Committee Meeting

of

SENATE COMMERCE COMMITTEE

"The Committee will receive testimony from invited guests on the current state of pharmacy benefits managers in New Jersey"

LOCATION: Committee Room 6
State House Annex
Trenton, New Jersey

DATE: June 23, 2025
10:00 a.m.

MEMBERS OF COMMITTEE PRESENT:

Senator Joseph A. Lagana, Chair
Senator Joseph P. Cryan, Vice Chair
Senator Gordon M. Johnson
Senator Jon M. Bramnick

ALSO PRESENT:

Liza Ackerman
Jamie E. Galemba
Office of Legislative Services
Committee Aides

Allison Meyers
David Smith
Senate Majority
Committee Aides

Alex Solomon
Senate Republican
Committee Aide

Meeting Recorded and Transcribed by
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NEW JERSEY LEGISLATURE

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COMMITTEE NOTICE

TO: MEMBERS OF THE SENATE COMMERCE COMMITTEE

FROM: SENATOR JOSEPH A. LAGANA, CHAIRMAN

SUBJECT: **COMMITTEE MEETING - JUNE 23, 2025**

The public may address comments and questions to Liza Ackerman or Jamie Galemba, Committee Aides, or make bill status and scheduling inquiries to Joanne W. Gillespie, Secretary, at (609)847-3845, fax (609)777-2998, or e-mail: OLSAideSCM@njleg.org. Written and electronic comments, questions and testimony submitted to the committee by the public, as well as recordings and transcripts, if any, of oral testimony, are government records and will be available to the public upon request.

The Senate Commerce Committee will meet on Monday, June 23, 2025 at 10:00 AM in Committee Room 6, 1st Floor, State House Annex, Trenton, New Jersey.

The committee will receive testimony from invited guests on the current state of pharmacy benefits managers in New Jersey.

Issued 6/13/25

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TABLE OF CONTENTS

TABLE OF CONTENTS (continued)

TABLE OF CONTENTS (continued)
APPENDIX (continued)

TABLE OF CONTENTS

TABLE OF CONTENTS (continued)

TABLE OF CONTENTS (continued)
APPENDIX (continued)

SENATOR JOSEPH A. LAGANA (Chair): Good morning everyone; welcome.

Today is June 23, 2025, in front of the Senate Commerce Committee for a special committee hearing dealing with PBMs, which will be discussed in greater detail as we proceed.

There will not be any bills up today for consideration. This is merely testimony on the pharmaceutical industry, involving several different layers, including independent pharmacies; pharma; PBMs; and health plans.

But, before we get started, I would like to take a roll call.

MS. ACKERMAN (Committee Aide): Senator Bramnick.

SENATOR BRAMNICK: Present.

MS. ACKERMAN: Senator Singer. (no response)

Senator Johnson.

SENATOR JOHNSON: Here.

MS. ACKERMAN: Vice Chair Cryan.

SENATOR JOSEPH P. CRYAN (Vice Chair): Here.

MS. ACKERMAN: Chair Lagana.

SENATOR LAGANA: Here.

MS. ACKERMAN: You have a quorum.

SENATOR LAGANA: Thank you.

As I noted just a minute ago, today is a discussion-only hearing on PBMs and the pharmaceutical industry -- just in general -- and what our concern is, as there are pieces of legislation that are making their way through the State Assembly. And, there were some introduced -- companion bills introduced in the Senate. They are dealing with a multitude of issues involving transparency and a number of other considerations.

We did, as a Legislature, pass a bill not -- I don't believe it was even a year ago -- but it was signed into law and took effect this past January, 2025, that does set a whole new criteria for transparency when it comes to this industry. And, we're going to hear a little bit about that today, what it does, and what we should be doing going forward.

Again, this is going to be a policy discussion, just on this specific issue. I have spoken to all the stakeholders. It's certainly not going to be a finger-pointing session, but really trying to understand how we as a Legislature can make sure that we're keeping policy premiums where they should be, and not letting certain aspects of what our taxpayer dollars -- because we're talking about State health benefits plans, generally -- to make sure taxpayer dollars are protected, and that the best rates are being negotiated for the insurance. And, that's what we are really looking for today: best practices; what should we be looking at going forward; and just having a discussion around all of those specific items.

So, prior to bringing up our first witnesses, I'm going to read a little bit of an overview, and we'll get the witnesses up.

MS. ACKERMAN: Pharmacy Benefit Managers, or PBMs, are companies that serve as intermediaries in the pharmaceutical access pathway. Currently, the main role of a PBM is to negotiate the terms and conditions for access to prescription drugs between the drug producers, large employers, and insurance companies.

Similar to the function of an insurer -- who negotiates prices; sets coverage terms; establishes networks; and processes claims for non-drug benefits -- a PBM acts to A, set prescription drug prices; B, determine patients' access to medications; and, C, establish contracts with pharmacies

to participate in insurance networks. Despite the original intention of PBMs to help set reimbursement rates; process claims; and pay pharmacies, over time they have evolved into complex organizations directly intertwined within the workings of insurance and pharmacies, as depicted further in the document, which has resulted in several issues which will be discussed in this Committee.

For the first panel: Matt Greller, representing the Pharmaceutical Care Management Association; with Heather Cascone, Assistant Vice President -- State Affairs, of PCMA; and, Amanda Frost, Vice President of Research.

SENATOR LAGANA: Good morning.

I would like to welcome the first panel. The first panel will be the trade organization representing the PBMs.

And, we will -- we have a traffic signal over there, to your -- to my left; to your right. We would like to give each panel about 40 minutes to kind of discuss. Obviously, we're going to have questions. We're going to try to keep to it -- obviously not hard and fast, but we want to make sure we get the right testimony and everybody has their opportunity to answer -- to ask and have their questions answered.

So, if we could first begin, please state your name and who you represent for the record.

M A T T H E W N. G R E L L E R, ESQ.: Good morning, Mr. Chairman, and members of the Committee.

My name is Matt Greller. I am a solo practitioner here on behalf of a client, the Pharmaceutical Care Management Association, or PCMA.

PCMA is the trade association representing America's pharmacy benefit managers.

Mr. Chairman, I appreciate the opportunity to testify -- and, more specifically, the invitation to testify. I feel as though today my role is akin to the body at an Irish wake: necessary to have the proceedings, but folks don't expect you to say so much. So, with that in mind, I am going to turn it over to my client, Heather Cascone.

Thank you.

H E A T H E R C A S C O N E: Good morning. (laughter)

Mr. Chair and members of the Committee, my name is Heather Cascone, and I am an Assistant Vice President of State Affairs here at PCMA, or the Pharmaceutical Care Management Association.

I really appreciate the opportunity to speak with you all today. We're going to cover a lot of ground.

And, I have with me also another associate of mine from the -- is that working? OK -- from PCMA, who I'll introduce shortly.

PBMs aggregate the buying clout of millions of enrollees, enabling plan sponsors and individuals to obtain lower prices for their prescription drugs. The groups that sponsor drug benefits are varied and come in different sizes, with varying mixes of population and different needs. Plan sponsors can be private employers; unions; health insurance carriers; the Federal government, through Medicaid Part D; the State of New Jersey, through the SHBP and the SCHBP; as well as State Medicaid programs; county governments; municipalities; and cities. Each has unique needs, and sponsor health insurance for very different groups of Americans.

In today's healthcare market, those plan sponsors choose whether to contract with a PBM and what they want out of that service. They choose how to set up their contract, and how to pay for the services of a PBM. They choose how best to use the savings delivered by their PBM to help lower costs for the plan and for the patients.

While employers could negotiate directly with the drug companies and pay for prices that each pharmacy charges the general public, nearly all them choose to work with PBMs because of the value that they provide. These employers, unions, and governments choose to hire PBMs to secure lower costs for prescription drugs and achieve better health outcomes for patients. Over the next 10 years, PBMs will save employers, health plans, labor groups, and State and Federal governments more than $1.2 trillion. That's a big number. (laughter)

But, here in New Jersey, that averages out to about $1,154 per person, per year. In order to achieve these cost savings, we strongly believe that competition is the key to lower prices.

That said, the quickest, clearest, least prohibitive path to lower drug costs is for drug companies to simply lower their drug prices. PBMs focus on helping plan sponsors with a balance of access and affordability, by specifically offering a variety of tools, programs, and services. They include negotiating with drug companies for rebates for brand drugs and discounts from drug stores. These savings are fully under the control of the PBM client in every aspect.

PBMs also encourage the use of more affordable medications, such as lower-cost brands; generic drugs; and biosimilars. PBMs offer services that benefit patients, such as home delivery, adherence programs, and drug

review. They also manage and help patients access high-cost specialty medications, or specialty drugs. And, they also keep costs down by identifying and rooting out fraud; reducing waste; and preventing potentially harmful drug interactions. It's crucially important that policymakers consider proposals to intervene in the commercial market with PBM mandates limitations. They do so with a more complete understanding of the numerous ways that the market continues to change and adapt, and its competitive characteristics. The PBM market is highly competitive. When a PBM does not perform as expected, employers and unions have many choices. There are more than 70 full-service PBMs in the market, and new entrants are coming -- emerging continuously, with about an 18% increase in the total number of PBM businesses over the last few years.

There are dozens more companies offering subsets of PBM services. PBM business models are structured in a variety of different ways, adding to the choice and optionality for employers and plan sponsors when they choose a PBM. Some PBMs are stand-alone companies; some stand-alone companies focus on only certain therapeutic areas and categories of medications. And, other PBMs may have an affiliated mail, specialty, or retail pharmacy, or be part of a larger health-care company, which can add to the ability to offer a total care package to a patient enrolled in the plan. The choice is up to the employer -- always -- and plan sponsor, to determine what will deliver the highest quality, best health outcomes, and lowest costs for the enrollees who they're servicing.

It's crucially important that as policymakers consider proposals to intervene in the commercial market, they understand that there are a

number of ways that the PBM market is evolving and adapting with its own competitive characteristics.

I'd also like to note that in 2023, a PBM law was enacted and included in a package of drug bills, which just took effect a few months ago, at the start of the year. Included in it were some of the most extensive PBM laws in the country, including greater transparency for PBMs and disclosure requirements in all of their contracts; all of their pricing formulas and models; all of the standards on how pharmacy networks are built; and PBM marketing. It also included licensing requirements for PBMs; contracting standards to act with good faith in fair dealing with all of the parties with whom they contract, and all of the stakeholders that they meet with; as well as *extensive* reporting requirements. And, all of that is on top of the various laws that have been enacted over the last 10 years dealing with the interaction between PBM, their clients, and pharmacies.

With that, I want to introduce to you my colleague Amanda Frost, who is our VP of Research at PCMA, to share some additional comments.

A M A N D A F R O S T, Ph.D.: Good morning, and thank you for the opportunity to join today's hearing.

As the Head of Research for PCMA, it is my job to help generate, evaluate, and understand the base of evidence demonstrating the value of pharmacy benefit managers for health plan sponsors and patients.

The main job of PBMs is to reduce spending on prescription drugs -- both through drug company-negotiated rebates, and a variety of other tools. The record of evidence produced by researchers validates that PBMs are good at this job. To measure prescription drug spending, we look at

utilization and multiply it by price. We usually expect to see annual increases in drug spending, and these are largely driven by increases in prices rather than utilization. For example, last year, utilization increased just 1.7%, which is quite low. To understand drug pricing trends, we start with list prices, which are set by the drug company that makes the drug. And, these are often raised either or both in January and July. In 2024, according to the gold standard data and research firm IQVIA, list prices on patent-protected brand drugs, on average, increased by 2.3%. In contrast, net prices are the list prices minus all discounts and rebates -- the majority of which are negotiated from drug companies by PBMs, then passed to their client sponsors. The flatter the trend of net prices, the more PBMs were able to mitigate list price increases on average.

According to IQVIA, net prices on those same patent-protected brand drugs grew just 0.1% in 2024; however, even with a flat net price trend, we still spent a lot of money on drugs last year. Drug spending across the entire system increased to $487 billion, with much of the growth in spending due to a small number of high-priced drugs.

The main way drug spending is reduced is through PBM negotiations on brand drugs through rebates. (indiscernible) found that by using new competitor products, PBMs were able to drive down spending by 18.5%, but a lack of competitor products leave little leverage for reducing spending. Brand drugs make up 87% of drug spending, and specialty drugs, 54% -- while they combine to just around 10% of drug use.

