OHIO LEGISLATIVE SERVICE COMMISSION

Wendy Zhan, Director

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Office of Research and Drafting

Legislative Budget Office

H.B. 229*
136th General Assembly

Occupational Regulation Report

Click here for H.B. 229's Bill Analysis / Fiscal Note

Primary Sponsors: Rep. Deeter

Impacted Profession: Pharmacy benefit managers

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LSC is required by law to issue a report for each introduced bill that substantially changes or enacts an occupational regulation. The report must: (1) explain the bill's regulatory framework in the context of Ohio's statutory policy of using the least restrictive regulation necessary to protect consumers, (2) compare the regulatory schemes governing the same occupation in other states, and (3) examine the bill's potential impact on employment, consumer choice, market competition, and cost to government.[1]

LEAST RESTRICTIVE REGULATION COMPARISON

Ohio's general regulatory policy

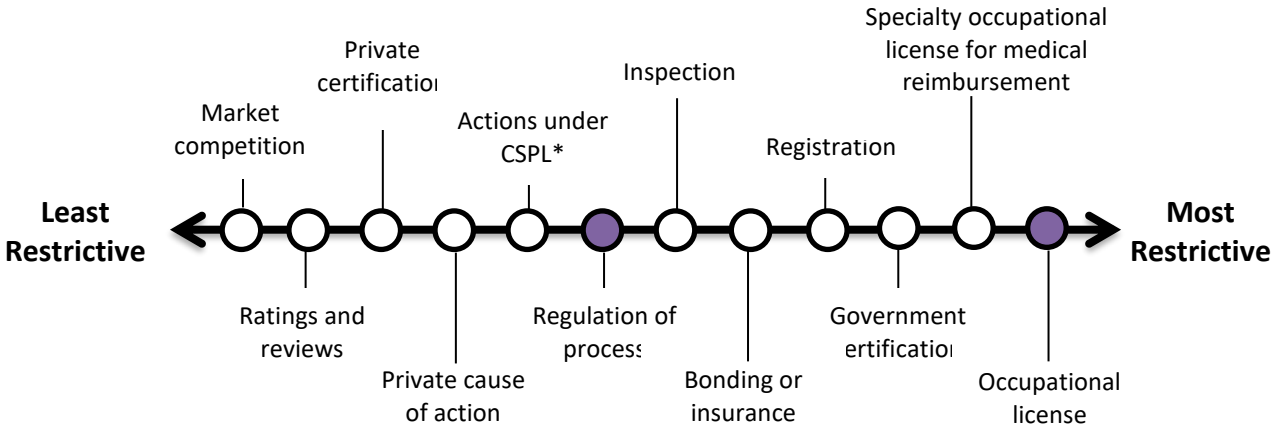
The general policy of the state is reliance on market competition and private remedies to protect the interests of consumers in commercial transactions involving the sale of goods or services. For circumstances in which the General Assembly determines that additional safeguards are necessary to protect consumers from "present, significant, and substantiated harms that threaten health, safety, or welfare," the state's expressed intent is to enact the "least restrictive regulation that will adequately protect consumers from such harms."[2]

The degree of "restrictiveness" of an occupational regulation is prescribed by statute. The following graphic identifies each type of occupational regulation expressly mentioned in the state's policy by least to most restrictive:

* This report addresses the "As Introduced" version of H.B. 229. It does not account for changes that may have been adopted after the bill's introduction.

[1] R.C. 103.26, not in the bill.

[2] R.C. 4798.01 and 4798.02, neither in the bill.



