HOUSE HEALTH COMMITTEE

PUBLIC HEARING ON HOUSE BILL 2270

Wednesday, June 10th, 2026

9:00am

Room 60, East Wing

Harrisburg, PA

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1. Call to Order
2. Attendance

   Panel One

   Sally Kozak, Deputy Secretary, Department of Human Services

   Panel Two

   Antonio Ciaccia, CEO, 46brooklyn

   Panel Three

   Scott Newton, Owner, Gaughn's Drug Store

   Rick Seipp, President, Value Drugs

   Ron McDermott, Vice President, Hometown Pharmacies

   Panel Four

   Emily Katz, President, Pennsylvania Medicaid Managed Care Organizations (PAMCO)

3. Any other business that may come before the committee.
4. Adjournment

HOUSE OF REPRESENTATIVES
DEMOCRATIC COMMITTEE BILL ANALYSIS

Bill No:	HB2270 PN3006	**Prepared By:**	Patrick O'Rourke (717) 787-4296
Committee:	Health		
Sponsor:	Matzie, Robert	**Executive Director:**	Erika Fricke
Date:	6/5/2026		

A. Brief Concept

Establishes a state pharmacy benefit manager (PBM) for Pennsylvania's Medicaid program, in which a single state Pharmacy Benefit Administrator (PBA) will manage prescription drug benefits for Medicaid recipients state-wide. Amends the Pharmacy Audit Integrity and Transparency Act.

C. Analysis of the Bill

HB2270 amends the Pharmacy Audit Integrity and Transparency Act of 2016 to direct the Department of Human Services (DHS) to establish a single Pharmacy Benefit Administrator (PBA) model by contracting with a single third-party entity to manage prescriptive drug benefits for Medicaid recipients in the commonwealth. DHS is tasked with creating a competitive process to select a single PBA, by July 31 of 2026. The bill includes stipulations for how the state PBA must be selected, as well as contract requirements between the selected PBA and the state. The bill also amends the definitions of "specialty drug" and "spread pricing," and adds the definitions of "pass-through pricing" and "state pharmacy benefits manager."

Under the bill's competitive procurement process, applicants must disclose:

- Any conflicts of interest with performing as the state PBA.
- All common ownership, board members, managers, or other control shared between the applicant (or its affiliates) and: (A) a Pennsylvania Medicaid managed care organization or its affiliate; (B) a pharmacy services administration organization or pharmacy-contracting entity and its affiliates; (C) a drug wholesaler/distributor and its affiliates; (D) a third-party payer and its affiliates; or (E) a pharmacy and its affiliates.
- Any fees, charges, or assessments imposed by the applicant on Pennsylvania-licensed pharmacies that share common ownership, management, or control with the applicant or its affiliates.
- Any financial terms or arrangements between them and a drug manufacturer or labeler, including formulary management, drug substitution programs, educational support claims processing or data sales fees.

State PBA contract requirements prohibit the PBA from:

- Steering enrollees to vertically integrated pharmacies (including specialty pharmacies) or exclusively to mail order pharmacies, unless the service or drug can only reasonably be performed or dispensed at a specialty pharmacy.
- Requiring a pharmacy to maintain or provide documentation different from legal or State Board of Pharmacy requirements to demonstrate the validity and intent of a medication.
- Retroactively denying or reducing a claim (or aggregate of claims), directly or indirectly.
- Engaging in the use of spread pricing.
- Charging pharmacies additional fees (claw backs, processing fees, hidden charges, etc.)

State PBA contract requirements require the PBA to:

- Pay a rate for pharmacy services that is no less than the National Drug Acquisition Cost guidelines for the drug, or if unavailable, the wholesale acquisition cost, plus the professional dispensing fee, for outpatient drugs.
- Establish a fiduciary duty owed to DHS and all pharmacies or pharmacists who provide pharmacy services to an enrollee.
- Require the use of pass-through pricing.

Key Definitions changes:

Specialty Drug: "Prescription medication used to treat complex or chronic conditions that requires special handling, provider coordination or patient education and monitoring for which a retail community pharmacy is not reasonably equipped to handle, store, provide counseling regarding use and safely distribute."

This definition raises the requirements for designating "specialty" drugs for complex and chronic conditions by specifying that a prescription medication cannot be deemed a specialty drug solely due to additional handling, monitoring, or distribution requirements, but rather only if those requirements make it impossible for the community pharmacy to safely provide the drug.

Spread Pricing: Clarifies that spread pricing occurs only when the contracted amount for a drug is higher than the amount paid to the pharmacy, rather than solely a different number.

Effective Date:

60 days.

G. Relevant Existing Laws

The Pharmacy Audit Integrity and Transparency Act of 2016 establishes standards for how pharmacy benefit managers (PBMs) audit pharmacies, requires pharmacy benefit managers to register with the Insurance Department, and as of 2024, sets standards for some contracts between PBMs and pharmacies.

Definitions include:

"Specialty drug." Either of the following:

(1) A prescription drug prescribed to a covered individual with a cost that meets or exceeds the cost of a drug on the specialty tier of Medicare Part D under 42 CFR 423.104(d)(2)(iv) (relating to requirements related to qualified prescription drug coverage) and meets three or more of the following criteria:

(i) The drug requires specialized product handling or administration by the dispensing pharmacy.