The most notable of these drugs are GLP-1s. Looking back at the 2023 drug trend, it has become obvious that the GLP-1s were breaking the drug trends. The extremely high list prices set by their drug companies,

combined with high demand, is leading to much higher drug spending than we would expect to see -- both on these drugs, and overall. And, $487 billion is a lot of money on prescription drugs. And, PBMs are the only actor in the prescription drug payment and supply chain whose job is to reduce that spending for payers who are health plan sponsors, such as employers; unions; health insurers; and Federal and State governments. And, also, for patients.

To do this, PBMs employ a variety of strategies, also known as PBM tools, to generate and pass through savings. One of the most important ways that patients save money is through the utilization of generic drugs in place of expensive brand drugs. Thanks to the work of PBMs preferring and promoting generic drugs, over 90% of the fills in the U.S. are for generics. Generic drugs are dispensed 97% of the time when they are available, and the average out-of-pocket cost for a generic script in 2024 for patients with commercial insurance was $5.18. And, the U.S. has the strongest generic drug market in the world. According to researchers at RAND Health, generic drug prices in the U.S. were just 67% of prices in comparable countries, while brand list prices -- on average -- were 422% higher.

Utilization management, or UM, refers to a variety of tools that are implemented by PBMs with the approval of -- and, often, at the request of -- planned sponsors. These often create savings for the planned sponsors, usually by encouraging the use of low-cost, high-efficacy options before higher priced alternatives. A 2019 study by the Government Accountability Office on PBMs found that the majority of published literature confirmed that UM tools are associated with financial savings. In addition to the financial reasons, there are also patients' safety reasons to implement UM, and GAO

also found that UM tools were associated with improvement in member health indicators.

Rebates are the discounts PBMs negotiate from drug companies on brand drugs. Rebates tend to be paid on brand drugs where there are direct competitor products, which act as leverage in PBM negotiations. Not all (indiscernible) drugs have rebates. An old estimate from the Health and Human Services Office of the Inspector General estimated that 61% of brand drugs in their part D (indiscernible) had rebates. Rebates offer important savings and discounts off of brand drug list prices. And, contrary to the claims of PBM critics, rebates are not inflationary. In other words, paying negotiated rebates does not cause drug companies to raise list prices. We can see this in the basic relationship between rebates and list prices. Rebate labels go up and down, while list prices go up. Research from the Health and Human Services Office of Inspector General has also found that rebate levels were not associated with increases in list prices.

In New Jersey, all of the PBM-collected rebates get passed through to the plan's sponsors. This means that employers, unions, and other payers and patients are receiving the full value of the rebates. According to a national survey of 695 employers of the well-known survey research organization, NORC, 90% of employers who received rebates in the last 12 months use them to offset their employees' costs. Health plan sponsors, like employers and unions, get to decide what happens with their rebate dollars, and they generally use them to reduce costs for their plan members.

This has been confirmed by the Congressional Budget Office. In their study of the entire prescription drug market they wrote, "With competitive forces in insurance markets and regulatory medical loss ratio, and

the law requirements, consumers probably receive a substantial fraction of those rebates in the form of lower premiums, or more generous benefits." They continue, "As a result, rebates benefit all enrollees of a plan, regardless of the number or type of prescription drugs they purchased." No employer, union, or other planned sponsor is under any obligation to hire a PBM, but nearly all do, and there is a lot of choice.

While some may think of the PBM industry as monolithic, it is actually characterized by a large variety of PBMs diverse in size, insurance market, and business model. Longtime PBM industry executives -- or experts -- PSG found that the market has over 70 full-service PBMs. In addition, there are many other firms that serve niche populations, or provide PBM-adjacent pharmacy benefit services. Writing just last month, economist George Ford declared the PBM market to be competitive, with a low bar for new entrants.

And, this variety of PBM companies is reflected in a strong and competitive market. It is not the case that a few large actors shut out smaller PBMs from winning business. Using a unique data set from the three largest PBMs, economist Dennis Carlton found that the so-called "big three" compete for business with each other but, also, with many other medium and small PBMs. He concludes that both today and historically, small PBMs can and do become significant competitors. PBM business models are structured in a variety of ways, adding to the choice and optionality from employers, unions, and other plan sponsors. But, regardless of the organizational structure, PBMs are low-profit, low-operating-margin companies. In 2017, the USC Shaeffer Center estimated that of a hypothetical $100 that flows through the prescription drug payment and supply chain, just 5% went to

PBMs. Of that 5%, just 2% was retained as profit. More recently, economists Dennis Carlton and George Ford separately estimated that the PBM margin was around 5%.

Where the largest PBMs are very large companies that see large revenues, little of that is retained as profit. Instead, it is used on behalf of payers and patients. In comparison, the profit margin of drug companies is high. According to the research team (indiscernible), large drug companies were significantly more profitable than other types of *Fortune* 500 companies. Dr. Ford, looking at the publicly available data for three of the largest drug companies, found pre-tax margins of between 16 and 25% -- well above that, of PBM. There was a natural tension between PBMs and drug companies and PBMs and pharmacies. Drug companies and pharmacies want to be paid more, while PBMs want to deliver savings to plan sponsors and patients. But, PBMs understand that both are vital to the health of the drug supply chain, and pharmacies in particular are an important partner in ensuring that patients have access to the medication they need.

In New Jersey in 2024, there were nearly an equal number of retail, independent, and chain pharmacies -- which is actually quite unique. This is due completely to the increase over time in the number of independent pharmacies, as the number of chain stores in the state has largely decreased over the last 10 years. In contrast to chain pharmacy trends, looking back over at least the last 15 years, we have seen the number of independent pharmacies in New Jersey increasing -- a trend I expect to continue, putting New Jersey in the enviable position of little risk of developing pharmacy deserts. Independent pharmacies join pharmacy

services administrative organizations -- PSAOs -- as collective bargaining organizations, effectively creating scale in their negotiations with PBMs.

According to the actuarial firm Milliman, in New Jersey, 94% of retail, independent pharmacies are contracted with a PSAO. The three largest PSAOs in New Jersey, in terms of independent pharmacy membership, are Cardinal Health; Elevate Provider Network, owned by AmerisourceBergen; and Health Mart Atlas, owned by McKesson -- the three largest wholesalers. Independent pharmacy owners in New Jersey have powerful corporations working on their behalf. It is worth noting that because pharmacies are important partners in patient care, PBMs do not reimburse independent pharmacies at rates lower than chain pharmacies or their affiliated pharmacies.

There have been organizations that have published reports claiming otherwise, for example, the FTC Interim Reports; however, these reports choose a very small number of drugs, and then try to draw broad and generalized conclusions. But, small or cherry-picked drug samples do not lead to results with generalizable conclusions, and do not reflect how prescription drug benefits are designed or reimbursed. Benefits are designed across the entire range of drugs, and are designed to be dynamic to reflect differences and changes across drugs and drug classes. Recently, noted economist Dennis Carlton used the same PBM claims dataset that was given to the FTC in order to examine reimbursement rates across the full basket of drugs, rather that just limited samples. He finds that reimbursement rates are -- on average -- across the entire basket of drugs, higher for independent pharmacies than they are for affiliated or non-affiliated chain pharmacies. He states very unequivocally that PBMs are not putting independent pharmacies

out of business. In fact, PBMs have partnered with independent pharmacies to develop programs to support both pharmacies and patient access. PBMs support expanding the scope of services that pharmacists are able to provide, and expanding reimbursement for clinical services provided at pharmacies, and offer increased reimbursement for pharmacies in rural areas.

The health-care space is constantly changing, and the PBM industry isn't waiting for government mandates to innovate and evolve based on changes and demands in the market. For example, PBMs' patient transparency tools are intended to empower patients with information they can use to help them make decisions. The availability of actionable information promotes more competition among healthcare providers, potentially leading to reduced health-care spending. Supplying transparent information on the most affordable and clinically effective drugs and services enhances patient care and improves quality. PBMs support transparency that empowers patients, their providers, and plan sponsors to make informed decisions -- leading to lower out-of-pocket prescription drug costs. Providing real-time technology at the point of prescribing gives providers and patients knowledge about which drugs are on their formulary; the most cost-effective drug options; and even pharmacy options. This way, patients can receive high-quality, cost-effective care while improving speed and reducing administrative frictions.

And, through new pharma innovations from drug companies, PBMs continue to find new ways to deliver savings to plan sponsors while improving health outcomes for patients. The GLP-1 drug class is causing drug spending to soar, and making many payers wonder if they can afford to offer these benefits to their enrollees. According to PSG, in 2023, well over

90% of employers covered GLP-1s for diabetes; just a third chose to cover them for weight management, mainly citing the cost of these drugs. And, despite the demand by patients, use trends also caused some reason for concern. Blue Health Intelligence found that 30% of patients stopped their GLP-1 treatment before four weeks, and more than half stopped before the recommended minimum of 12 weeks. To support patients in their weight management goals, and plan sponsors in their desire for value, many PBMs have created holistic support programs that combine lifestyle supports, such as nutrition and exercise, with these medications. Employers and other health plan sponsors not only choose whether to use a PBM, but they also have the final say on the pharmacy benefit design that best meets the needs of their populations. They choose how to set up their contract and how to pay for their services, and they choose how to best use the savings delivered by their PBM. PBMs implement those choices while keeping affordable access for patients at the center.

Thank you.

MS. CASCONE: Thank you, Amanda.

Just, in closing, I want to make sure to mention PBMs have participated frequently in the legislative process here in Trenton. We often will take position or engage on a piece of legislation that the Legislature is considering, and we do so not in the interest of PBMs specifically, but, rather, on behalf of the employers and the unions that we represent, and their members and patients.

We often will engage in dialogue like this one today, and do so on behalf of those payers, because that is our focus. Our ability to work successfully as a pharmacy benefit management industry is in our ability to

retain the tools and services that we offer to our clients to help them keep their costs down.

And, so, we very much welcome the opportunity for future discussion, and for your questions today.

Mr. Chair, thank you.

SENATOR LAGANA: Sure; thank you.

Thank you for your testimony, I appreciate the information.

I just have -- just a few questions that I would like a little bit more explanation.

First, I noted earlier that a new wall went into place. Can you just discuss that, what that meant for PBMs -- what changed in your lives over the past few months?

MS. CASCONE: Yes, sure.

So, it has just taken effect in January of 2025, and it's still being implemented by the Department of Banking and Insurance. We are meeting with them quite soon, actually, to discuss the licensure requirements in that bill. It covered a wide variety of PBM interactions -- everything from the strongest licensure requirements in the nation, that PBMs must disclose all of their contracts with pharmacies and with PSAOs. And, then, in order to get a license through DOBI, they have to satisfy a number of requirements, including disclosing conflicts of interest; anything anti-competitive -- DOBI can ask us about any unfair claims practices, for example. They also have to disclose all their pricing models; all the standards that they use to create pharmacy networks. And, also, everything that they do in terms of managing the network.

They also are being held to a new standard in their contract relationship with their clients called "Good Faith and Fair Dealing," that we, with all parties with whom we contract, must act in that manner. This is a little different than what was originally proposed in the bill, which would require a fiduciary responsibility for PBMs, but the Legislature recognized appropriately that fiduciary standards apply to those managing plan assets, and instead move forward with the "Good Faith and Fair Dealing" requirement. It also has all kinds of disclosure requirements in it for PBMs that they must disclose their pricing formulas, and all their contracts; how we work to reimburse drugs, both multi-source drugs, brand drugs; and our relationships with wholesalers. It also, most notably, required that PBMs retain zero rebate dollars that they negotiate from drug manufacturers, and instead pass 100% of the savings they achieve from drug companies back to plans for use in either lowering payments, or for plans to pass directly to patients. It also very strictly defined the term "PBM compensation" so that it did not just apply to the strict definition of what we would consider to be a rebate, but any fee or any compensation derived between PBMs and drug companies.

It also dictated how we operate and work with pharmacy and therapeutics committees. These are independent panels of experts who help review drugs that are approved by the Food and Drug Administration for use by Americans. The P&T committees make recommendations -- not in consideration of cost, but rather on clinical efficacy. And, those recommendations are then shared with health plan sponsors who develop formularies. It banned any conflict of interest on those P&T committees and

also required that national accreditation standards be met. There were other things as well, but that's a good--

SENATOR LAGANA: Sure--

MS. CASCONE: --overview--

SENATOR LAGANA: --no, but thank you; thank you.

I appreciate it.