*CSPL – The Consumer Sales Practices Law

On and after January 1, 2027, H.B. 229 requires pharmacy benefit managers (PBMs) to obtain a new, separate license issued by the Superintendent of Insurance.[3] PBMs are entities that contract with pharmacies on behalf of specified third-party payers (such as employers or insurers)[4] to provide pharmacy services or administration.[5]

PBMs currently must be licensed by the Superintendent as third-party administrators (TPAs),[6] which are defined more broadly as persons who adjust or settle claims on Ohio residents involving specified types of insurance programs. The bill eliminates the current requirement that PBMs obtain a TPA license, thus requiring them to obtain a separate PBM license *instead of*, rather than in addition to, a TPA license.[7]

The bill also requires PBMs to comply with certain new process regulations.[8]

Under continuing law governing occupational regulation reports, a report must discuss a bill's substantial impacts on the following: (1) an individual's occupation, or (2) a business that must obtain a license for which the applicant must satisfy a personal qualification.[9] Because the bill defines a PBM as "an *entity* that contracts with pharmacies,"[10] it appears likely that a PBM license functions primarily as a business license regarding which a renewal applicant must satisfy a personal qualification that involves past compliance with specified laws. (The Superintendent may refuse to renew a PBM license on finding that the applicant has not complied with such

[3] R.C. 3957.03.

[4] R.C. 3957.01(I); R.C. 3901.38, not in the bill.

[5] R.C. 3957.01(J) and 3959.01(N).

[6] R.C. 3959.05, not in the bill.

[7] R.C. 3959.01(B).

[8] R.C. 3957.09, 3957.10, 3957.14(A) and (G), and 3957.15(B).

[9] R.C. 103.26 and 103.27, not in the bill.

[10] R.C. 3957.01(J).

laws.)[11] However, because the bill's prohibition against acting as a PBM without a license applies to a "*person*," it also appears that an individual possibly may apply for and obtain a PBM license.[12] Consequently, this report addresses a PBM license as both an individual license and a business license.

Necessity of regulations

Representative Kellie Deeter, the bill's sponsor, testified that the bill will establish greater transparency for PBMs. She stated that PBMs are a central player in the pharmaceutical supply chain, significantly influencing drug pricing, access, and reimbursement.

Representative Deeter said that PBMs historically functioned similarly to administrators of vision or dental benefits. However, she explained that over the past decade, PBMs have evolved to operate in a space between traditional TPAs and full-scale insurers. She stated that, during this time, the industry has seen extensive consolidation and vertical integration, leading to reduced competition. She testified that, today, three PBMs process approximately 80% of all pharmacy claims, and just six PBMs control over 90% of the market. She asserted that this monopolistic behavior has led to narrower provider networks, forced pharmacy closures, and reduced patient access to care. Furthermore, she said that a persistent lack of transparency in how pharmacy benefits are managed and reported has compounded the problem.

Representative Deeter explained that PBMs currently are regulated as TPAs and that these regulations do not provide sufficient regulatory oversight or sufficient definitions or reporting requirements relative to PBMs. She asserted that, as a result, the pharmacy benefit space remains highly opaque, subjective, and at times misleading.

To address these issues, Representative Deeter testified that the bill proposes a protective regulatory framework that requires the Department of Insurance to separately license PBMs in Ohio and that it standardizes key terms and reporting requirements. She asserted that this will help eliminate the subjective interpretations that PBMs often apply to obscure pricing and reimbursement mechanisms. Further, she stated that it empowers the Department of Insurance to exercise proper oversight and gives consumers and payers the information they need to make informed decisions. She pointed out that the bill also balances transparency with confidentiality and safeguards sensitive business information from public records requests.

In short, Representative Deeter testified that the bill modernizes the oversight of PBMs by moving them into an appropriate regulatory structure. She explained that, most importantly, it empowers employers, payers, and individuals with the transparency they need to assess the true value of their pharmacy benefits. She asserted that if we fail to address the current regulatory gaps, Ohioans will continue to face rising drug costs, shrinking access to care, and increasingly limited market choices. She concluded by stating reform is much needed, as illustrated by factors such as the expansion of pharmacy deserts, a pattern of monopolistic

[11] R.C. 3957.11.