(ii) The drug requires specialized clinical care, including, but not limited to, frequent dosing adjustments to the prescription drug, clinical monitoring or expanded patient service, intensive patient counseling and ongoing clinical support, such as individualized disease or therapy management to support patient outcomes for a covered individual.

(iii) The drug is prescribed for a covered individual with a rare medical condition, complex or chronic medical condition or life-threatening medical condition.

(iv) The prescription drug has a limited or exclusive distribution and is not typically stocked or dispensed by a retail pharmacy.

(2) A prescription drug that is prescribed to a covered individual and that is listed as a specialty drug on the medical assistance fee-for-service specialty pharmacy drug list.

"Spread pricing." A model of prescription drug pricing in which the PBM charges a health benefit plan or health insurer a contracted price for prescription drugs and the contracted price for the prescription drugs differs from the amount the PBM directly or indirectly pays the pharmacist or pharmacy for prescription drugs and related pharmacist services.

Act 77 of 2024 allows for the Pennsylvania Insurance Department to have oversight of pharmacy benefit managers contracted with some commercial insurance providers.

Act 98 of 2022 amended the Human Services code to to give the Department of the Auditor General authority to conduct full-scale audits and reviews of PBMs that subcontract with Medical Assistance Managed Care Organizations (MA-MCOs).

The Department of Human Services already uses a uniform Preferred Drug List (PDL) to eliminate variability and maintain quality.

Preferred Drug List | Department of Human Services | Commonwealth of Pennsylvania

E. Prior Session (Previous Bill Numbers & House/Senate Votes)

N/A.

Pennsylvania
Department of Human Services

Public Hearing: HB 2270

Deputy Secretary Sally Kozak

Office of Medical Assistance Programs

House Health Committee

June 10, 2026

Good morning, Chair Frankel, Chair Rapp, and members of the House Health Committee. I am Sally Kozak, Deputy Secretary for the Department of Human Services' (DHS) Office of Medical Assistance Programs. Thank you for inviting us to join you today. I am here to provide testimony regarding House Bill 2270, which would move the Pennsylvania Medicaid (Medical Assistance) Program to a single Pharmacy Benefit Administrator (PBA) model. This is referred to as a Pharmacy Benefit Manager, or PBM. For consistency, I will use term PBA throughout my testimony.

The Shapiro Administration has worked closely with the General Assembly to protect access to pharmacy services across the Commonwealth. Act 77 of 2024 set higher standards for the commercial market (35% of the total prescriptions in PA), and DHS has taken steps within our Medical Assistance program (12% of the total prescriptions in PA),to support both access to services and the pharmacists who make this work possible in their communities.

Over the past several years, Pennsylvania has already made the specific changes that produced savings in other states. Because of that, moving to a single PBA would add cost, time, and risk here without delivering the savings those states saw. And a Medicaid single PBA would reach only a small share of the prescriptions Pennsylvanians fill, so on its own it cannot solve the pressures that are closing pharmacies. I would like to walk through why.

DHS is responsible for ensuring Pennsylvania Medical Assistance (MA) beneficiaries have access to all covered services, including pharmacy. DHS contracts, through the competitive bidding process, with qualified managed care organizations (MCOs) and pays

the MCOs a fixed per member per month (PMPM) payment for assuming the financial risk of all covered health services, including pharmacy services. The MCOs may choose, but are not required, to subcontract with PBAs to administer the pharmacy benefit. The MCOs generally contract with one PBA to perform the administrative functions related to the pharmacy benefit in the MCO's entire book of business, which generally includes Medicaid, Medicare, and commercial lines of business.

State Medicaid programs may implement single PBAs for a variety of reasons:

- Administrative Ease: Managing a single vendor for Fee-for-Service (FFS) allows the MCOs to streamline administrative processes, reducing complexity and the burden on state resources.
- Pharmacy Provider Payment Consistency: A single vendor model may provide uniform drug payment to all MA enrolled pharmacies.
- Consistency in Utilization Management: A single vendor may offer a uniform approach for the provider community such as a single preferred drug list (PDL) and prior authorization guidelines.
- Improved Data Management: Centralizing data collection with a single vendor may allow for better tracking of drug utilization and costs moving forward.

States approach the decision to implement a single PBA with their own unique goals based on the needs of their specific state and program. There is no "off the shelf" single PBA offering that fits the needs of all states. Each state that decides to utilize a single PBA must design and procure the single PBA contract that addresses their own individual needs. A state may prioritize statewide consistency in benefit administration, network

management, claims processing and provider payments, elimination of spread pricing, enhanced care coordination, fiscal savings, or all of the above. DHS' MA pharmacy program design already considers these elements in both the fee-for-service and managed care programs through the following strategies:

- DHS utilizes a single preferred drug list (PDL) to optimize drug rebates, lower net drug costs, and provide consistency to providers.
- DHS negotiates and collects all drug rebates while prohibiting the MCOs and their contracted PBAs from collecting rebates.
- DHS contractually prohibits MCOs from allowing contracted single PBAs from engaging in spread pricing and charging transmission fees.
- DHS instituted MCO pharmacy payment parameters and a pricing dispute process for providers.