MS. CASCONE: (indiscernible)

SENATOR LAGANA: You hit the major points.

Just to go back on one of the things that was -- and, just explain whether or not this was a change or just created more transparency -- the rebate--

MS. CASCONE: Pass-through?

SENATOR LAGANA: The rebate pass-through. Can you explain -- was that something new in the law, and how did it used to work, and how does it work now? I know you kind of explained it, but just--

MS. CASCONE: Sure, sure--

SENATOR LAGANA: --give a--

MS. CASCONE: So, before the 2023 law was enacted, it was always an option for plan sponsors to decide in their contracts where negotiated rebate dollars would flow. They had the option to either retain them; pass them through into patients; or allow PBMs to retain them as compensation. The law created a new standard prohibiting PBMs from keeping any of those dollars.

So, 100% of them now are pass-through.

SENATOR LAGANA: So, the savings that would have been realized through the rebate that the PBM could have--

MS. CASCONE: All goes--

SENATOR LAGANA: --could have kept as compensation, they now cannot.

MS. CASCONE: Correct.

SENATOR LAGANA: OK, so, can you just explain the real rudimentary explanation of, how do PBMs make money? How are you compensated?

MS. CASCONE: So, that's always determined by our employer plan sponsors. We can make money in a variety of different ways, but the employer union always decides at the point of contracting how they want to compensate their PBM. They can do so on an incentive basis, or on a flat fee arrangement. They can decide that for however they're compensated -- either quarterly or semi-annually or annually -- that they will pay a flat fee arrangement to their PBM, or they can incent their PBM to push for deeper savings, in which case the PBM would retain a portion of that incentive payment.

SENATOR LAGANA: OK, thank you.

MS. CASCONE: Sure.

SENATOR LAGANA: Joe, question?

SENATOR CRYAN: Oh, yes, I have a couple.

Thank you, and good morning to everybody.

I appreciate it.

I just want to begin with some basics so that I understand. I completely admit this is an issue for me I want to learn a little bit more about as well.

So, I noticed the PCMA represents quite a number of folks who do business here in New Jersey. And, that includes, if I understand it right, the three big folks -- and, maybe you could correct me -- are CVS, would that be right? Caremark? UnitedHealthcare? Optimum (*sic*) -- would that be correct?

MS. CASCONE: Optum, yes.

SENATOR CRYAN: And, Cigna/Express Scripts. Would that be right?

MS. CASCONE: (affirmative response)

SENATOR CRYAN: So, what I'd like you to do is tell me how many employees and the profit margin and the worth of each one of those companies are.

MS. CASCONE: I'm sorry, I don't have that information.

SENATOR CRYAN: So, if I told you that CVS Caremark did $357 billion in 2023, would that shock you?

MS. CASCONE: On a revenue basis, it would not--

SENATOR CRYAN: OK--

MS. CASCONE: --given the number of claims that they are processing--

SENATOR CRYAN: I appreciate that; thank you--

MS. CASCONE: --for millions of Americans.

SENATOR CRYAN: And, Cigna, $100 -- let me see if my notes are right -- $185 billion? By the way, with over 70,000 people employed, is that right? That might be the whole company.

MS. CASCONE: I'm not sure if that includes just the PBMs business, or if that includes broader interest that they have in their insurance line.

SENATOR CRYAN: OK, but Cigna just bought Express Scripts fairly recently, right? How much was that deal? Sixty-seven billion, does that sound right?

MS. CASCONE: Sure.

SENATOR CRYAN: OK.

And, if you could -- just so I understand who we're talking to here. And, United/Optimum (*sic*)? Four hundred and fifteen billion, is that right -- $99 billion, excuse me. Is that right? Over 200,000 employees, does that sound right?

You folks are the folks, right? We could only call the PCMA to get PBM folks here. Can you give us an overview of the three largest folks, tell us how much -- how many -- what kind of revenue, what kind of profit margin?

SENATOR LAGANA: If I could just-- If maybe-- So, vertical integration was something that is part of this, and I think that's what--

SENATOR CRYAN: That's where I'm going.

SENATOR LAGANA: Yes, OK, thank you.

SENATOR CRYAN: OK.

SENATOR LAGANA: Maybe you could explain that.

MS. CASCONE: Sure.

And, Amanda, feel free to jump in at any time.

I-- We don't at all deny that there are millions of claims resulting in millions of dollars being passed through PBM business in the State of New Jersey--

SENATOR CRYAN: OK.

MS. CASCONE: The prescriptions are exceedingly expensive, but when you take -- as my colleague mentioned -- when you take a look at the amount of profit that a PBM is deriving from the amount of revenue that they are processing, it is a much, much smaller number. While that number is still big, based on the millions and millions of claims that flow through the claims adjudication systems, the amount of money that they're retaining is still less than 5-6%; and, of that 5% or 6%, only two of it is profit. The rest has to--

SENATOR CRYAN: I heard that--

MS. CASCONE: --pay for those--

SENATOR CRYAN: I heard-- I heard those comments.

I just want to understand who I'm talking to, here. So, my understanding from, again, my little internet search -- because it's not quite easy to find -- is that all three of these companies have a profit of over $20 billion last year. Would that be correct?

Just so I understand, because when you-- Is that correct? If it isn't, feel free to correct a fella.

MS. CASCONE: It could be.

SENATOR CRYAN: OK, it might be north of that as a matter of fact, right?

MS. CASCONE: I couldn't say.

SENATOR CRYAN: Because, I listen to you talk about choice, repeatedly. And, I was fascinated as to how three companies can dominate this kind of market. And, to come here and tell me I have one agency that we can call to get comments back, here about $20 -- actually, $60 billion when you add them up, in profits, and then talk about choice as if it's something that's actually accessible. Those are fascinating to me to listen to.

MS. CASCONE: (affirmative response)

SENATOR CRYAN: And, I would like to know how your process works. That's where I want to go first, all right.

And, I'm just going to-- You can help a fella here as long as you want. By the way, speak to the process of the drug price setting. Invert-- You guys are a part of every part of this, let's face it. You've got 289 million -- if I read that right -- 289 million folks. And, you guys are involved-- I mean, to sit here and listen to you, you would seem like that somebody could just decide to start, on their own, a drug -- a PBM, or a drug company, and that's just fantasy. You can't, in reality here, based on the dominance of the market, and the numbers that we just went over, that either you don't want to say or you don't know -- and, neither one of those are acceptable -- that there is somehow some understanding that people can just make a choice. And, I don't think that's the case. I don't think it's the case at all, but I'm sure you can work through that.

But, speak to us about the process of drug price setting, and the role that each party plays in it.

MS. CASCONE: Sure. I'll take a stab at that; sure -- first.

And, thank you for the question.

PBMs do not set the price of prescription drugs. They are set solely by drug companies.

In terms of your process question, PBMs aggregate the buying power of hundreds of millions of Americans. They're plan sponsors; employers; in governments; in unions. They take all of those lives and come to drug manufacturers, and incent them to lower prices. Now, some employers may find that integrated PBMs that are affiliated with various parts of either pharmacies or drug companies provide a seamless patient experience that's a benefit to them as a plan sponsor across the health-care spectrum. Other employers may find that standalone PBMs benefit them more, because they offer separate strategic services to meet individual needs, and that benefit their individual strategy.

I would respectfully disagree that new PBMs are -- have a difficult entry window. New PBMs are being created and coming to market all the time. There are more than 70 different PBMs. I don't represent *all* of them at PCMA; however, many of them are regional or provide specific services that plan sponsors find to be more, frankly, advantageous than those offered by the big three. Which is why this is such a competitive market.

SENATOR CRYAN: OK.

Would you -- feel free to correct me -- but when the three I had talked to you about – Optimum (*sic*), Caremark, Express Scripts -- if I added in Magellan, Humana, and MedImpact, would they cover more than 95% of the market?

MS. CASCONE: I would say that they cover the majority of claims that are processed, not necessarily based on price, or cost, but rather on the number of claims adjudicated.

SENATOR CRYAN: Let's say the consumer -- in following that up, where does the consumer-- Let's talk about the people we work for, the consumers. Let's talk about them for a minute.

How can a consumer see what's factored into the final price of their prescription?

MS. CASCONE: PBMs are really focused on providing that type of information to consumers through real-time benefit tools. Many PBMs now offer online systems that are member protected portals where they can log on and understand how much the plan paid for the cost of their prescription drug, as well as their own out-of-pocket cost. It also allows them to shop for different prices at different pharmacy providers. For example, one pharmacy store -- retail brick-and-mortar store -- might offer one price versus a different price at a mail-order pharmacy where they can derive more savings out of getting the prescription that way. They have the ability to understand what drugs will cost them more, in terms of out-of-pocket costs.

SENATOR CRYAN: So, do all six of the folks who dominate this claim market, do they offer the idea that somebody can get on a computer and find a drug cheaper elsewhere?

MS. CASCONE: We believe--

SENATOR CRYAN: That's what you're basically telling me. Is that correct?

MS. CASCONE: Yes, I believe that is correct.

SENATOR CRYAN: And, can you also explain for me the process as to how-- And, again, I'm literally asking as an education.

So, Senator Johnson here gets a prescription for Crestor. So, who gets a data sheet in the PBM and takes a look at it? And, what is the process

to approve whether he gets Crestor? Who is that person, and how is that person certified, and what is the process whether he's approved and/or denied? And, who reviews that, and what are their certifications?

And, by the way, for all of you, is that person employed here in New Jersey?

MS. CASCONE: So, there's -- that's a lengthy process, and I'm going to try to walk through some of it.

So, first and foremost, we talked about the Pharmacy and Therapeutics Committee. These are independent clinicians -- doctors, prescribers, nurses -- who sit on an independent committee from the PBM. They exist solely to review new drug applications that come from the FDA. They review those new drug applications and make a recommendation back to the PBM, who then shares that information with the plan sponsor.

The kinds of recommendations they can make are: You *must* add this drug, because it's revolutionary, there's no other drug like it on the market, for example; it's new, and we have to offer it to everyone; you may *not* add this prescription because it presents some side effects, or it's dangerous in some way. And, we've had examples of that in the past where PBM and P&T committees have pulled drugs from the market just before FDA has made recommendations with black box warnings, for example. But, the vast majority of drugs that the P&T committees review fall into a big category called "may add." And, this is when they're making a recommendation that this drug could be useful on a formulary, but there are other drugs that are offered by competitors that provide similar services.

The P&T committee -- the thing that's most important to understand about them -- when they're making their clinical review, they're

doing so blind to the cost of any of these medications. So, the clinical recommendations they make are then shared with the PBM. The PBM then shares those recommendations -- formulary recommendations -- with the plan sponsor. The employer or the union then makes the ultimate decision about what drugs should be covered on the formulary; in what manner; and, with what cost.

SENATOR CRYAN: So, this committee -- I'll be--

SENATOR LAGANA: Yes, that's fine; we're good.

SENATOR CRYAN: So, this committee of independent people, OK, states for example that Crestor can use some generic, and that therefore -- how does it work from there? How does his claim become the generic versus the -- is there some clerk, or is there a database, or -- how does it work?

MS. CASCONE: The PBM is always following the plan's recommendation of the formulary. So, if there are different options, some -- one drug might be preferred and placed in a preferred status of the formulary. Other-- Sorry.

SENATOR CRYAN: So, Senator Johnson, for example, could decide to use a different insurer. Can he use a different PBM?

MS. CASCONE: Typically, his employer will choose both the insurance company and the PBM that will provide his service and manage his prescription drug benefit.

SENATOR CRYAN: OK.

I have a couple others for this round, because I know other people want to speak.

I listened to you talk about, Miss Amanda -- What's your last name? I'm sorry. Frost, is that right?

DR. FROST: Frost.

SENATOR CRYAN: Ms. Frost; I want to be correct.

I listened to you talk about the GLPs, the wonder drugs. And, again, I don't do your business, but I was-- In my little internet searching, I was more struck by the insulin suing of PBMs by the Federal government, and the fact that people who need life-saving insulin have to go through significant cost difficulties with you folks. And, I was wondering if you could talk about that.

DR. FROST: Well, I can't comment on the--

MS. CASCONE: Yes, I might mention here that New Jersey actually capped the cost of insulin several years ago--

SENATOR CRYAN: In part because you guys weren't doing your job.

MS. CASCONE: Well--

SENATOR CRYAN: But, tell me what the Federal lawsuit meant.