[12] R.C. 3957.03.

behavior, and a growing number of successful lawsuits against PBMs for overcharging customers.[13]

Restrictiveness of regulations

Licensure

Licensure is the most restrictive of all regulatory options identified within the state's continuum of regulations. Accordingly, the state's policy prescribes a narrow range of situations in which required licensure is appropriate; specifically, when all of the following circumstances are present:

- The occupation involves providing a service regulated by both state and federal law;
- The licensing framework allows individuals licensed in other states and territories to practice in Ohio; and
- The licensing requirement is based on uniform national laws, practices, and examinations that have been adopted by at least 50 U.S. states and territories.[14]

It appears that the state policy's first criterion is met regarding the service of pharmacy benefit managing. Both current Ohio law and the bill regulate PBMs, and the federal Employee Retirement and Income Security Act of 1974 (ERISA) also regulates PBMs in certain respects.[15]

Both current law and the bill also appear to satisfy the state policy's second criterion with respect to the licensure of PBMs. The Occupational Licenses for Out-of-State Applicants Law[16] generally requires licenses to be issued to applicants who hold analogous out-of-state occupational licenses. However, that law does not apply unless the applicant is applying in the applicant's capacity as an individual, so with respect to a PBM license that is issued to a business, it is not clear that this requirement is met.[17]

Regarding the state policy's third criterion, neither current law nor the bill appears to satisfy it because licensure of PBMs is not based on uniform national laws.

PBM licenses

Because the bill's licensure framework for PBM licenses generally mirrors that for the TPA licenses that PBMs must obtain under current law, most of the bill's licensure provisions have a neutral impact on restrictiveness for PBMs.

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[13] Representative Kellie Deeter, H.B. 229 Sponsor Testimony, House General Government Committee, May 13, 2025, which is available on the General Assembly's website, legislature.ohio.gov, by searching for "H.B. 229" and looking under the "Committee Activity" tab.

[14] R.C. 4798.02, not in the bill.

[15] 29 United States Code 1001 *et seq.* See also R.C. 3957.09(H); R.C. 3959.11, not in the bill.

[16] R.C. Chapter 4796.

[17] R.C. 4796.03 and 4796.26, not in the bill.

The main exception to this generality, however, involves the fees that PBMs must pay under the bill for initial, renewed, and reinstated PBM licenses; these fee amounts are ten times more than the amount of fees that they currently must pay for a TPA license. For example, the fee for an initial TPA license is $200, and the analogous fee for a PBM license is $2,000.[18] In this respect, the bill significantly increases restrictiveness.

There is another, less impactful, difference between licensure of PBMs under current law and the bill. Unlike a TPA license, if a PBM license is approved in May or June, the license will not expire until June 30 of the following year.[19] By increasing the time period for which a PBM's license may be valid, the bill somewhat decreases restrictiveness.

Process regulations

The state's policy does not provide specific guidance as to when a regulation of process is the best means of protecting the health, safety, and welfare of consumers. However, the policy as a whole suggests that regulations of process are the most preferred method of regulation when market competition, ratings and reviews, private certifications, private causes of action, and actions under the state's Consumer Sales Practices Law do not provide sufficient protection.[20]

Whether these mechanisms are a sufficient means of protecting consumers is a policy decision. However, continuing Ohio law establishes numerous process regulations that currently apply to PBMs under the Third-Party Administrators Law (TPA Law) and that are mirrored in the bill, such as requirements for information that a PBM's description of a disbursement must include.[21]

Conduct under written agreement with plan sponsor

The bill increases restrictiveness for PBMs by establishing new recordkeeping, accounting, and disclosure requirements that currently do not apply to them under the TPA Law. These requirements involve the written agreement that a PBM must enter into under both the current TPA Law and the bill with the person who establishes a drug benefit plan that the PBM administers (i.e., the plan sponsor).[22] It appears that the new process regulations generally are designed to increase transparency, such as requiring a PBM to disclose any conflicts of interest to the plan sponsor and to account to the plan sponsor for rebates or other benefits the PBM receives.

