contract or agreement is amended or renewed after the effective date of this amendment, the contract or agreement shall conform to the requirements of that division. Division (C)

of this section does not prohibit a pharmacy benefit manager from paying drug product reimbursements or dispensing reimbursements in excess of the amounts required by that division.

(2) Divisions (C) and (D) of this section do not apply with respect to the state pharmacy benefit manager established pursuant to section 5167.12 of the Revised Code.

(G) Notwithstanding division (B)(5) of section 3959.01 of the Revised Code, a health insuring corporation or a sickness and accident insurer shall comply with the requirements of this section and is subject to the penalties under section 3959.12 of the Revised Code if the corporation or insurer is a pharmacy benefit manager, as defined in section 3959.01 of the Revised Code.

(D)-(H) No pharmacy benefit manager shall retaliate against an Ohio pharmacy that reports an alleged violation of, or exercises a right or remedy under, this section by doing any of the following:

(1) Terminating or refusing to renew a contract with the Ohio pharmacy without providing notice to the Ohio pharmacy at least ninety days in advance;

(2) Subjecting the Ohio pharmacy to increased audits without providing notice to the Ohio pharmacy and a detailed description of the reason for the audit at least ninety days in advance;

(3) Failing to promptly pay the Ohio pharmacy in accordance with sections 3901.381 to 3901.3814 of the Revised Code.

(I) If an Ohio pharmacy believes that a pharmacy benefit manager has violated this section, in addition to any other remedies provided by law, the Ohio pharmacy may file a formal complaint and provide evidence related to the complaint to the superintendent of insurance.

(J) The superintendent of insurance shall adopt rules ~~as necessary to implement the requirements of this section~~in accordance with Chapter 119. of the Revised Code for the purposes of implementing and administering this section. Notwithstanding any provision of section 121.95 of the Revised Code to the contrary, a regulatory restriction contained in a rule adopted by the superintendent in accordance with this section is not subject to sections 121.95 to 121.953 of the Revised Code.

Sec. 3959.121. (A) The superintendent of insurance shall evaluate any complaint filed by an Ohio pharmacy pursuant to section 3959.111 of the Revised Code.

(B)(1) If the superintendent determines, based on a complaint filed by an Ohio pharmacy or other information available to the superintendent, that a pharmacy benefit manager has violated section 3959.111 of the Revised Code, the superintendent shall do both of the following:

(a) Issue a notice of violation to the pharmacy benefit manager that clearly explains the violation;

(b) Impose an administrative penalty on the pharmacy benefit manager of one thousand dollars for each violation.

(2) Each day that a violation continues after the pharmacy benefit manager receives notice of the violation under division (B)(1)(a) of this section is considered a separate violation for

the purposes of the administrative penalty under division (B)(1)(b) of this section.

(C) Before imposing an administrative penalty under this section, the superintendent shall afford the pharmacy benefit manager an opportunity for an adjudication hearing under Chapter 119. of the Revised Code. At the hearing, the pharmacy benefit manager may challenge the superintendent's determination that a violation occurred, the superintendent's imposition of an administrative penalty, or both. The pharmacy benefit manager may appeal the superintendent's determination and the imposition of the administrative penalty in accordance with section 119.12 of the Revised Code.

(D) An administrative penalty collected under this section shall be deposited into the state treasury to the credit of the department of insurance operating fund created by section 3901.021 of the Revised Code."

Update the title, amend, enact, or repeal clauses accordingly.

The motion was _____agreed to.

SYNOPSIS

Pharmacy benefit managers

R.C. 3959.01, 3959.111, and 3959.121

Requires pharmacy benefit managers (PBMs), other than the state PBM, to reimburse Ohio-incorporated pharmacies that dispense a drug product for the "actual acquisition cost," i.e., the amount paid to the drug wholesaler, plus a minimum

dispensing fee determined by the Superintendent of Insurance.

Prohibits a PBM from reimbursing an Ohio pharmacy less than the amount the PBM reimburses its affiliated pharmacies for providing the same drug product.

Allows an Ohio pharmacy to decline to provide a drug product if the pharmacy would be reimbursed less than the required amount.

Prohibits a PBM from retaliating against an Ohio pharmacy that reports an alleged violation of, or exercises a remedy under the provision by doing any of the following:

- Terminating or refusing to renew a contract without providing notice at least 90 days in advance;

- Increasing audits of the pharmacy without providing notice and a detailed description of the reason for the audits at least 90 days in advance;

- Failing to comply with prompt pay laws.

Establishes a procedure by which an Ohio pharmacy may file a formal complaint alleging a violation and the Superintendent may impose an administrative penalty on the PBM of $1,000 per day for each violation.

Allows the Superintendent to adopt rules to implement and administer the provisions and exempts those rules from requirements, under continuing law, related to reducing regulatory restrictions.