MS. CASCONE: Respectfully, the price of insulin was high because there is a limited amount of competition in the insulin drug marketplace, due to--

SENATOR CRYAN: Kind of like PBMs.

MS. CASCONE: I'm sorry?

SENATOR CRYAN: No, go ahead, I'm sorry.

I apologize, I was rude. I was rude, I apologize.

You go ahead.

MS. CASCONE: That's fine.

That's the answer, is that New Jerseyans here, now, only pay I believe $30 for insulin drug products, in addition to a number of other products that PBMs, frankly, were unable to achieve savings on, because there was not competition to be had amongst the drug makers. That included EpiPens, rescue inhalers, and insulin products.

Where PBMs have an ability to, essentially, incent one drug maker over another -- against another -- to lower their price, they're extremely successful at doing so. But, when only one drug product is made by one drug maker and it's patent protected, there's a limited incentive for that drug maker to lower their price. That is why we have an instance where the Legislature had to step in to cap the cost.

SENATOR CRYAN: Was that the kind of situation that happened with the Sacklers in pharma, and the opioid crisis? The rebates, and PBM after PBM making sure they kept the rebates and that the opioid fillage was -- for example, instead of $60, decided to be $124 and, frankly, help create this opioid crisis and continue it in this country? Was that part of that decision-making?

MS. CASCONE: No, sir, that's completely different.

SENATOR CRYAN: Yes, it is. Actually, it isn't.

All right, thank you, from me, for this turn.

SENATOR LAGANA: Thank you, Senator.

Senator Johnson, do you have any questions?

SENATOR JOHNSON: Yes, thank you, Chair.

The end user, an employee -- if he or she is in a union, then the union would negotiate their health benefits with a PBM.

MS. CASCONE: That's right.

SENATOR JOHNSON: So, if I require a certain prescription drug, it would be contractual through the union to get this drug through a PBM that was -- that signed a contract with the union or my employer. Did I get that right?

MS. CASCONE: You would get -- the union employee or worker would get the drug through a pharmacy--

SENATOR JOHNSON: Right--

MS. CASCONE: --but the claim would be processed through a PBM.

SENATOR JOHNSON: OK.

Now, we have-- Let's talk about Amazon Pharmaceutical.

MS. CASCONE: Not one of my members.

(laughter)

SENATOR JOHNSON: But, they're coming to my town, so I figured I'd ask this question. Amazon Pharmaceutical -- will you be -- will they be using a PBM to, I guess to -- you have no idea? Because you're--

MS. CASCONE: I don't represent Amazon, unfortunately.

SENATOR JOHNSON: Or, Mark Cuban when he does his--

DR. FROST: He does--

MS. CASCONE: I-- I'm sorry, did you want to speak?

DR. FROST: Yes, Mark Cuban's drug company does contract with PBMs.

SENATOR JOHNSON: OK. And, actually, Amazon -- which will be a big player -- may or may not. All right.

So, I cannot-- As an employee, I cannot choose a PBM outside of my contracted employers, outside of my employer's -- unless I want to pay for it myself.

MS. CASCONE: You cannot contract with a PBM as a--

SENATOR JOHNSON: I mean, to get, to--

MS. CASCONE: --patient or individual.

SENATOR JOHNSON: --choose a different PBM.

MS. CASCONE: You couldn't--

SENATOR JOHNSON: An end user cannot do it, cannot--

MS. CASCONE: That's right. The PBM is essentially -- if I could just elaborate for a second--

SENATOR JOHNSON: Yes--

MS. CASCONE: --the PBM is essentially there to implement your employer's plan design decisions on your behalf.

SENATOR JOHNSON: All right.

MS. CASCONE: So, the PBM is executing on the formulary decisions and the pharmacy network decisions. A person couldn't decide to purchase benefits from a PBM outside of their employer -- unless they did so through, like, Medicare Part D, for example; Health Exchange; a fully insured plan in this individual market.

SENATOR JOHNSON: OK, I got -- understood.

All right, Chair, that's all I have for now.

SENATOR LAGANA: Thank you, Senator.

Senator Bramnick.

SENATOR BRAMNICK: I saw that flashing light; that's what they do to the comics. They flash it and your time's up, so you gotta keep an eye on that flashing light.

So, I walk into my pharmacy, which is Tiffany's -- actually, Brian is here; he owns Tiffany's. And, I get a prescription from my doctor, it's 10 pills of the X drugs. Then-- So, I understand Brian over at Tiffany's, he's buying those drugs through a wholesaler. Let's assume Pfizer makes the X drug. Do I understand he buys that likely through some wholesaler that buys it from Pfizer? Is that correct?

MS. CASCONE: That's right.

SENATOR BRAMNICK: OK.

So, the wholesaler is a middleman. Correct? OK. So, he's got a whole pile of these X drugs, I walk in, and he punches into the computer my insurance company. And, the insurance company, at that point, I assume tells him whether I can have the drug -- because the prescription doesn't mean I get it in today's world; doctors are not controlled by insurance companies. So, now, the prescription, he types it in, and the insurance company makes a decision -- we pay X amount of dollars for Bramnick's X drugs. That is not an unusual scenario for us as consumers, correct? OK.

Is your argument that you're the ones between me and my insurance company to negotiate in some way -- under certain circumstances -- what I'm paying or what he's getting reimbursed, is that right? In certain -- not in every circumstance, but in certain circumstances, you're another middle person between me and my insurance company, correct?

MS. CASCONE: I would only qualify that by saying that we work on behalf of your employer who hires an insurance company--

SENATOR BRAMNICK: Well, once again, I'm not asking you on who you work on behalf of. We'll make that decision as lawmakers, who you're helping and who you're not helping.

But, my question is this: Somehow, I'm assuming you negotiated-- Your argument is you're negotiating a better price for me for that insurance company, because of the price of pharma, correct?

MS. CASCONE: I would say that we're negotiating on behalf of your employer. They are the contractual entity who hired the PBM, not to debate where the value is derived; our client contracts are with employers and unions and governments who ask us to implement the--

SENATOR BRAMNICK: Yes, I got that--

MS. CASCONE: --drug benefit that they design.

SENATOR BRAMNICK: I got that part; I got that part.

So, you're another layer between-- Well, regardless of who hires you, you're another layer between me and my insurance company, correct? No?

MS. CASCONE: I think I understand what you're asking.

I would say it's an important layer because--

SENATOR BRAMNICK: I'm not asking whether it's important. I'm asking you whether-- You are somehow between me and my insurance company, correct? Because you are arguing to us today that you're a real benefit, because you're lowering prices and you're benefiting me as a consumer. So, you've got to be between me and somebody. You've got to be between me and somebody; you're not out there alone, right?

MS. CASCONE: Understood.

SENATOR BRAMNICK: OK.

So, I'll stipulate for purposes that you benefit us.

I'm just trying to put it in terms of where you are in the world.

MS. CASCONE: Sure.

SENATOR BRAMNICK: So, now, do any insurance companies own any of the PBMs?

MS. CASCONE: They do, yes.

SENATOR BRAMNICK: OK.

So, you're between me and my insurance company, but you might be owned by the insurance company. Correct?

MS. CASCONE: With a firewall, but, yes.

SENATOR BRAMNICK: OK, so, but, just so--

MS. CASCONE: So, for example that PBM--

SENATOR BRAMNICK: Yes, I just--

MS. CASCONE: --could also contract with other insurance companies that don't own them--

SENATOR BRAMNICK: I don't know too much about firewalls; I do know that your argument is you're benefiting us, you're a benefit, but you -- to some degree -- are negotiating with the same company that owns you.

I'm just-- How it works or it doesn't work from the third party view, like a jury. They would sit up and go, "Oh. Huh." So, you're negotiating, but you're negotiating through a company that you own.

OK, I just wanted to make sure if I understood that.

In an old-time, simple world, when you used to walk into the pharmacy, the drug -- the X drug that I was buying -- was paid for by the insurance company directly. There wasn't a lot between-- How long has--

MS. CASCONE: That's right--

SENATOR BRAMNICK: --PBMs been around?

MS. CASCONE: At least 30 years.

SENATOR BRAMNICK: And, have they grown over the years?

MS. CASCONE: As prescription drug usage and spending has grown exponentially, yes, the claims volume has grown substantially.

SENATOR BRAMNICK: So, the answer is they've grown.

MS. CASCONE: Yes.

SENATOR BRAMNICK: OK.

So, if-- If the argument was that pharmaceutical companies were pricing fairly, would you be needed?

MS. CASCONE: Yes, absolutely.

SENATOR BRAMNICK: OK, and why is that?

MS. CASCONE: PBMs do a lot more to manage prescription drug cost to the plan sponsor and patient beyond their role in negotiating with drug companies. We would love nothing more to have an affordable drug world, but we provide savings in a variety of other ways, including--

SENATOR BRAMNICK: So--

MS. CASCONE: --all the clinical ways that we manage adherence; persistence of filling prescriptions; checking for drug safety interactions; things that no one else in your--

SENATOR BRAMNICK: So, more than--

MS. CASCONE: --drug supply chain can do--

SENATOR BRAMNICK: --more than pricing.

So, you would agree with me that people are more frustrated than ever in terms of having their prescription filled, meaning that there's constant battle between whether or not they need to do something prior--

MS. CASCONE: Yes--

SENATOR BRAMNICK: --to getting that prescription -- OK.

So, all of this frustration that has occurred over the years -- and, it's reached a boiling point; even people have said that cancer was less stressful than getting the MRI. Can you, without going on for a long period of time, can you tell me why that exists?

MS. CASCONE: I can. Put simply, it's because drugs are very expensive, and the only reason that utilization review programs exist today is so that the greatest number of patients who really need the drugs that they need have access to them in an affordable way.

Utilization management programs are most definitely a point of frustration. Everything from prior authorizations, step therapy -- it's a point of friction that we stipulate regularly--

SENATOR BRAMNICK: But, you're saying it's based on how expensive everything got, and then how-- I'm trying to use terms that people know. Utilization review, I think I know what they means, but-- So, all of these rules, all of these -- what people think are obstacles -- are in place, you believe, because of how expensive drugs have gotten. Is that right?

MS. CASCONE: For cost *and* safety reasons, absolutely, equally cost and safety.

SENATOR BRAMNICK: OK, the safety part, I don't want to debate that. But, there's this argument that, somehow, that the bureaucrats and insurance companies know more than your physician. I'll leave that for

another day, but, arguably, you're saying the reason people are frustrated, because costs are so high and PBMs are there to try to reduce that frustration?

MS. CASCONE: Not reduce the frustration, but provide a discount on the drugs that are costing the system so much in making sure that the right people are getting the right drug at the right time.

SENATOR BRAMNICK: OK, so, there's a step in between frustration that you're saying that you'd do these other things. All right, well, so far as all of you know, the frustration continues to increase. And, one of the things we try to do as lawmakers is try to reduce that frustration.

Thank you.

MS. CASCONE: Can I make just one last short comment?

SENATOR LAGANA: Sure.

MS. CASCONE: My understanding is the Legislature enacted a law recently around prior authorization that we hope will be very helpful in the system.

SENATOR BRAMNICK: We've done a lot of those.

MS. CASCONE: But, recently.

Thank you, Chair.

SENATOR LAGANA: Thank you.

Follow-up, Senator Cryan?

SENATOR CRYAN: A couple follow-ups.

And, thank you.

Just a follow-up on Senator Bramnick's point -- what's your position on direct contracting between the pharmacies and employers?

MS. CASCONE: Direct contracting between pharmacies and employers?

Employers could, at any time, decide to build pharmacy networks. They would need to provide that service directly, reach out to the more than -- well, there are 60,000 pharmacies nationwide; there are close to, what, 2,000 here in the State of New Jersey -- reach out to them, contract with them individually; negotiate their rates individually; handle all of their claims-processing information; purchase the software to communicate with those pharmacies; and, then ultimately reimburse them.

SENATOR CRYAN: So, you think it would be a high mountain -- high mountain to climb? Or, how would you word it? It's impossible?

MS. CASCONE: It's not impossible -- not impossible. But, there's a reason why employers hire PBMs, is to remove that administrative burden for themselves.

SENATOR CRYAN: And, that would include -- would that be your position as well on direct transactions between drug manufacturers and the people who need the meds? Would that also be--

MS. CASCONE: Again, employers are negotiating -- they'd be negotiating only on behalf of their employee base, which would not benefit them. They are hiring PBMs because PBMs are able to aggregate all of the lives of the employers that they represent, thus enabling them to get deeper discounts on behalf of all of the clients they represent.