PBM's duties to insurer regarding prescription drug benefits

The bill increases restrictiveness by specifying that both of the following apply to a PBM that enters an agreement with an insurer to perform services related to prescription drug

[18] R.C. 3957.04(B) and 3957.08; R.C. 3959.06(B) and 3959.10, neither in the bill.

[19] R.C. 3957.07; R.C. 3959.09, not in the bill.

[20] R.C. 4798.01, not in the bill.

[21] R.C. 3757.14(B) and(C); R.C. 3959.15, not in the bill.

[22] R.C. 3757.09; R.C. 3959.11, not in the bill.

benefits: (1) the PBM must act as the insurer's agent under the agreement, and (2) the PBM owes a fiduciary duty to the insurer regarding the prescription drug benefits. ("Fiduciary" has the same meaning as in ERISA.) Under the bill, it is the insurer's responsibility to ensure that the PBM complies.[23]

No such provisions currently apply to PBMs under the TPA Law.

Advertisements and reimbursement of nonaffiliates

The bill increases restrictiveness by prohibiting a PBM from doing either of the following:

- Causing or knowingly permitting the use of an advertisement, promotion, solicitation, representation, proposal, or offer that is untrue, deceptive, or misleading;
- Reimbursing a pharmacy or pharmacist in an amount that is less than the amount the PBM would reimburse a PBM affiliate for providing the same service.

A "PBM affiliate" is a pharmacy that owns or controls, is owned or controlled by, or is under common ownership or control with a PBM.[24]

Neither prohibition currently applies to PBMs under the TPA Law.

Records retention

The bill establishes books – and records-related requirements for PBMs that mirror requirements in the TPA Law with which they currently must comply (and that therefore do not impact restrictiveness). These books and records reflect all transactions administered by the PBM, specifically regarding premiums or contributions received and deposited as well as claims and authorized expenses paid.

However, the bill increases restrictiveness somewhat by potentially extending the time period during which a PBM must retain the books and records to ten years. Currently, under the TPA Law, a PBM must retain the books and records only for the period in which the PBM provides services to the insurer or plan sponsor.[25]

Examination of books and records

The bill increases restrictiveness by expressly subjecting PBMs to the Superintendent's authorized examination of a PBM's books and records to determine specified information regarding rebates, amounts a health care payor paid a PBM for pharmacist services, and amounts the PBM paid for pharmacist services.[26] No similar provision currently applies to PBMs under the TPA Law.

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[23] R.C. 3957.01 and 3957.10.

[24] R.C. 3957.01(E) and 3957.15(B).

[25] R.C. 3957.14(A); R.C. 3959.15, not in the bill.

[26] R.C. 3957.14(G).

Additional disclosures

The bill establishes disclosure requirements for PBMs that generally mirror those with which they currently must comply under the TPA Law (and thus do not impact restrictiveness). The exception to this generality is that, unlike current law, the bill does not require PBMs to disclose fixed plan costs, levels of the specific excess insurance stop-loss deductible, and aggregate excess insurance stop-loss attachment point factors.[27] In this respect, the bill decreases restrictiveness.

IMPACT STATEMENT

Opportunities for employment

Under the bill, employment opportunities for PBMs are unlikely to be significantly affected. About 80% of all equivalent prescription claims were processed by three PBMs, which could absorb the bill's higher licensing fees and increased compliance costs. While the new requirements may create a higher challenge for smaller or new entrants, the overall employment impact is expected to be insignificant, with existing PBMs making internal adjustments rather than ceasing operations.

Consumer choice

The bill aims to enhance consumer choice by promoting transparency and addressing oligopolistic behaviors within the PBM market. By standardizing terms, requiring greater disclosure, and prohibiting deceptive practices and discriminatory reimbursement, the bill intends to provide consumers with better information to make informed decisions about their pharmacy benefits. Potentially, the bill could avert additional pharmacy closures in the future, which would increase pharmacy accessibility for consumers.