As a result of the actions taken by DHS, contracting for a single PBA offers little in the way of further opportunity for unrecognized cost and administrative controls.

Three states recently implemented a variation of the single PBA model. Because the DHS' program design is already highly optimized for cost efficiency, it's important to recognize that the cost savings reported by other states are not an exact comparison to Pennsylvania.

1. Kentucky moved to a single PBA model on July 1, 2021, and at the same time moved to a single PDL, eliminated spread pricing, and aligned payments with its FFS program. DHS' pharmacy program already uses a single PDL model and disallows spread pricing. The Kentucky single PBA manages prior

authorizations for their MCOs. Kentucky reportedly reduced pharmacy administrative costs from $2.57 PMPM to $0.37 PMPM. Some of the total program savings are attributable to implementation of a single PDL and collection of all drug rebates, which DHS already collects, rather than just a transition to single PBA.

2. Ohio transitioned to a single PBA carve out in October 2022, removing the pharmacy costs from managed care capitation and assuming the risk in FFS. The carve out resulted in the use of a single PDL and the state collecting all drug rebates. In a recent publication, total program savings from carving out the pharmacy costs from the MCOs were estimated at $19 million over a 2-year period.
3. Louisiana moved to a single PBA model in October 2023. Like the Commonwealth, Louisiana had a single PDL in place before the single PBA transition. Their single PBA managed prior authorizations, and independent pharmacies were paid at the FFS rate, while chain pharmacies were paid at single PBA contracted rates. Based on public reporting, Louisiana previously estimated a reduction in administrative costs from $1.98 PMPM to $0.78 PMPM. Due to access issues and provider outcry, in October 2025, Louisiana moved away from the single PBA model and back to the model where each MCO manages its own pharmacy services.

Mercer Government Services (Mercer), DHS' actuarial consultant, evaluated the fiscal impact of implementing a single PBA in the Pennsylvania MA program. The Mercer

analysis considered a number of options for how a single PBA might be structured, including having the MCOs retain some administrative functions versus carving out all administrative functions. While Mercer's analysis found administrative savings to capitation payments, these savings did not offset the cost that would be incurred by DHS to contract with a single PBA. Thus, the overall MA capitation line in the state budget would need to increase. Mercer's evaluation did not include an analysis of the impact of a single PBA on the Fee-for-Service (FFS) program. Mercer also reviewed options for changes to the pharmacy payment rates including directed payments using FFS pricing to all pharmacies as is proposed in the legislation. This directed payment, if even approved by the Centers for Medicare & Medicaid Services (CMS), is projected to result in a possible increase in MA costs of $200M in total funds. In addition, the required cost of a dispensing survey every three years would increase MA program costs on an on-going basis. This projected increase is driven by the bill's requirement to pay all pharmacies fee-for-service rates and dispensing fees, not by the single PBA structure itself.

Mercer's analysis found the cost savings reported in other states do not translate to Pennsylvania, as program efficiencies recognized by a single PBA have already been implemented in our program over the past several years.

There are also federal requirements related to implementation of a single PBA. First, CMS approval of a State Directed Payment is required to pay all pharmacies the same as FFS if the MCOs remain at risk for the pharmacy benefit. CMS is critically reviewing all state directed payments and their associated outcomes. Approvals are being rationed under the MCO capitation model. If CMS approval is not received, this part of the bill may be

unenforceable. Second, a new contract with a single PBA also requires CMS approval for enhanced federal funding. If not secured, the cost to develop and implement may negate savings through MCO administrative consolidation. The MCOs will incur costs to remove PA Medical Assistance from their existing PBA contracts, and the costs must be considered in the calculation of their capitation rates.

From a clinical perspective, one major challenge in a single PBA model is the coordination of member care if pharmacy utilization data is not promptly available to the MCOs via a mechanism similar to what is employed by the MCOs and their subcontracted PBAs today. The challenge can be mitigated by the creation of a robust data exchange between the single PBA and the MCOs. If a single PBA is pursued, it is imperative that systems are in place to ensure clinical information is available to the MCO clinicians in real time to avoid adverse consequences and gaps in care.

The proposed legislation requires DHS to enter into a contract with a single PBA by July 31, 2026. It is not achievable to meet this deadline with statutory procurements processes, which is a multi-year process. Any contracted single PBA would need to interface with new claims, financial, and federal reporting system, currently in the procurement process. Implementation of these system changes will not be completed until 2030.

We know that when pharmacy closes it hurts communities. But Medicaid is a small part of the picture. Medicaid accounts for about 12% of prescriptions, while Medicare Part D accounts for about 42% and commercial insurance about 35%. Very few pharmacies operate on Medicaid alone, so a Medicaid-only change will have very minimal impact.

In summary, while some states have benefitted from implementation of a single PBA, the impact in Pennsylvania is less clear and challenges exist. Continuity of care must be addressed to ensure care management for MCO beneficiaries. Our Medicaid program has already implemented many beneficial aspects of a single PBA, such as a statewide PDL, elimination of spread pricing, and pharmacy provider pricing dispute processes. Savings reported by other states with single PBAs may not correlate to Pennsylvania based on the pharmacy program changes that we have already implemented in the past several years.