SENATOR CRYAN: But, yet, costs continue to go up.

MS. CASCONE: Costs continue to go up, but PBMs don't set the price of drugs.

SENATOR CRYAN: And, by the way, these contracts that are with employers and those sort of things -- is there a general length? How long are those contracts?

MS. CASCONE: How long are they?

SENATOR CRYAN: Yes (indiscernible)

MS. CASCONE: I'm going to speak an average here. Don't hold me to this, but typically they run several years -- perhaps three years -- with the option to renew through a market check every year annually thereafter.

SENATOR CRYAN: OK.

MS. CASCONE: Yes, so, if I could just take one second just to explain what a market check is.

SENATOR CRYAN: Yes.

MS. CASCONE: So, that would allow the employer to essentially put out a shorter procurement bid out to the marketplace, and allow them to verify that the savings that they're getting out of their PBM is appropriate and deep. They could ask another PBM to compare their pricing, and how much the contract would cost them at that time, and they'd have the option to then renew with the current PBM or hire a different one.

SENATOR CRYAN: OK, thank you.

Can you -- do me a favor, can you break down for me-- I'll be--

SENATOR LAGANA: (indiscernible)

SENATOR CRYAN: Sure.

Can you break down for me the administrative fees that a PBM charges, and to who? In other words, fees for network access, for the formularies, for claims processing. Is there an average price or profit from those that you can talk to?

MS. CASCONE: Are we talking about pharmacy fees, or fees to plan sponsors?

SENATOR CRYAN: Fees to plan sponsors, and--

MS. CASCONE: Fees to plan sponsors--

SENATOR CRYAN: --network (indiscernible)

MS. CASCONE: --are fully transparent to the plan sponsor. They're available and known by the plan sponsor in advance, at the point of contracting.

SENATOR CRYAN: So, what's an average?

MS. CASCONE: I don't know.

SENATOR CRYAN: You really expect me to believe you don't know?

MS. CASCONE: I really don't, truthfully.

DR. FROST: At the trade association, we don't have visibility into any -- any of those contracts.

SENATOR CRYAN: So, you wouldn't have any idea what the average prices or profits are from these?

MS. CASCONE: No, but I would note that the Department of Banking and Insurance, as part of this new PBM law, would have information about all of those fees in a fully transparent way as the law gets implemented.

SENATOR CRYAN: Would you know if any of the administrative fees get used to either benefit the consumer, and/or directly lower drug prices?

MS. CASCONE: PBM fees, that the PBMs retain?

SENATOR CRYAN: (affirmative response)

MS. CASCONE: PBMs aren't directly impacting the patient's drug cost in that way. It would flow through their employer. So, this would be part of the package that an employer uses to compensate their PBM, and

would be known to their employer at the beginning. I'm not sure if I'm getting at your question appropriately; I'm sorry, Senator.

SENATOR CRYAN: I think you are.

Also, do you happen to know, are there any hidden or unexpected fees that are passed on to consumers from your experience?

MS. CASCONE: Not that I'm aware.

SENATOR CRYAN: Last from me, and just a follow-up. And, somebody had mentioned -- one of you mentioned it and I apologize for not noting it down -- about how the previous legislation didn't require fiduciary responsibility.

MS. CASCONE: Correct.

SENATOR CRYAN: Why not?

MS. CASCONE: If I could take a minute to explain that.

So, the Legislature did consider that level of responsibility for PBMs, and we had lengthy discussions about what a fiduciary means. In this context, fiduciary means that you are a manager of plan assets; that you collect plan's assets, meaning you would collect premium dollars, for example, and then be responsible for holding them or investing them in a way in the best interest of the plan. PBMs do not collect *any* plan assets. We do not collect premiums like an insurance company; we collect no money from -- or retain any money from patients. It's purely a pass-through. So, any money that's retained by the pharmacy then is paid by the PBM and then back to the plan sponsor.

We don't manage or invest any of those assets, and so it has been found through case law and other -- in the (indiscernible), the federal (indiscernible) law, for example, what a fiduciary means to a plan, and has

been found that PBMs do not fit that criteria. So, the Legislature decided to remove that requirement and, in exchange, create a new high standard using the terms of Good Faith in Fair Dealing.

SENATOR CRYAN: It sounded like you were ready for that one. Well done.

All right, thank you.

I just have to tell you, to sit here and listen to the idea that there's choice when the kind of money and the profits that you make is -- frankly, it's hard to take, OK. And, to listen to this and to realize-- By the way, let me ask again, how many employees -- how many folks on those claims are actually working in the State of New Jersey? I asked earlier; we passed by that question.

MS. CASCONE: We can follow up with you. I'm not sure off the top of my head.

SENATOR CRYAN: You don't know that, Matt? Seriously?

MR. GRELLER: Vice Chairman, off the top of my head I don't, but we will follow up with you with that number.

SENATOR CRYAN: Look forward. If you could share it through the Chair, if that's OK.

MS. CASCONE: Sure.

MR. GRELLER: Asolutely.

SENATOR CRYAN: All right.

Thank you, all.

MS. CASCONE: Thank you, Senator.

SENATOR LAGANA: Senator Johnson, you've got--

SENATOR JOHNSON: Quick follow-up question, regarding the contractual -- or, the contracts between you and the employer unions, or what have you. On average, it's about a three-year contract? On average of a three-year contract, right?

MS. CASCONE: Rougly.

SENATOR JOHNSON: And, after that, the employer--

MS. CASCONE: Up to the employer. It's up to the employer.

SENATOR JOHNSON: --they can shop around and say, "Well, this PBM here or my employees or my union members -- I see an uptick in diabetes, therefore--

MS. CASCONE: Sure--

SENATOR JOHNSON: --let's try to find a PBM that will have more medications that are geared towards that particular issue--

MS. CASCONE: That's right--

SENATOR JOHNSON: --or maybe cancer, in a particular field."

So-- But, they can shop around through another PBM to get a better pricing for medication that their employees or members need just to fit -- to make them healthier.

MS. CASCONE: Yes.

SENATOR JOHNSON: That kinda makes sense?

MS. CASCONE: Yes.

SENATOR JOHNSON: Oh, OK.

Thanks.

I'm done.

SENATOR LAGANA: Senator Bramnick, do you have any other questions?

SENATOR BRAMNICK: No, thanks.

SENATOR LAGANA: Thank you; thank you to the panel.

MS. CASCONE: Thank you.

MR. GRELLER: Thank you, Mr. Chairman, and members of the Committee.

If there are other individual questions, we're happy to follow up individually.

I appreciate the opportunity.

SENATOR LAGANA: Thank you so much.

If you want to stick around and you may get called back up. (laughter)

MS. ACKERMAN: For the second panel: Chrissy Buteas, President and CEO of Healthcare Institute of New Jersey and Kyle Sullender, Director of Government and External Relations; Mary Kay Roberts of Riker Danzig, with Kelly Ryan, the Pharmaceutical Research and Manufacturers of America Vice President, State Advocacy; and, Debbie Hart, President/CEO of BioNJ.

SENATOR LAGANA: So, this is the full panel? I see Mary Kay is hiding in the corner over there. (laughter)

UNIDENTIFIED SPEAKER: (indiscernible)

SENATOR LAGANA: I'm just kidding. (laughter)

Thanks, Mary Kay.

Whoever would like to begin, please state your name for the record and who you represent.

D E B B I E H A R T: I was just checking it's still the morning; good morning, everyone.

Thank you for having us.

I am Debbie Hart, the President and CEO of BioNJ.

To Chairman Lagana, Vice Chairman Cryan, and members of the Committee, thanks so much for the opportunity to be here.

Again, Debbie Hart, President and CEO. I represent the life sciences ecosystem in New Jersey. Our 450 members include the full continuum of companies from biotech startups to the world's largest biopharma companies, patient advocacy organizations, and more.

Over the past two years, companies with a footprint in New Jersey produced 43% of all novel FDA-approved medications, and we're on track to do that again this year -- despite what's happening in Washington. However, for all that incredible productivity, unfortunately, due to the practices of pharmacy benefit managers, patients are having difficulty accessing their medications. And, my focus here is just that the effect that PBM practices have on patients.

At BioNJ, we regularly organize events with patients who confront a variety of medical conditions, from mental illness, to diabetes, to rare autoimmune disorders and genetic diseases. Without fail, those patients tell us that PBM practices are one of their main sources of stress, struggle, and unaffordability. PBMs -- which, as Senator Cryan pointed out, represent the most valuable components of the insurance industry; they manage prescription drug benefits on behalf of health insurers; Medicare Part D drug plans; large employers; and other payers.

Patients are *not* their customers. PBMs negotiate discounts on behalf of employers with drug manufacturers, and have significant decision-making power over which drugs are included on a formulary and what they

cost. PBMs frequently prioritize more expensive drugs, subjecting patients to even higher costs when cheaper, equally effective drugs are available.

Although patients with chronic conditions typically require long-term continuous treatment to slow, or even prevent the progression of disease, medicines to treat these conditions are frequently excluded from PBM formularies. While PBMs are able to profit from discounts they've negotiated with pharmaceutical companies, they're rarely sharing the savings with patients, driving up health-care costs and forcing patients to pay a higher price for treatment -- or, worse yet, walk away from the pharmacy counter without their medicine -- with more than 25% of patients abandoning their treatment at the pharmacy counter when faced with out-of-pocket costs over $75. Treatment non-adherence can lead to a host of higher medical costs down the road for patients and New Jersey's health-care system.

About three in five New Jersey adults report experiencing at least one health-care affordability burden in 2022. Also in 2022, a survey revealed that 85% of New Jerseyans are concerned about their ability to afford health care in the future. PBM practices can be particularly detrimental for patients living with chronic conditions who typically require long-term treatment to slow or prevent the progression of their disease and to manage their symptoms. Medications that treat these conditions -- such as diabetes; cardiovascular disease; cancers; mental health conditions -- are frequently excluded from PBM formularies. In 2023, the three largest PBM -- which we heard a bit about earlier -- each excluded roughly 600 medications from their formularies. These tremendous drugs and therapies that our companies are working so hard to bring to the market are not able to get to patients because of these practices.

My colleagues on this panel will address many of the questions the Committee has raised already, and they'll detail the practices that have such a detrimental effect on patients. So, for now, suffice it to say that the practices of pharmacy benefit managers are key factors in patients not being able to afford their medications or to access them. And, in some case, their health is being compromised.

In one recent case -- and, I'll only share one, because there are many -- a change in his insurance formulary forced an epilepsy patient to switch from a medication that had been successfully managing his condition. As a result, he began experiencing over 20 seizures a day, leading to a substantial rise in his medical expenses, and a precipitous drop in the quality of his life. How in the world does that make sense?

In closing, this is a significant challenge to the cost of healthcare, to patient access, and to our overall health. We are heartened by your efforts here and those of your colleagues in the Assembly to address these practices.

Thank you for your time, and happy to answer any questions.

SENATOR LAGANA: Thank you so much for your testimony.

Do I have any questions for this witness?

Senator.

SENATOR JOHNSON: One basic, direct question.

Hi, Ms. Hart, how are you doing?

MS. HART: Great; thank you.

SENATOR JOHNSON: How do we fix it?

MS. HART: How do we fix it? Well, I think that--

SENATOR JOHNSON: Very -- very basic question, "How do we fix it?"

MS. HART: Yes, it's complicated -- as we've heard--

SENATOR JOHNSON: Yes--

MS. HART: --right. There are so many players and so many important pieces to it. And, I think that you're considering one of those fixes today, and we hope that this and many of the other proposals that are happening at this -- at various states across the country and the Federal level will indeed make their way to practice.

SENATOR JOHNSON: OK.

Thank you.

MS. HART: Thank you.

SENATOR LAGANA: Thank you, Senator Johnson.

Senator Cryan.

SENATOR CRYAN: Thanks, just a couple.

Twenty-five percent of patients abandon their treatment at the pharmacy counter? Do I have this stat right?

MS. HART: That's what we understand--

SENATOR CRYAN: I didn't know this--

MS. HART: --to be the case, yes--

SENATOR CRYAN: Twenty-five percent of patients abandoning their treatment at the pharmacy counter when faced with out-of-pocket costs over $75. And, yet, I just heard from a group that basically let -- told us everything was swell.