Market competition

The bill may deter market competition in the PBM industry by requiring a separate, more stringent license and imposing new process regulations. These provisions could create barriers to entry for new PBMs. However, the overall intent of the bill is to curb anti-competitive practices by dominant firms and promote a more competitive market environment (i.e., prohibiting a PBM from reimbursing a pharmacy or pharmacist an amount that is less than the amount the PBM would reimburse a PBM affiliate for providing the same service).

Cost to government

The bill would incur additional administrative costs, specifically for the Superintendent of Insurance, due to the new PBM licensing rules and enhanced regulatory oversight. The increased licensing fees for PBMs may be sufficient to offset these administrative costs. For further details, please refer to the LBO fiscal note (PDF).

[27] R.C. 3957.13 and R.C. 3959.14, neither in the bill.

SUMMARY OF PROPOSED REGULATIONS

Confidentiality

The bill specifies that all information obtained by the Superintendent or the Department of Insurance in administering the bill is proprietary and exempt from the Public Records Law.[28]

Provisions that mirror the TPA Law

The bill includes numerous provisions that mirror regulations that currently apply to PBMs under the TPA Law and therefore have no impact on restrictiveness, such as the penalty for acting as a PBM without a license;[29] procedures for license application, issuance, denial, and renewal;[30] grounds for suspending, revoking, or refusing to renew a license or imposing a fine on a PBM;[31] and a requirement that a PBM maintain any insurance or bond required under ERISA.[32]

For a complete explanation of the bill, please see the LSC bill analysis (PDF).

[28] R.C. 3957.15(A).

[29] R.C. 3957.99; R.C. 3959.99, not in the bill.

[30] R.C. 3957.04 to 3957.08; R.C. 3959.06 to 3959.10, not in the bill.

[31] R.C. 3957.11; R.C. 3959.12, not in the bill.

[32] R.C. 3957.09(H); R.C. 3959.11, not in the bill.

COMPARISON TO OTHER STATES

All of the states surrounding Ohio regulate PBMs and require them to obtain a separate, stand-alone credential specifically for PBMs. The table below discusses aspects of these regulations and requirements.

State	What Type of State-Issued Credential must PBMs Obtain?	Initial PBM Credential Fee	Disclosure Requirements that Expressly Mention PBM Conflicts of Interest
Ohio (under the bill)	A license *(R.C. 3957.03)*	$2,000 *(R.C. 3957.04(B)*	A PBM must disclose to a sponsor of a drug benefit plan any activity, policy, practice, contract, or arrangement that presents a conflict of interest concerning the PBM's relationship with the plan sponsor *(R.C. 3757.09(F)*
Indiana	A license *(Ind. Code § 27-1-24.5-18)*	Cannot exceed $500 *(Ind. Code § 27-1-24.5-20)*	No clear equivalent
Kentucky	A license *(Ky. Rev. Stat. § 304.9-053(1))*	$1,000 *(Ky. Rev. Stat. § 304.9-053(2))*	An entity must disclose any activity, policy, practice or contract that may present a conflict of interest when seeking to become the state PBM for managed care organizations that contract with the state to deliver Medicaid services *(Ky. Rev. Stat. § 205.5512)*

State	What Type of State-Issued Credential must PBMs Obtain?	Initial PBM Credential Fee	Disclosure Requirements that Expressly Mention PBM Conflicts of Interest
Michigan	A license (but also must be certified as a TPA[33]) *(Mich. Comp. Laws § 550.821(1))*	$5,000[34] *(Mich. Admin. Code R. 500.33)*	A PBM must disclose to a health plan any activity, policy, or practice of the PBM that presents a conflict of interest with the duties the PBM owes to the health plan *(Mich. Comp. Laws § 550.825(3))*
Pennsylvania	A registration *(40 Pa. Cons Stat. § 4521(a))*	$10,000 *(40 Pa. Cons. Stat. § 4521(b))*	No clear equivalent
West Virginia	A license *(W.Va. Code § 33-51-8(a))*	Cannot exceed $10,000 *(W.Va. Code § 33-51-8(b))*	No clear equivalent

[33] See, Pharmacy Benefit Managers, which is accessible by conducting a keyword "pharmacy benefit manager" search on the Michigan Department of Insurance and Financial Services' website: michigan.gov/difs.