Thank you for the opportunity to provide testimony here today. Like you, we are committed to supporting our pharmacy providers and MCO providers who deliver essential services to the Pennsylvanians we serve and strive to provide a clinically sound and fiscally responsible Medical Assistance pharmacy program.

Testimony of J. Scott Newton, PharmD
Owner and Pharmacist, Gaughn's Drug Store
Before the Pennsylvania House Committee Regarding House Bill 2270

Chair Frankel, Chair Rapp, and distinguished members of the committee:

My name is Scott Newton, and I am a pharmacist and owner of Gaughn's Drug Store in Warren, Pennsylvania. I sincerely appreciate the opportunity to appear before you today and share my experiences as both a pharmacist and independent pharmacy owner for more than 20 years.

Gaughn's Drug Store has served the Warren community continuously since it was founded in 1917, and it has operated from its current location since 1922. For generations, our pharmacy has been far more than simply a place to pick up prescriptions. We have been a trusted healthcare destination, a source of professional guidance, and, especially in recent years, providers of immunizations, medication management, delivery services, and direct patient care for the people of our community.

I grew up in Warren, Pennsylvania, and during high school I worked as a stock boy at another local independent pharmacy. That experience inspired me to pursue pharmacy as a profession. After graduating from Duquesne University with my Doctor of Pharmacy degree, I was given the opportunity to return to my hometown and become a part owner of Gaughn's Drug Store in 2005 at the age of 27. It was truly my dream career opportunity — to serve the community that helped raise me while building a small business in the profession that I love.

In 2011, my wife and I expanded and purchased a second independent pharmacy in Port Allegany, Pennsylvania. At the time, life was good, business was stable, and independent pharmacy ownership still represented a viable path to serving patients while supporting a family. Unfortunately, over the past two decades, the business environment for community pharmacy has changed dramatically — and not for the better.

Today, independent pharmacies are facing challenges unlike anything I could have imagined when I entered this profession.

I want to be clear: I am not here to complain about the ordinary difficulties of running a small business. Every business owner understands the realities of hard work, rising costs, and changing markets. Throughout the years, especially during and after COVID-19, we adapted constantly. We improved operational efficiency, negotiated aggressively with suppliers, reduced expenses wherever possible, expanded clinical services, increased vaccinations, and diversified revenue streams.

In 2018, as financial pressures intensified, we were forced to make extremely difficult decisions just to stay afloat. We reduced our operating hours from nearly 70 hours per week to 50 hours per week. We changed wholesalers in search of better pricing. Most painfully, we had to lay off employees, including a full-time pharmacist and additional staff members. These were not just employees — they were people we cared about and who cared deeply about our patients and community.

Then, in late 2019, four other independent pharmacies in Warren County—one of which was the same pharmacy where I had interned in high school — closed their doors. Overnight, our prescription volume nearly doubled. We hired additional staff, expanded our delivery services, and worked tirelessly to meet the healthcare needs of our growing patient population.

And just a few months later came COVID-19.

During the pandemic, our pharmacies became the first retail pharmacies in Warren and McKean counties to offer COVID vaccines. Since that time, we have administered more than 10,000 vaccinations and became known throughout the region as trusted vaccination providers. My staff and I are incredibly proud of the role we played in protecting our communities during one of the most difficult public health crises in modern history. When our communities needed access to vaccines, mass immunization clinics, and in-home vaccinations, it was Gaughn's Drug Store and Port Allegany Pharmacy — locally owned independent pharmacies — that stepped up and met that need.

Despite all of this growth, all of this work, and all of this patient demand, our financial situation did not improve proportionately. In fact, in many ways, it became worse.

The fundamental problem lies in how pharmacies are reimbursed by Pharmacy Benefit Managers, or PBMs.

The core role of a pharmacist is straightforward: ensure that patients receive medications safely, accurately, and effectively. The dispensing of medications is the foundation upon which pharmacies operate. Yet today, that very foundation has become economically unsustainable.

According to the National Community Pharmacists Association, the average cost for an independent pharmacy to dispense a prescription is approximately $15. At Gaughn's, through every efficiency we could realistically implement, our dispensing cost is closer to $12 per prescription. And yet approximately 80% of the prescriptions we dispense are reimbursed below our cost to dispense them. Across Medicaid prescriptions, we average approximately $8 above acquisition cost, meaning we still lose roughly $4 per prescription after accounting for dispensing and operational expenses.

Imagine requiring $20 worth of ingredients and $10 in operational costs to make a pizza and then being forced to sell that pizza for $10 or $15. No business can survive indefinitely under that model. Yet that is precisely what pharmacies are required to do every day. In fact, in 2025 we were reimbursed less than the cost of the medication (not including our operating costs) for approximately 10% of the prescriptions that we dispensed. That is approximately 9,000 prescriptions that we did not recoup our cost of goods. To put that in perspective, that is the equivalent of filling 30 days of our average dispensing volume at a loss without accounting for the costs of paying our staff, keeping the lights on and using our clinical skills.