Does -- did-- I mean, I'm stunned by that stat, I will tell you. I have-- Those are the people we work for. So, I don't know if anybody here has ever watched somebody decline a drug use at a counter. I know I have. It's just-- What's the source of that? Is that your data, or is--

MS. HART: That, actually-- So, we work on various projects with the pharmacist associations, and that's where that data comes from.

SENATOR CRYAN: Through the Chair, I would like to ask for a backup on that, if you don't mind.

MS. HART: Absolutely.

SENATOR CRYAN: And, I'm not challenging you--

MS. HART: Absolutely.

SENATOR CRYAN: --but it's a stunning stat.

MS. HART: Yes.

SENATOR CRYAN: The 600 medications from the formularies -- which is also quite a stunning number -- can you give us some idea of what those -- can you give us more color to it, for lack of a better way to put it? Because in 2023, the three largest PBMs -- and, as we heard here, they control a significant amount of the market -- excluded roughly 600 meds from their formularies. I understood the argument back that the employer and all the -- it's a Kumbaya moment and everybody looks at the formularies, which I don't think is actually the case, but that's the way I understood it. Could you give us some color on this?

MS. HART: Sure. I mean, I can give an example.

I actually have rheumatoid arthritis, and I was accessing a medication that worked for me, and all of a sudden it was taken off the formulary, so I had to switch medications. And, the one that I'm on is working OK, but it was just an abrupt switch; it took lots of paperwork and lots of time and aggravation to get the -- to access the new medicine, and after being surprised that it was actually being taken off the market -- not off the market, I'm sorry; off of the formulary.

SENATOR CRYAN: So, I'm interested in that particular example, and I don't want to -- if I'm too nosy, just say so.

But, what we heard here was that there was this independent council, committee, group, that reviewed and therefore made a decision that your medicine should be changed, and that all the many thousands of folks who work there are simply applying those independent things. Were you ever notified that you have an upfront on this -- if I'm way out of line, just say so, but I'm curious. The way I kind of heard it here was all swell. Were you notified of that? And, maybe you were--

MS. HART: Unless I missed the memo, Senator, I was not notified. When I went to renew my medication, they told me that it would no longer be X, it would be Y.

SENATOR CRYAN: At the time of renewal.

MS. HART: Yes.

SENATOR CRYAN: No upfront, no--

MS. HART: Again, I may have missed something in the mail, or in an email, but--

SENATOR CRYAN: You don't have to apologize for that--

MS. HART: --no, I was not aware.

SENATOR CRYAN: OK, I'm sorry to -- and, I was a little nosy, I apologize.

MS. HART: It's OK.

SENATOR CRYAN: And, my last thing is this case with the epileptic patient, with the medication. Do you see this stuff often? Do you guys see this stuff? I mean, you read this stuff-- These are the people we work for, by the way. And, I'm struck as to how something like that happens.

Because the way I heard it here was that a formulary change would be approved by independent professionals.

Can you add any more color on this? Was the new drug cheaper? Was there a better profit margin? Any other parts of this story, or just--

MS. HART: So, I am not a medical professional, I'm not practicing medicine. But, yes. What we hear -- because, again, we're a trade association representing the biotechnology and biopharmaceutical industry, we have regular communication and our members are also patient advocacy organizations, regular contact with them, so we hear stories from them.

I imagine you may get some additional color here from this panel, and then also I understand you have another panel -- at least one other panel -- that will shed some light on some of these access issues and how these decisions are made.

SENATOR CRYAN: But, they're certainly not made with the input of the epileptic patient. Is there a fair way to put it?

MS. HART: Certainly not. Certainly not.

SENATOR CRYAN: Or the rheumatoid arthritis patient.

MS. HART: Certainly not.

SENATOR CRYAN: All right, thank you.

MS. HART: Thank you.

SENATOR LAGANA: Thank you, Senator Cryan.

Senator Bramnick.

SENATOR BRAMNICK: So, I'm taking you back to Tiffany's Pharmacy in Westfield. Brian there is sitting over there. And, I want the X drug now. Isn't the-- Because, you're talking about PBMs kind of making it

more difficult for me to access that X drug, isn't it the insurance company -- isn't the insurance company making the final decision here?

So, for example, if I have ABC insurance company, isn't the PBM -- the middle person -- isn't the -- doesn't the buck stop with the insurance company whether I get that X drug?

MS. HART: I can't speak to what the communication is between the insurance company and the PBM, but I can tell you that it should be the physician who is actually prescribing the medication making the decision--

SENATOR BRAMNICK: Oh, I agree-- We don't have to go there, OK.

The physician has already made the decision. What I'm trying to figure out -- we're looking at the frustration that Senator Cryan talked about, and I talked about. So, I there-- The PBM, I see how they're a middle person, but isn't it that ABC insurance company that's saying, "Hey, Bramnick's not getting the X drug?" PBM is making the recommendation to the insurance company, but doesn't the buck stop with the insurance company?

MS. HART: My understanding is it's a -- it's a collaboration, and ultimately--

SENATOR BRAMNICK: So, you might be saying that the PBM is giving advice to my insurance company, possibly, as to whether or not to allow me to have that drug, or whether or not I need to do something before I take that drug? Is that how they're making it more difficult? You think the insurance company, if the PBMs were eliminated tomorrow, are more likely to get that drug and not go through all the obstacles we go through now?

MS. HART: I certainly can't speak to that, but I can also speak to the fact that I've been delayed accessing certain drugs along the way until, ultimately, I get to the drug that my doctor originally prescribed.

SENATOR BRAMNICK: We don't have that problem. I'm just wondering whether or not that's -- who is really making the more difficult decision for patient?

So, the PBMs are doing that. What motivates them sounds like -- sounds like they may be motivated by the same factors that an insurance company are being motivated. But, I was drawing the inference that PBMs were making that final decision from your testimony.

MS. HART: At the end of the day, I don't really know exactly who is making the final decision, but PBMs are certainly putting up barriers to the ultimate acquisition of the drug that the physician ordered.

SENATOR BRAMNICK: Thank you.

MS. HART: Again, a complex system, so.

SENATOR LAGANA: Thank you, Senator Bramnick.

We can continue along with the testimony.

K E L L Y R Y A N, J.D.: Thank you.

And, I-- Hopefully, I can start to tease out some of the questions from the Committee already.

So, good morning.

My name is Kelly Ryan; I am Deputy Vice President for State Policy at PhRMA. So, we're the trade association that represents the brand manufacturers.

And, I come to this conversation both as a policy nerd and my background is in health insurance and pharmacy benefits. So, kind of the

insurance geek at the table. And, I just wanted to drill down a little bit on some of what I've already heard today, and tease out a little bit about the realities of the marketplace and the supply chain and hopefully answer some of the Committee's questions.

So, first, we've heard a couple times, it's-- If manufacturers would just lower list prices, all of these problems would go away and we could just flick a switch and move forward. And, I think the Committee is picking up on the fact that there are some complexities well beyond that. And, one of the kind of key points that I think is important to understand when we talk about drug spending and managing spending is that about 50 cents of every dollar spent on brand medicines goes to players in the supply chain other than the folks who research, develop, and manufacture medicines just like those right here in New Jersey.

And, so, when we're talking about drug spending and we're trying to understand how to address what is, admittedly, a big issue, drug spending is a big piece of the health-care dollar; it is growing. I would argue that spending on drugs is not necessarily a bad thing, because it very often keeps people away from more expensive care, but I don't want to diminish the fact that this is an issue that we need to talk about. We need to understand sort of where all of the incentives along the supply chain are and where the dollars are really going.

So, to put a little bit of a finer point on it, the growth in gross expenditures on brand medicines from 2022 to 2023 -- that total growth was 6.2%, which is about $39 billion. The largest share of that growth, the jump from '22 to '23, went to PBMs, insurers, and other supply chain entities -- 26.7% of that. When you factor in government that gets rebates, that

number jumps to 58.7%. And, then, manufacturers come in third in driving the growth at just under 20%.

We talked a little bit about consolidation in the PBM space, and you've already heard and talked about it earlier, that about 80% of claims are covered by the big three PBMs, all of whom are very vertically integrated with health insurers either they own or are owned by. Very often they have provider practices; have retail pharmacies; have specialty pharmacies. So, up, down, sideways, these folks are involved in every step of that supply chain I just mentioned. And, it came up earlier -- so, the top three are about 80%; you get well over 90% when you go to the top six. So, the idea that there is robust competition, they may be fighting amongst each other, but certainly there are just some big players.

And, let's see, we already talked-- That's a big piece on why, when you look at dynamics in the supply chain, the idea that the problem is all list prices; if you just lower the list price, everything would go away. And, we heard from Debbie, drugs do not end up on formularies. The number of drugs that have been excluded from formularies, I actually have numbers that I think are a little bit higher, but same thing. So, in 2014, the top -- the big three PBMs excluded a total of about 110 drugs, and that is well over 1,000 and getting higher. So, the idea that in the negotiations we are just simply not providing access to medications, we are just going to take it off the formulary altogether, and then you walk into the pharmacy and find out, hey, this drug isn't covered at all, or we've moved it to a higher tier that has cost sharing that is tied to the list price of the drug, like co-insurance.

So, on average, drug prices are about half of the list price. Those rebates that are sloshing around the system *do* go to plan sponsors very often.

So, the PBM compensation model has changed a lot from retaining a percentage of a rebate to fees. But, those fees are still tied to the list price of the drug. So, there is an incentive in the system to favor high-list-price, low-net-price drugs, because then whether you're getting a fee based on the percentage, or your sister health insurance company is keeping a section of the rebates, there's all those dollars that (indiscernible) sloshing around the system.

The problem is, when a patient walks in during her deductible phase, she's paying the list price of the drug -- very often more than what her health insurer is paying through what's been negotiating by the PBM, or during the co-insurance phase. You're paying 20% based on the list price of the drug. So, there are really some broken incentives in the system. You know, the insulin market came up a little bit earlier, and that's a great example of sort of the most broken system. So, net prices on insulin were 60-70% lower than list prices, and a number of manufacturers said, "OK, this is way off kilter; we're going to issue authorized generic medications. We're not going to play the rebate game, we're going to just say this is the price and that's it, take it or leave it." Those drugs didn't end up on formularies, so PBMs were choosing -- and, their health plan clients were choosing -- the higher list price medicines, refusing to put the "we're not playing the rebate game" medicines on the formulary, and then when patients are walking in, their deductible they are paying based on that much higher price when there are cheaper options in the system.

So, I know Chrissy is going to get into vertical integration a little bit more, so I'll stop there, and then we can kind of dig into questions from the Committee, or happy to take any now.

SENATOR LAGANA: Sure. Why don't we hear about the -- that portion, and then we can kind of circle back with questions.

C H R I S S Y B U T E A S: Thank you, Chairman Lagana, and members of the Committee.

I'm Chrissy Buteas; I'm the President and CEO of the Healthcare Institute of New Jersey. I have the pleasure of serving as the President and CEO who represents New Jersey's research-based biopharmaceutical companies and medical technology companies, and I'm pleased to be here today.

I hope I'm not going to be redundant, but I apologize in advance if I do.

New Jersey has, really, a great story to tell in the pharmaceutical space. We are really at the cusp -- at the edge of discovering new medicines and therapies and diagnostics in the state, and comprised nearly a fifth of the State's GDP, as well as employ around 360,000 direct and indirect jobs. But, more importantly, to your point about the patients who we serve, we serve countless patients -- not only in New Jersey, but around the United States and across the world. And, life expectancy has increased by decades because of the life-saving treatments that our members discover.

We're home of eight of the top 10 pharmaceutical companies, as well as eight of the top 10 med tech companies as well. And, so, we're known as the medicine chest of the world; the patients can't access our medicines. That's clearly not a good thing, and, in many cases, that could be due to what's -- what we're here discussing today.

And, to be clear, concerns regarding the role of PBMs and their impact on patients is not limited to the life sciences. Our concerns are also

the result in multiple independent reports from journalistic and government agencies, including *New York Times*, *The Wall Street Journal*, the U.S. House Energy and Commerce Committee, and the Federal Trade Commission. But, as this Committee has already elaborated, most importantly it comes from the patients who interact with them each and every day.

And, so, a couple of things that I want to point out that may have been said, but I just want to put a finer point on as well. PBMs' customers are the insurers' employers -- they're not the patients. We've already mentioned that three of the largest PBMs now control up to 80% of the prescription drug market. And, due to this vertical integration, PBMs can directly or indirectly affect decisions on whether medications are covered or not by insurance; where they are placed on drug formularies; how much patients are charged out of pocket; and which pharmacies they can use -- the result of which is higher cost and limited access for patients.