[34] See, FIS 2397: Fee Processing Card for Pharmacy Benefit Manager, which is accessible by conducting a keyword "FIS 2397" search on the Michigan Department of Insurance and Financial Services' website: michigan.gov/difs.

INFORMATION FROM SPONSOR

Sponsors of bills involving occupational regulations are expressly permitted by law to provide LSC with information that may be relevant to an occupational regulation report.[35] The information below was submitted by Representative Deeter. It has been reformatted to fit the structure of this report but otherwise is reproduced in its entirety. Inclusion of sponsor-provided information in this section of the report is not an endorsement or affirmation of accuracy by LSC.

Evidence of present, significant, and substantiated harms to Ohio consumers;

For decades, Pharmacy Benefit Managers (PBMs) have traditionally played a vital role in claims administration within the pharmacy benefit. More recently though, that role has expanded beyond third party claims administration to resemble a more risk-based model but falling short of a health insurance corporation. This new PBM role appears unregulated, growingly uncompetitive and opaque to payers, consumers, and pharmacy providers.

Evidence for such thoughts have recently been expressed by the Federal Trade Commission (FTC) in a January 14, 2025 report titled FTC Releases Second Interim Staff Report on Prescription Drug Middlemen. The FTC Chair stated, "The FTC staff's second interim report finds that the three major pharmacy benefit managers hiked costs for a wide range of lifesaving drugs, including medications to treat heart disease and cancer," said FTC Chair Lina M. Khan. "The FTC should keep using its tools to investigate practices that may inflate drug costs, squeeze independent pharmacies, and deprive Americans of affordable, accessible healthcare—and should act swiftly to stop any illegal conduct."

In Ohio, PBMs have abused tax payers within Ohio Medicaid as was found in a 2021 case in which Centene Agrees to Pay a Record $88.3 Million to Settle Ohio PBM Case Brought by AG Yost. This was further demonstrated in 2023 when Cigna's PBM, two others sued in Ohio over drug price fixing and nationally last year when the FTC Sues Prescription Drug Middlemen for Artificially Inflating Insulin Drug Prices. These are just a few examples of how taxpayers, employers, and consumers are paying excessive prices for drugs unrelated to manufacturer or provider influence. Simply put, PBMs have become the price maker and price taker in an unregulated market space with narrow competition and very limited oversight or transparency. In June of 2024 The Congressional House Committee on Oversight and Accountability Staff filed a report titled *The Role of Pharmacy Benefit Managers in Prescription Drug Markets* which concluded by saying " The Committee's findings indicate that the present role of PBMs in prescription drug markets is failing and requires change. Congress and states must implement legislative reforms to increase the transparency of the PBM market and ensure patients are placed at the center of our health care system, rather than PBMs' profits."

[35] R.C. 103.26(D), not in the bill.

▪ An explanation of why existing laws and procedures are inadequate to prevent those harms;

Current Ohio law places PBMs within the Third-Party Administrator (TPA) chapter of code. As discussed above, PBMs no longer operate like traditional TPAs when compared to vision, dental or other claims processors. The Ohio Department of Insurance is limited in its oversight of PBMs because of PBM placement within Ohio law. Title 39 (Insurance) grants very specific chapters of code and oversight for specific insurance products, pet insurance as an example, but no direct oversight of the pharmacy benefit. Historically, one could say the pharmacy benefit was regulated and tied directly to the health benefit but as health plans delegated this benefit to PBMs, that oversight no longer flows through the health plans as it once did. Ohio's code should be reflective of modern-day use of insurance products and services while providing payers, employers and consumers regulatory relief, should it be needed. A March 2024 US Government Accountability Office Report highlighted regulatory actions taken by some states. More recently in March 2025, the State of Tennessee released their audit report of Express Scripts which found Express Scripts violated law governing commercial pharmacy claims. This was the first audit of a PBM by a state government over commercial plans. As STAT+ news reported the findings "Specifically, the company failed to properly reimburse pharmacies, favored its own specialty pharmacy operations by paying higher dispensing fees than to other pharmacies, and did not properly handle appeals filed by pharmacies, according to the state Department of Commerce and Insurance, which audited transactions that Express Scripts handled for commercial health insurers in 2023." As more states take action on PBMs, the National Conference of State Legislatures has produced a summary of state by state PBM regulatory activity through December 2024.