There continue to be situations where reimbursements are so poor that I have had to ask family members, including my own father-in-law, if they would be willing to fill certain prescriptions elsewhere because every fill represented a significant financial loss to my pharmacy.

These reimbursement practices are driven largely by PBMs — entities that control drug pricing, reimbursement formulas, formularies, and pharmacy networks with very little transparency or accountability. Independent pharmacies like mine have virtually no leverage within that system, particularly when very large, vertically integrated corporations own the insurer, the PBM, specialty pharmacies, and retail chains simultaneously. If I don't participate with these entities, then I can't serve my patients. That is the reality of this environment.

We have reached a point where operational excellence alone is no longer enough to survive.

If you compare Gaughn's Drug Store to national pharmacy benchmarks, you would likely conclude that we are a very well-run pharmacy. We meet or exceed national operational metrics. We carefully manage expenses. We aggressively negotiate purchasing costs. We provide high-quality patient care along with valuable, expanding clinical services. Yet despite doing nearly everything "right," we struggle to remain financially viable because the reimbursement system itself is fundamentally broken.

The consequences are already visible across Pennsylvania.

More than 1,000 pharmacies have closed in Pennsylvania since 2020, including over 70 independent pharmacies in 2024 alone. Approximately 200 community pharmacies closed between January 2024 and January 2025.

My own family experienced this firsthand.

On June 14, 2023, we announced the closure of our pharmacy in Port Allegany. That pharmacy had served its community since 1937. We did not close because of lack of patients or lack of demand. In fact, we were busier than ever. We closed because volume no longer translated into sustainability. We felt that by selling the pharmacy to Rite Aid, a large corporate chain, that we would at least ensure the continuation of care for our patients. However, Rite Aid eventually closed their location as well, along with other nearby pharmacies. Today, many patients in that region no longer have a pharmacy within reasonable proximity. For elderly patients, patients without transportation, or those managing chronic conditions, that is not merely inconvenient — it is life-threatening. In a similar scenario, in Warren County, with the recent pharmacy closures, roughly 50% of the population lives in a pharmacy desert according to data compiled by the University of Pittsburgh.

That reality should concern every member of this committee.

We know from examples set in other states that changes to the administration of the Medicaid system can be beneficial to the state as well as to the pharmacies that serve their communities. If I were operating my pharmacy in Ohio, or Michigan or Tennessee or even West Virginia the picture would be significantly different. We are talking about the same medications dispensed for the same health conditions and being dispensed by pharmacies following essentially the same procedures being paid substantially differently for their services.

House Bill 2270 represents an important step toward restoring fairness, transparency, and sustainability within Pennsylvania's pharmacy reimbursement system.

I support this legislation for several reasons:

1. It would create greater transparency and accountability within the PBM system, reducing hidden fees, retroactive clawbacks, and opaque reimbursement practices that make it nearly impossible for pharmacies to plan and operate responsibly.
2. The use of NADAC pricing benchmarks would more accurately reflect the true acquisition cost of medications than outdated benchmarks such as AWP or WAC that have been manipulated by PBMs for their own financial gains at the expense of all others.
3. Ensuring a fair and realistic dispensing fee would properly recognize the operational, cognitive, clinical, and patient-care services pharmacists provide every single day, and cover all of the necessary costs to operate a community pharmacy sustainably.
4. A more transparent and sustainable reimbursement structure would help preserve access to local pharmacy care, particularly in rural communities like mine.
5. Most importantly, this legislation would help ensure that pharmacies like Gaughn's Drug Store can continue serving our communities for future generations.

This legislation is not about making independent pharmacy owners wealthy. It is about allowing community pharmacies the opportunity to survive while continuing to provide accessible, high-quality healthcare to the patients who depend on us.

I stand before you today not only as a pharmacy owner, but as an advocate for my patients, my staff, my profession, and my community. While I do not claim to be an expert in every technical aspect of PBM operations or legislative policy, I am an expert in what it takes to care for patients and operate a community pharmacy. I have seen firsthand the consequences of the current reimbursement system on small businesses, healthcare access, and patient care in rural Pennsylvania.

I respectfully urge this committee to support House Bill 2270 and take meaningful action to preserve access to community pharmacy care throughout Pennsylvania before more pharmacies are forced to close.

Thank you again for your time, your consideration, and the opportunity to share my testimony today. I would be happy to answer any questions.

Respectfully submitted,

J. Scott Newton, PharmD
Owner and Pharmacist
Gaughn's Drug Store
Warren, Pennsylvania

Good morning, Chairman Frankel and Chairwoman Rapp and members of the House Health Committee. Thank you for the opportunity to testify today in strong support of House Bill 2270. My name is Rick Seipp, and I am here representing Value Drug Company and Value Specialty Pharmacy as well as countless other retail community pharmacies. We believe this legislation is a critical step toward improving transparency, fairness, and, most importantly, patient-centered care to Pennsylvania's Managed Medicaid program.