PBMs are also responsible for collecting and directing billions of dollars of rebates awarded by our pharmaceutical manufacturers. Those rebates could be used to offset a patient's cost-sharing requirements, but are most often used to offset premiums for the entire insurance pool, rather than helping that particular patient. So, again, what's happening is, a lot of times, you're not -- that patient that had that rebate come is getting spread across.

So, as we can see, these and other factors create an environment in which PBMs have extraordinary power over how and where patients can access these medications they need, and what those medications will cost. And, because its incentives are tied to the price of drugs *and* the utilization of those tied to higher rebates, rather than to lower prices, the result for

patients is often higher out-of-pocket costs, limited pharmacy options, and restricted access to affordable medications.

So, a couple of things I also want to point out that might be mentioning some -- a little bit of fact versus fiction. So, on pricing, we heard that PBMs, PBMs-- I'm sorry, manufacturers set pricing alone, so PBMs claim that they are powerless when it comes to drug pricing, and try to circumvent their culpability for their role in the patient affordability by pointing to the manufacturers. This simply does not fairly represent the supply chain, or their role in it. In order for a manufacturer's product to be placed on a drug formulary, they must negotiate with PBMs to reach a mutually agreeable price for that medicine. This process typically results in substantial price decreases in the form of rebates and other discounts. We want to make sure, obviously, the patient recognizes or receives that discount. There's also some misaligned incentives, so PBMs claim that their job is to lower drug costs, but their fees are often tied to the price of those medicines or the size of the rebates or the discounts they negotiate. So, I think we touched upon that already as well.

And, then, who benefits? So, we have heard claims that, despite all of this, manufacturers stand to benefit the most. But, the truth is that pharmaceutical manufacturers typically collect only half of every dollar spent on the brand name medications, which was already stated as well.

And, so, I think what we can get into a little bit of a discussion is how do we address some of these things, and I want to acknowledge that this Committee has already done a great job of already addressing this through some of the legislation that you've already passed and signed into law, which was already talked about a bit, and we can go into that a little

further. But, also, legislation that is now going to be pending before the full House, which is on making sure that any rebates that the manufacturer does pass through in terms of rebates is -- through co-pay accumulators -- is passed on to the patient.

And, so, I do want to acknowledge and thank this Committee for moving that legislation. And, it was the patient community that was the one who stood before you and asked for that. And, so, again, we have our patients who are coming up saying they need the assistance, and that's why, again, we're here to make sure that our -- the medicines that we're here innovating each and every day to make this world a healthier place actually reach the patients who need them the most.

So, thank you for the opportunity.

SENATOR LAGANA: Thank you.

Just a couple follow-ups.

So, when you talk about drug price -- prices -- and, we have a list of prices, right?

MS. BUTEAS: (affirmative response)

SENATOR LAGANA: I guess I can call it the MSRP, is that fair to categorize?

So, if that particular price-- Who is actually setting that price? Where does it go; where does it come from; what list does it make it on? Generic versus non-generic.

MS. BUTEAS: So, I can speak for the brand industry. The brand manufacturers set the list price.

SENATOR LAGANA: OK.

And, generics -- how are they priced?

MS. BUTEAS: I believe it's a little bit more of a commodity system, so I don't represent the generics. But, I know that the price of generics will fluctuate a little bit more, whereas in the brand space it's usually set for the year, and there may be quarterly or semi-annual adjustments. But, it can change as much as daily in the generic system, as I understand.

SENATOR LAGANA: Pricing.

MS. BUTEAS: (affirmative response)

SENATOR LAGANA: So, as far as the brand prescriptions, how often are they changed? Somebody mentioned earlier that it's twice a year -- is that--

MS. BUTEAS: It varies from manufacturer to manufacturer. In my experience -- and, again, coming from the trade, so I know -- my members don't talk to me about their choices, because they can't -- but what I know from public information, sometimes it's once a year; sometimes they do adjust it; there may be semi-annual updates. It can vary.

SENATOR LAGANA: And, what triggers an adjustment? For what reason is it adjusted?

MS. BUTEAS: It can be all sorts of reasons. It can be input; it can be market share; it can be -- the same reason a loaf of bread changes prices over the course of the time.

SENATOR LAGANA: And, like, usage? Would that change the quote?

MS. BUTEAS: Yes, it could.

SENATOR LAGANA: So, once that-- Let's say we have that list price. We have the MSRP, and here comes a -- you have an employer, whether it's the State of New Jersey or if it's a -- let's say it's a building trades

union who are self-insured -- I mean, the State is also self-insured -- but self-insured versus fully insured plans. Obviously, there's a whole lot going on here. I know we're going to hear from Board next about the insurance plans.

But, if I'm an employer, and I have insurance company A, and I need to hire somebody, a PBM, to negotiate my drug prices, I hire them, they now go to the manufacturer. And, I'm guessing there's already existing relationships, and they're negotiating from other people. So, they'll come to you, and they'll say, "This employer hired us," and it's based upon the terms of the contract exactly where they're going with what they need.

So, explain how that works. So, if an employer says, "I need you to negotiate," is it just all drugs that my employees may need? Is it a particular line of drugs? How do they make that determination?

MS. BUTEAS: So, I don't have a lot of visibility into specific contract negotiations of our members. But, I will say the list price is a national price that is set nationally. And, then, as we heard this morning, earlier, then the PBMs will negotiate with manufacturers. Very often, they are also doing that on a national basis. So, what they will typically do is say, "OK, here is our standard national formulary; here's what we're going to negotiate for that." An employer may come in and say, "Hey, I want a better deal for my members, the unions, I want -- I don't want any co-insurance." And, so, then, their insurer and their PBM working together, very often, speaking (indiscernible) it would be a self-insured plan, so, they're either using a TPA or they're using a PBM--

SENATOR LAGANA: Sure--

MS. BUTEAS: --would then adjust accordingly. But, starting from the manufacturer, that's a national price, and then it kind of goes from there.

So, I don't think there would be a situation where Union X is, like -- the manufacturer price is directly changing because of that. It's all the folks in the middle who are planning (indiscernible)

SENATOR LAGANA: I got it.

So, let's say they enter into a contract with a PBM. PBM now negotiated with the manufacturer. So, now we have the list price, and then we have this phenomenon known as a rebate. And, the rebate is the contractual relationship between the PBM and the manufacturer, correct, and how much they're going to pay.

MS. BUTEAS: Yes.

SENATOR LAGANA: So, let's say the drug is $100, and you negotiate $50. So, the $50 is now -- that's the rebate pass-through.

MS. BUTEAS: Yes.

SENATOR LAGANA: OK, what would happen in the past is that could be used as compensation for the PBM, it could go back to the plan. But, what's lost in the sauce here is that the insured almost realizes none of those savings, correct?

MS. BUTEAS: Correct; yes.

SENATOR LAGANA: OK.

And, that's because you explained earlier, because they go to get their prescription, and there's things like co-payments, co-insurance. Just, can you discuss how that factors into those payments?

MS. BUTEAS: Yes, absolutely.

So-- Wait, the insurer and the PBM working together established the net price of the drug. But, typically, when you are in a deductible, that price is based on the list price of the drug. So, $100 drug, my health insurer is paying $50 -- because that's what the PBM has negotiated -- but I walk in, I pay $100 at the pharmacy counter until I hit my deductible. If I am in the co-insurance phase -- so, say I have a 20% co-insurance, I am paying that on the $100, not the $50, and that spread is staying within the insurance company PBM ecosystem.

SENATOR LAGANA: So, just, personally speaking, my insurance requires me -- my family -- to spend $3,000 out of pocket before I actually get those savings. So, let's say you have the average family who isn't sure as they're going in. Even though this is the list price, this is the net price -- correct -- this is the savings. The savings is now, with the new law, supposed to go back to the plan--

MS. BUTEAS: Yes--

SENATOR LAGANA: --but the person who is going in, until they hit their deductible -- again, this is an insurance issue -- they're paying the full amount, right? They're going--

MS. BUTEAS: Yes--

SENATOR LAGANA: --full freight, up until they hit a certain number--

MS. BUTEAS: Or, likely, as we heard earlier, walking away from the pharmacy counter.

SENATOR LAGANA: Or, they get dumped because they--

MS. BUTEAS: Yes.

SENATOR LAGANA: OK, so, in a situation where there is a-- Because, I guess these are like rolling negotiations, I don't know how else to--

MS. BUTEAS: Yes, but an important piece of that is very often -- and, again, I'm speaking in broad terms, because I'm not looking at contracts between my members every day -- but, in broad terms, very often there are what are called "price protection rebates" built into these contracts. So, the idea that rebates are not inflationary is not entirely accurate. Perhaps there is a 50% rebate negotiated on the front end, but in the terms of that contract, if the list price goes up, that will adjust as well. That is a very common contract term.

So, the idea that, "Just stick with our simple numbers," the $100 and the $50 is probably pretty consistent throughout the year, based on that.

SENATOR LAGANA: But, for the purposes of prescription drugs being something that is available to an insurer, or -- and then becomes unavailable--

MS. BUTEAS: Yes--

SENATOR LAGANA: --again, we had a conversation about who makes that decision. Senator Cryan mentioned a panel that came up who is kind of -- who's got the gavel on that committee.

But, I'm sure it's all contractual in that -- and, we could sit here and be cynical and just say, "It just costs -- it's costing us too much money, and we're not making enough money, so we're going to bump the drug." But, if there's some other explanation like, hey, maybe the generic came out, and it works as well -- or, in your situation, it doesn't work as well--

MS. BUTEAS: Right--

SENATOR LAGANA: These are the points that we, as lawmakers, want to make sure we hit. Because, when I hear that you have these gazillion dollar businesses negotiating within each other, and then the insureds can't pay the price that was negotiated because of insurance provisions, that's where we -- our ears kind of peek up, pop up.

And, we also hear about drugs; who is making the decisions-- If there's a valid reason--

MS. BUTEAS: Yes--

SENATOR LAGANA: --if a generic drug came out and said, "Hey, it doesn't have to cost us this amount of money," I get it. I mean, we all understand that. But, if it's because some other reason, that's where we kind of have to step in as legislators.

Any-- Senator Bramnick, questions?

SENATOR BRAMNICK: So, it seems to me that this PBM and this insurance company are starting to be one unit. Because, now we have insurance companies that own the PBMs. So, now there's this double layer-- I assume a lot of finger pointing, because of them, "They did it."

We're at the point now that the insurance companies own the PBMs. We do have one massive-- We have two companies where all of that should go in-house to an insurance company, if they already own it. And, that's-- I'm getting a sense that this is another layer that is frustrating the patients and somehow creating more confusing policy decision-making if it was just Pfizer, and in house they made these decisions. Everybody would know where the decision came from. Now, there's this -- allegedly two different entities that are really one.

Thank you.

SENATOR LAGANA: Thank you, Senator.

Senator Cryan.

SENATOR CRYAN: All right, just a couple follow-ups for edification.

I think when you spoke-- It's Ms. Ryan right?

MS. RYAN: Yes.

SENATOR CRYAN: Did I say it correctly?

You spoke about 50% goes to -- for lack of a better way to put it -- the manufacturer. And, then, the other 50% in terms of administrative costs go down the line in the supply line. Did I say that correctly?

MS. RYAN: Yes. So, that would be-- The PBMs, the insurers, that also includes government rebates. So, the automatic rebate to Medicaid, for example. So, all and wholesalers and pharmacies, so all along the supply chain.

So, I don't want to give the impression that half goes to us and half goes to the PBMs.

SENATOR CRYAN: No, but, actually, that was my follow-up is, do you have any sort of educational way for the Committee to understand what that--

MS. RYAN: There's a great report that the consultancy BRG does that really breaks it down. It's a little nerdy, but it's actually pretty accessible, and we certainly can make sure that--

SENATOR CRYAN: How nerdy--

MS. RYAN: --the Committee gets that--

SENATOR CRYAN: --and how long is it? (laughter)

MS. RYAN: It's not too bad. In my terms, it's really only a couple pages, and there is a good one-pager.

SENATOR CRYAN: Through the Chair, could I--

MS. RYAN: I will not drop a 50-page white paper on your desk, I promise.

SENATOR CRYAN: I appreciate that; thank you.

Through the Chair, could we ask for that?

MS. RYAN: Yes.

SENATOR CRYAN: You were here, and I've got to ask about the GLP discussion. And, obviously, everybody is excited for weight loss.