▪ An explanation of why a less restrictive regulation is not proposed;

Today, there is little regulatory oversight of PBMs by the Ohio Department of Insurance. One could reasonably argue less would simply mean removing PBMs from 3959.01(N) and eliminating their $200/yr licensing fee. The existence of any meaningful PBM oversight appears to have resulted from the General Assembly (current pricing, resolution of appeals, MAC lists, and contract disclosure and compliance) rather than inherent regulatory authority.

An FTC report from July 2024 titled *Pharmacy Benefit Managers: The Powerful Middlemen Inflating Drug Costs and Squeezing Main Street Pharmacies* found:

1.) The top three PBMs processed nearly 80 percent of the approximately 6.6 billion prescriptions dispensed by U.S. pharmacies in 2023, while the top six PBMs processed more than 90 percent
2.) PBMs can often exercise significant control over which drugs are available, at what price, and which pharmacies patients can use to access their prescribed medications.
3.) Vertical integration in PBM business structures, particularly with respect to integrated health insurers and specialty and mail order pharmacies, likely creates the ability and incentive for PBMs to increase utilization of certain drug products at affiliated

pharmacies to generate the greatest revenue and profits for their respective conglomerates

4.) Independent pharmacies generally lack the leverage to negotiate terms and rates when enrolling in PBMs' pharmacy networks and subsequently may face effectively unilateral changes in contract terms without meaningful choice and alternatives.

5.) Evidence that PBMs and brand pharmaceutical manufacturers sometimes enter agreements to exclude generic drugs and biosimilars from certain formularies in exchange for higher rebates from the manufacturer. These exclusionary rebates may cut off patient access to lower-cost medicines and warrant further scrutiny by the Commission, policymakers, and industry stakeholders.

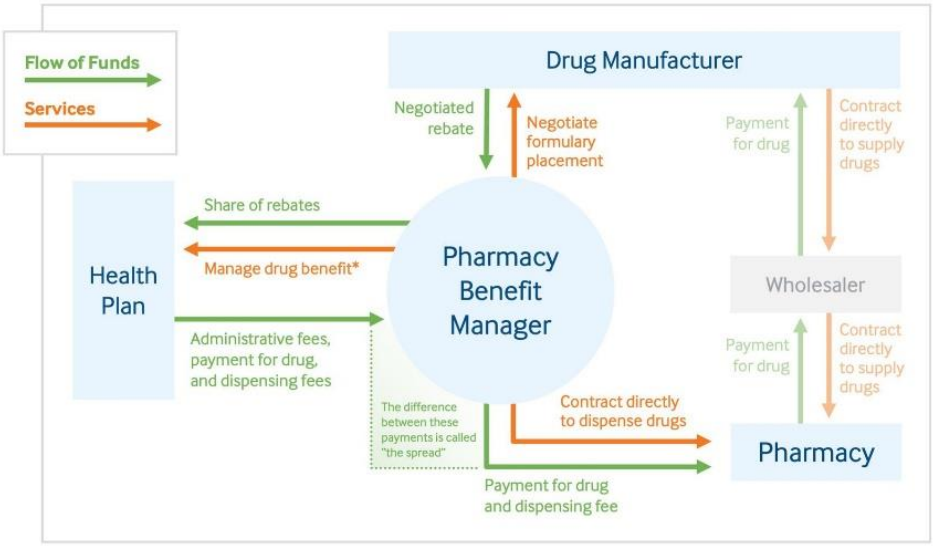
As such, cost is largely the determination of the PBM and has various definitions depending on the entity making such request to the PBM. Cost can also be one price to a PBM integrated pharmacy, another price to an unaffiliated contract pharmacy, and yet another depending on the drug in question. An FTC report from January 2025 titled *Specialty Generic Drugs: A Growing Profit Center for Vertically Integrated Pharmacy Benefit Managers* highlights the lack of transparency on drug costs due to a lack of regulatory oversight and transparency. Simply put, there is no objective way to determine value for those who purchase pharmacy benefits other than subjective data supplied by PBMs. Regulatory oversight would standardize reporting for PBMs and thereby allow pharmacy benefit purchasers to determine value in a competitive and comparable marketplace. In a properly functioning and regulated market, this would either decrease cost and/or bend the cost curve downward.