We cannot overstate the importance of implementing these changes quickly. For years, the complex web of Pharmacy Benefit Managers (PBMs) has created barriers that threaten patient access to life-saving medications. Well over 1,000 pharmacies have closed in the state since 2020. House Bill 2270 requires the Department of Human Services to enter into a master contract for a State PBM. The committee and legislature have the power to provide immediate relief to a healthcare system under immense strain.

Currently, providers and patients must navigate a fragmented landscape of multiple PBMs in the Managed Medicaid Program, each with its own rules and hurdles. This includes prior authorization, provider services, audit requirements, step therapy requirements, etc. HB 2270 streamlines this by establishing a single State PBM to administer all pharmacy benefits for Managed Medicaid recipients. Centralizing these benefits under one master contract will ease administrative burdens for providers—both prescribers and pharmacies—and simplify the process for patients, ensuring that a Pennsylvanian’s access to medicine is not dictated by which PBM they are enrolled in. It would also help simplify patient access issues related to the plans in which a pharmacy is enrolled.

Furthermore, this model could potentially enhance state rebates and overall savings. By one PBM’s formulary and STEP therapy requirements and explicitly prohibiting spread pricing—where a PBM charges the state more than it pays the pharmacy—and instead requiring pass-through pricing, every dollar the Commonwealth spends on drugs will be accounted for. Those dollars should also be paid back into the community that serves patients, not to vertically integrated health plans. Often, the Managed Medicaid PBM is connected to the MCO, which may even be owned by a large health system. The profit and transparency in that model can easily be lost within the organization’s infrastructure. The bill establishes a fiduciary duty for the State PBM to the Department of Human Services, ensuring the Commonwealth’s financial interests are always the priority. Today, Medicaid is built on a capitated program for all services within the Managed Care Organization. The contracted PBM for the MCO is at arm’s length from DHS, but often not from the MCO. The program should not be funded, in part, through below-cost reimbursement for medications, never mind the cost to dispense those prescriptions.

Benefits will extend to MCOs as well in this bill. As an example, under the Ohio model, the MCOs have a more efficient care coordination platform than they did before. The SPBM vendor has a real-time data exchange platform that gives the MCOs access to all claims information; including, real-time prior authorizations, instant eligibility and coverage checks, and faster claims approval; consistent updates to formularies and drug lists; and a full-time MCO Care Coordinator nurse whose sole purpose is to work with the health plans.

By refining the definition of "specialty drug," the legislation ensures that medications are only categorized as such when they truly require specialized handling that a retail community pharmacy cannot provide. Too often, medications are shunted to other pharmacies with undisclosed reimbursement, potentially limiting access to those medications.

This change, combined with provisions that prevent Medicaid steering, will allow more pharmacies to serve their communities. HB 2270 prohibits the State PBM from coercing or enticing enrollees to use PBM-owned or affiliated specialty pharmacies. It also prevents the PBM from mandating mail-order services unless absolutely clinically necessary. These protections ensure that patients can receive care from the local pharmacist they know and trust. This is not a hypothetical issue. It is happening daily. Pharmacies are being prevented from having prescriptions sent to the pharmacy of their choice in these massive vertical integrations—even if they want to pay cash for a low-cost generic medication.

To illustrate why these changes are so vital, I want to share a troubling trend we are seeing across the Commonwealth. Not only are there too many pharmacy closures and too many patients waiting in long lines forcing patients to choose between gas, food, and medications, but many specialty pharmacies have also been forced to limit the formulary of drugs they dispense due to chronically poor reimbursement rates. When a pharmacy is reimbursed less than the actual cost of the drug, it simply cannot afford to stock it. This is true for specialty and traditional medications. HB 2270 addresses this crisis directly by requiring reimbursements to be no less than the National Average Drug Acquisition Cost (NADAC) plus a professional dispensing fee based on an actual in-state cost-of-dispensing survey. The cost-to-dispense study was conducted in 2016 and finalized in 2017 for Fee-for-Service. Imagine still being paid for services today at 50–80% of what was determined during the Obama Administration and when President Trump was first elected.

Finally, I want to emphasize the pharmacy community’s strong desire to work collaboratively with the Department of Human Services on the implementation of this bill. We are eager to assist the Secretary and her team in any way requested during the competitive procurement process to ensure the selected State PBM meets the highest standards of eligibility and transparency.

We believe HB 2270 is a fair, transparent, and necessary solution to the PBM crisis. The Single PBM would operate under the direction and transparent oversight of the state and Department. We urge the committee to move this bill forward to protect our pharmacies and, most importantly, the patients we serve.

Thank you for your time and your commitment to Pennsylvania's healthcare. I am happy to answer any questions.

We appreciate the Pennsylvania House Health Committee holding this hearing to consider legislation that would establish a single PBM model for the Commonwealth's Medicaid program. I would like to thank the Chair for scheduling this important hearing and for the tremendous bipartisan support this committee has shown.

Legislators on both sides of the aisle have expressed interest in Ohio's successful approach, and I can offer a unique perspective because my independent pharmacy team and I operate pharmacies in both Pennsylvania and Ohio.

We have seen firsthand what a single PBM model can accomplish. It gives the state greater oversight, accountability, and transparency. If a reimbursement issue arises, we can sit down with one entity and work toward a solution. In Pennsylvania, where multiple managed care organizations and PBMs are involved, addressing the same problem can feel like herding cats.

Ohio's single PBM model uses NADAC as a reimbursement benchmark and provides a dispensing fee that helps pharmacies cover the true cost of caring for patients. Is it perfect? No. There are still occasional reimbursement issues, particularly with certain brand-name medications. The difference is that when problems occur, there is a clear process and a single point of contact to resolve them.

The reality is that pharmacy reimbursement remains broken in many cases. There is nothing more discouraging than filling a prescription, obtaining prior authorization, placing medications in specialized adherence packaging, delivering them to a patient's home because they have no transportation, and then receiving just 35 cents in reimbursement. Meanwhile, a child can walk into the store and buy a bottle of soda for $1.89. Something is clearly wrong with that equation.

I am not speaking about theory. I am speaking from experience. I have watched reforms work in Ohio while Pennsylvania continues to fall behind. In Pennsylvania, we have already been forced to close a Pennsylvania pharmacy. That should never have happened when a proven model exists right next door.

We need to move forward with single PBM legislation now to help stabilize the pharmacy market and prevent additional closures. Pennsylvania is in the midst of a pharmacy desert crisis. Independent pharmacies are disappearing from communities across the Commonwealth, leaving seniors, individuals with disabilities, and low-income families with fewer options to access medications and healthcare services.

I know this crisis is real because I am living it. Despite operating successful pharmacies in Ohio under a single PBM model, we have been forced to close a Pennsylvania pharmacy. That should be a wake-up call. If pharmacies cannot survive under the current system, more communities will lose access to care, more patients will face longer travel times for prescriptions, and gaps in healthcare will continue to grow.

Every pharmacy closure makes the crisis worse. The longer we wait to act, the more difficult and expensive it will be to rebuild the healthcare infrastructure that local pharmacies provide.

We also need this reform for the future. A single PBM model gives the Commonwealth the ability to better oversee, manage, and improve the Medicaid pharmacy program as healthcare continues to evolve.

The question I continue to ask is simple: If Ohio and many other states have successfully implemented these reforms, why is Pennsylvania still waiting?

Please help Pennsylvania pharmacies survive and continue caring for our most vulnerable patients — your constituents — by passing single PBM legislation.

I would again like to thank the Chair for holding this hearing today. I will be happy to answer your questions.

Sincerely,
Ron McDermott, Senior Vice President, at The Hometown Pharmacies

Pennsylvania House Health Committee
Informational Hearing on House Bill 2270 – Single PBM

Testimony provided by Emily Katz, Executive Director of PAMCO

Wednesday, June 10, 2026

Majority Chairman Frankel, Minority Chair Rapp, and Members of the Committee:

Thank you for the opportunity to provide testimony regarding proposals to implement a single, state-selected pharmacy benefit manager (PBM) within Pennsylvania's Medicaid program. This testimony is submitted on behalf of the Pennsylvania Medicaid Managed Care Organizations (PAMCO). Pennsylvania Medicaid Managed Care Organizations (PAMCO) represents the seven Physical HealthChoices Managed Care Organizations (MCOs) across the Commonwealth who contract with the Department of Human Services to deliver the Physical HealthChoices program.

PAMCO and its member (MCOs) share the Committee's goal of ensuring access to high-quality, cost-effective pharmacy services for Medicaid beneficiaries, particularly those with complex care needs. Any policy changes should be carefully evaluated to ensure they strengthen the pharmacy system without creating unintended consequences for patients, providers, or the broader healthcare system.

Under a single PBM model, the Commonwealth would require all HealthChoices MCOs to terminate their current PBM contractual arrangements for Medicaid services. Core pharmacy functions, including benefit design, claims processing, pricing, auditing, and pharmacy network management, would be transferred to a state-designated PBM. In addition, the Department of Human Services (DHS) would assume responsibilities that are currently managed by MCOs, including administration of reimbursement methodologies such as maximum allowable cost (MAC) pricing, dispensing fees, and compliance oversight. This represents a fundamental restructuring of the current managed care model, under which MCOs are accountable for both cost and quality outcomes and directly manage pharmacy benefits as part of integrated care delivery. MCOs would remain responsible for overall quality performance and total cost of care but would lose direct oversight of a major driver of both—pharmacy services. This separation reduces transparency, introduces operational complexity, and reduces alignment between pharmacy management and broader care coordination efforts. It also limits value-based innovation and contributes to the inability to deploy targeted strategies such as faster conversion to biosimilars.

The transition to a single PBM is expected to have significant financial implications. Estimated increases in Medicaid dispensing fees alone could result in additional costs of

approximately $74 million or more annually, not including all associated expenditures. Additional costs may also arise from required system modifications, including Medicaid Management Information System (MMIS) updates and operational transitions. There may also be broader market impacts. As PBMs serving MCOs would have fewer Medicaid members under management, they may adjust pricing, rebate guarantees, or fee structures across other lines of business. This could lead to increased costs in the commercial or other public markets served by those entities.

Centralizing PBM functions within a single vendor may also limit competition and reduce flexibility for plans to negotiate pricing and manage benefits across populations. A single-vendor model may lessen incentives for innovation or performance improvement and reduce the ability to tailor services to specific patient populations such as care coordination tied to specialty drugs.