▪ **The names of associations, organizations, or other groups representing the occupation and the approximate number of Ohio members in each;**

Pharmaceutical Care Management Association – Members are national rather than state specific as the included link to the membership page will show.

▪ **The functions typically performed by members of the occupation and a list of any other occupations that perform the same or similar functions;**

A Pharmacy Benefit Manager (PBM) is a third-party administrator that manages prescription drug benefits for health insurers, employers, and government programs. There are no other comparable business models that substitute.



https://www.commonwealthfund.org/publications/explainer/2025/mar/what-pharmacy-benefit-managers-do-how-they-contribute-drug-spending

Key functions a PBM may provide include:

1.) Negotiate drug prices: PBMs negotiate rebates and discounts with drug manufacturers to obtain lower prices for prescription medications.
2.) Manage drug formularies: PBMs create and maintain lists of covered drugs (formularies) that insurers and employers use to determine which medications their members can access.
3.) Process prescription claims: PBMs receive, review, and adjudicate prescription drug claims from pharmacies.
4.) Provide pharmacy network services: PBMs establish and maintain networks of pharmacies where members can fill their prescriptions.
5.) Monitor drug utilization: PBMs track and analyze prescription drug usage patterns to identify potential cost-saving opportunities.
6.) Educate patients: PBMs provide information and resources to help patients understand their prescription drug benefits and make informed medication choices.

Role in Healthcare System: PBMs play a significant role in the healthcare system by managing prescription drug costs and ensuring access to medications. They act as intermediaries between health insurers, drug manufacturers, and pharmacies, working to strike a balance between affordability and patient care. However, PBMs have also been criticized for their influence on drug prices and their potential conflicts of interest. Vertical integration being one concern.

▪ An indication of whether specialized training, education, or experience is required to engage in the profession and a description of how that training, education, or experience is acquired by current practitioners;

Pharmacy Benefit Managers are business entities and as such may require business licensure in so far as the services and areas in which they operate. They are not practitioners within the medical field.

▪ A description of any way in which the bill would change how practitioners of the occupation acquire necessary specialized training, education, or experience;

Not applicable/No impact.

▪ An indication of whether current practitioners in Ohio lack necessary training, education, or experience and a description of how the bill addresses that deficiency;

Not applicable/No impact.

▪ An indication of whether new entrants into the occupation or current practitioners would be required to provide evidence of training, education, or experience, or to pass an examination;

Not applicable/No impact.

▪ The expected impact of the bill on the supply of practitioners of the occupation and on the cost of services or goods provided by the occupation;

Not applicable/No impact on the supply or services provided. Nominal to no impact on the cost of services due to reporting and licensure requirements.

▪ Information from others knowledgeable about the occupation and the related economic factors.

Contacts:

- National Community Pharmacists Association – Joel Kurzman – 703-600-1186
- American Pharmacists Association – E. Michael Murphy – 614-832-4168
- Ohio Pharmacists Association – David Burke – 614-389-3236

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