A key concern with a single PBM model is the potential disruption to patient care. MCOs currently contract with hundreds of community pharmacies across Pennsylvania, which serve as critical access points for Medicaid members. Pharmacy management at the MCO level is integrated with medical and behavioral health services, supporting medication adherence and improved health outcomes. In addition, MCOs also play a key role in member experience as they serve as a point of contact for patients experiencing customer service needs or seeking help navigating their care.

Transitioning to a centralized PBM may result in changes to pharmacy networks, reimbursement policies, and specialty pharmacy arrangements. These changes carry a risk of disrupting patient access to medications and providers, further reducing care coordination to an already vulnerable population. Experience in other states highlights these risks. For example, Louisiana's implementation of a single PBM model experienced a challenging rollout, during which some providers were unable to prescribe medications, and some patients experienced delays in accessing necessary therapies. This underscores the importance of ensuring continuity of care throughout any transition.

Pennsylvania already has robust oversight mechanisms in place governing PBM practices within Medicaid managed care. Through DHS contract requirements, MCOs must adhere to a number of transparency and accountability provisions ensuring programmatic and fiduciary stewardship. These include reporting PBM payment methodologies, submitting unredacted contracts upon request, and documenting both amounts paid to PBMs and amounts paid by PBMs to pharmacy providers on each transaction. MCOs must also report any differences between those amounts and disclose all PBM fees charged to both the plan and providers. Additionally, MCOs are required to implement monitoring processes to ensure PBM compliance, conduct independent audits when requested, and maintain formal dispute resolution mechanisms for pharmacy providers.

Current DHS contract provisions also prohibit practices such as spread pricing, pharmacy steering, and retroactive claim adjustments. Requirements for pass-through pricing and

price transparency reporting are already in place. As a result, many of the policy goals associated with a single PBM model—particularly around transparency and cost control—have already been addressed in Pennsylvania's Medicaid program.

While pharmacy reimbursement sustainability is an important issue, shifting to a single PBM may not resolve underlying challenges related to drug pricing or market dynamics. Instead, it may introduce new risks, including fragmented care delivery, reduced accountability alignment, and increased administrative complexity. Policymakers may wish to consider approaches that directly address reimbursement levels and support community pharmacies, while maintaining the integrated care model that allows MCOs to coordinate pharmacy, medical, and behavioral health services.

PAMCO and its member organizations remain committed to working with the General Assembly and DHS to strengthen Pennsylvania's Medicaid pharmacy program. However, based on the considerations outlined above, a single PBM model represents a significant structural change with uncertain benefits and potential risks to patient care, program costs, and system stability.

We respectfully encourage the Committee to focus on targeted policy solutions that support pharmacy sustainability while preserving the integrated accountability, transparency, and care coordination that currently exist within the Medicaid managed care system.

Thank you for your time and consideration. PAMCO looks forward to continuing this dialogue and serving as a resource to the Committee.

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June 5, 2026

Rep. Dan Frankel
Chair, House Health Committee
152 Main Capitol Building
P.O. Box 202023
Harrisburg, PA 17120-2023

RE: HB 2270, Single Pharmacy Benefit Administrator Model

Dear Chair Frankel:

AHIP appreciates the opportunity to provide comments on HB 2270, which would replace Pennsylvania's managed care approach with a fee-for-service model for administering prescription drug coverage for millions of Pennsylvanians.

AHIP shares policymakers' goal of lowering prescription drug costs, a key driver of overall health care spending. However, reverting to a fee-for-service structure through a statutorily mandated single, statewide pharmacy benefit manager (PBM) is not the appropriate means to achieve this goal. Medicaid managed care remains one of the most effective tools available to states for improving health outcomes, enhancing beneficiary experience, and supporting fiscal stability.

HB 2270 would require the Medical Assistance Program to utilize a single, state government-contracted PBM. This approach would limit managed care organizations' ability to customize formularies, coordinate care interventions across medical and pharmacy benefits, or tailor coverage to local needs. It would also reduce competition that helps constrain drug costs by concentrating purchasing authority and decision-making within a single entity. This shift risks disrupting care coordination, undermining beneficiary outcomes and reversing longstanding progress in quality and fiscal stewardship.

As states nationwide work to strengthen and modernize Medicaid programs, managed care continues to serve as a proven, value-driven delivery model that advances state policy goals while improving outcomes for beneficiaries.

For these reasons, **AHIP respectfully opposes HB 2270.** Thank you for your continued leadership and commitment to strengthening Medicaid for the individuals and families who rely on it. We welcome the opportunity to discuss these findings further or assist in tailoring insights for Pennsylvania's unique needs.

Thank you.

Sincerely,

Keith Lake
Regional Director, State Affairs
klake@ahip.org / 220-212-8008

About AHIP
AHIP is the national association whose members provide health care coverage, services, and solutions to hundreds of millions of Americans every day. We are committed to market-based solutions and public-private partnerships that make health care better and coverage more affordable and accessible for everyone. Visit www.AHIP.org to learn how working together, we are **Guiding Greater Health**.