MS. RYAN: Yes.

SENATOR CRYAN: Any comments-- I mean, what were you thinking when you heard it?

MS. RYAN: Well, so, a couple things. And, I will-- Again, I hate to keep putting the trade association hat on, but it's difficult for me to get really granular about something that only a couple of my members work on.

But, what I will say is the parallel for me, having worked in this space for a long time-- I flash back to when I was dealing with New York Medicaid and the hepatitis C drugs, and it was like, the end of the world because these very expensive drugs were coming on the market. Well, they changed lives; they cured people; they kept people from getting whatever transplants. Within a couple of years, there were multiple great-- So, yes, there is a tail to get through the patent system and get to generic drugs, but within a couple years there were multiple brands on the market -- much like in the GLP-1 space where there's competition.

So, the idea that even in the brand space there's not competition, it feels-- And, we now know that even with the cost of treatment of those medications, Medicaid programs have saved hundreds of millions of dollars. And, this feels like a very similar parallel to me, having been sort of a pharmacy nerd for a long time. Like, yes, they are new breakthrough expensive drugs. They started in the diabetes space; indications are expanding it a lot. But, if you're keeping people out of the hospital, you're keeping people from getting heart attacks; if you're doing all of this, I think it's really important to look at spending in the silo.

And, that's not to diminish the immediate impact that it's having on spending, because it's an impact. But, I would say that competition among the options out there-- I bet you're going to see a change pretty quickly.

SENATOR CRYAN: So, through the Chair -- just to put some color on it -- so, it's a reasonable expectation that perhaps there would be less blood pressure medications; less--

MS. RYAN: Yes--

SENATOR CRYAN: --all those sort of things that combine with weight, right?

MS. RYAN: I think that's a reasonable expectation.

SENATOR CRYAN: I did want you to -- if you don't mind, because you mentioned higher tiers, and we haven't really chatted about the tier corollary thing, and I thought it might be-- For a moment, if you could talk about two things that you both mentioned, but whoever wants to -- the tier corollaries, how they work, at least from your perspective.

And, then, also -- because you went into it a little bit with the example that the Chairman brought up on spread pricing. So, if you could just kind of elaborate on this.

MS. RYAN: Sure.

So, plan design can vary pretty dramatically. So some plans may say -- and, this can be an employer choice; it can be a cost choice, it varies -- some plans can say, "Hey, we only want three tier--" Back when I started working in this space, it used to be three tiers: brand co-pay; preferred brand co-pay; generic co-pay; and it was all flat and everyone was like, "Ok, you pay $50, $25, or $5 on the three." That has-- That doesn't exist today; maybe some state and play plans are still really great and have it, but by and large what you're seeing now is four, five, sometimes more tiers. And, what happens is, for various incentives, if all of those higher tiers -- it's not a flat co-pay; you don't know what you're going to pay when you walk into the pharmacy counter. It's co-insurance; it depends on the list price of the drug; it depends on sort of where your plan design has moved all of those medicines around. And, that can change over the course of the year, which also sort of relates to that surprise.

SENATOR CRYAN: So, that's the argument of the employer and the PBM have made that decision.

MS. RYAN: Right, but it's the employer's decision to-- Yes.

Now, to go back to the idea, to kind of take that one next step. So, the idea, it's all the employers' decision and that, "Hey, we're just taking all the rebates and we're sort of spreading this around, and it's good for everybody." I see tiering very much the same way. It's kind of upside down from how insurance is supposed to work. Like, if you think about your car

insurance, we're all sort of like, pitching in every month, really hope we don't get in a car accident. But, if we do -- if we have that catastrophic event -- we've all kind of pitched in and we pay our deductible and it's OK.

Health insurance, especially in the drug space, has been flipped on its head. So, I am relatively healthy, I pay my flat co-pay for my inhaler once or twice a year, and that's fine. God forbid I get cancer; I'm now probably paying for medicine on the fourth tier, and a deductible, and co-insurance. So, the rebates and all of the savings in the system are being spread amongst many at the detriment of the few, and that feels upside down. And, I think that's a lot of the angst that you're hearing is that's what happens.

It's true -- most people have very low out-of-pocket drug costs. Like, most people do. But, the people who don't are folks with chronic disease; folks with cancer; folks with really expensive, scary things that we want the insurance system to be protecting them, and it's not.

SENATOR CRYAN: I-- So, you get that cancer midway through the (indiscernible), theoretical -- God bless you.

MS. RYAN: Yes, hope not.

SENATOR CRYAN: Like, an employee signs up for insurance once a year. You sign up with your employer, and with all those folks -- it's once a year. Can these tiers and all-- They change throughout the year, do they not? That's what we heard earlier?

MS. RYAN: They can. Some states have prohibited changing formulary placement tier or placement within the course of the year. I will be honest, I don't know off the top of my head if New Jersey is in that category. I'm certain maybe my colleagues know, or I can check, but--

SENATOR CRYAN: Does anybody know? I'm just curious--

MS. RYAN: Some states *do* prohibit that, but, in general, yes.

So, you sign up your health plan, you could be an incredibly health-literate, conscientious consumer, and you look at the formulary, and you're like, "OK, I'm going to take this PPO versus that plan, because I know that I have these complex conditions and I need these medicines." And, yes, in theory, that can change mid-course even though you've signed up for something (indiscernible)

SENATOR CRYAN: That point about the inhaler versus the cancer--

MS. RYAN: Yes--

SENATOR CRYAN: --right, and then you as the patient--

MS. RYAN: Yes--

SENATOR CRYAN: --and, the real consumer here--

MS. RYAN: Correct--

SENATOR CRYAN: --just left out to tiers and corollaries that he probably can never understand--

MS. RYAN: Exactly--

SENATOR CRYAN: (indiscernible)

OK, thank you; thank you.

MS. RYAN: Sure.

SENATOR LAGANA: Thank you.

Senator Johnson, any questions?

SENATOR JOHNSON: Just one question.

It just sounds like to me that supply and demand, so to speak-- There's a-- As I've been told that in the United States about 25% of our

population are either pre-diabetic or diabetic -- maybe even a third, up to a third.

In response to that, I would think that the drug companies and these PBMs would provide the medications to try to -- not cure, but at least reduce the impact of the situation with our population. I'm not hearing that at all. It's based on-- It sounds to me it's based on just basic numbers. Can we make -- what's our bottom line, and we cut certain products out of the -- off the list just to ensure that we maintain our profits, which doesn't-- It makes sense, I guess, in a capitalistic society, but, still, when you try to, as Senator Cryan says, our constituents are the ones who are suffering because of this -- these decisions.

I would like to hear more from the insurance company when they come up, because it sounds like to me they're tied into this whole -- this structure. So, I'm just saying that I don't see a response to a situation that we have in this country, pre-diabetes, diabetes, where we're trying to resolve that or at least reduce that in some way through this system that we have. That's all I'm saying.

Do you have a response to that?

MS. RYAN: I'll just say that -- and, Chrissy hit on this earlier -- our members don't manufacture medicines so that they just sit on the shelf and patients can access them. So, that's why we come to the table to have meaningful policy conversations. And, yes, some of our medicines are expensive. I'm not going to diminish that. Biologics are live cells that are grown in a tank. I've had the opportunity to see it; I'm sure a lot of you have.

Some medicines are just expensive, but, you're right; the system should be focused on value. And, I think the issue that you pick up on exactly

-- if we can keep people from evolving from pre-diabetes into diabetes, if we can keep them from congestive heart failure, if we keep-- We're saving the system money. So, it's really important to not think about spending in these silos. I think we get very siloed about it, like, "Oh, we're spending this on hospitals, or we're spending this on drugs." We have to make sure we're looking holistically at how we're providing value to our patients.

SENATOR JOHNSON: Long-term.

MS. RYAN: Yes, absolutely.

SENATOR JOHNSON: OK, Chair, thank you.

SENATOR LAGANA: Thank you, Senator.

Thank you so much for your testimony.

MS. RYAN: Thank you.

MS. ACKERMAN: For the third panel: Ward Sanders, President of the New Jersey Association of Health Plans.

SENATOR LAGANA: Good afternoon, Ward.

If you could just please--

W A R D E L L S A N D E R S: Yes--

SENATOR LAGANA: --say your name and who you represent for the record.

MR. SANDERS: Sure.

Ward Sanders with the New Jersey Association of Health Plans.

I am here with my entire research department from the association--

(laughter)

MR. SANDERS: --and, all the other employees. The light switch is off since I'm here.

SENATOR BRAMNICK: You don't need any help.

SENATOR LAGANA: You have all the stats; I've seen it.

MR. SANDERS: So, I really appreciate, Chairman, you for organizing this hearing today and hearing from disparate and different perspectives on the pharmaceutical coverage and PBMs and pharmacies and so forth.

Ward Sanders with the Association of Health Plans.

We represent the major payers in the state, and we are a-- I just want to make this point, that we are a nonprofit like a lot of all these other trade organizations that represent the interest of our members. We have bylaws; we have some members who have PBMs that are in there, sort of a corporate -- think corporate partnerships. And, then, we have some that contract for services. So, like, they contract with hospitals and doctors and pharmacies and so forth. They will contract with PBMs externally. So, we have membership in both categories.

And, I just wanted to-- One of the themes I'd like to strike here is that both insurers and PBMs play roles that are important in the health-care system in the United States. I do have some written testimony, I didn't get a chance to send it beforehand; I'll send it afterwards, and hopefully folks will have a little time to look at it. But, just historically, I just want to take a very short time to talk a little bit about this.

In the United States, the idea of it -- of health insurance -- sort of grew up, originally, with hospitals and doctors coming together as a means of trying to assure payment. And, in World War II, there was a lot of wage laws; the strength of labor really took the United States in sort of a different path, and I think a lot of countries where coverage is provided mostly through

employers. In World War II, there was wage and price controls; health insurance became a means of providing additional resources to employees and helped to-- It avoided those price controls. It was a way of attracting good employees.

In the 1980s, because of the rise in a lot of technology and so forth, which were great for providing coverage, it did put price stress on the system, and it was sort of the birth of managed care, which use selective contracting as a means to try to control cost. We've seen that balanced out by a lot of regulation through HIPAA, state laws, and so forth. And, then, you also saw the public programs through Medicare and Medicaid, in those hard-to-cover population.

But, at its very core, insurance was designed to meet a need that people had to try to improve health outcomes, socialize the cost throughout the system, provide financial protection to consumers, and as a retention tool. Similarly, PBMs have grown up to help serve a need, and have evolved over the past -- I don't know, we'll say 30 or so years, and it's sort of constantly changing. Part of the role and prominence of PBMs has grown because the cost and depth of the prescription drug market has changed remarkably since -- in the last eight years. And, that's a very good thing, that these technology is available.

So, why do health insurers hire PBMs, and why do employers contract with PBMs? So, the first principle here is that nobody *has* to contract with a PBM, and Senator Cryan, I think it goes to one of the points that you were making. There were alternative arrangements that can be made, but most unions, employers, governmental entities, and carriers -- health insurance carriers -- will contract with a PBM because it serves as a

really important function of increasing bargaining power to help negotiate the price discounts. Think of them as a group purchaser in some respects. It's kind of one of the reasons for being at PBMs, is that they will amass their membership and help negotiate rates based on their size.

One of the points I was sort of getting into the insurance markets here is that, for individuals and small employers for the most part, you have an integrated health insurance package. So, you might contract with Horizon, or Aetna, or Fidelis, or AmeriHealth, or whomever it is; your benefit package will include pharmacy as one of the essential health benefits, products under the ACA, and your medical and surgical needs. So, there's not-- As an employer or an individual, when you go to buy insurance, you're buying it with the pharmacy benefit included. The insurance company then may -- or, may not -- contract with an external PBM to administer the pharmacy portion of that benefit.

Larger size employers -- unions and governmental entities -- will often sort of split and bifurcate the benefit package. A good example is the State Health Benefits Program. So, the State contracts with insurers to cover the medical, surgical, and other needs for their membership. The pharmacy is contracted separately through that process. So, I just want to make this point that there is-- Health care is complicated, but there's a difference, sort of, in how it plays out for individuals and small employers, versus large employers who were contracting separately.

Even if the insurance company in the insurance market contracts with a PBM, they retain responsibility for the conduct of the PBM. So, you can't contract away your responsibilities. And, insurance companies have all sorts of vendors: They have fraud, waste, and abuse vendors that are looking

at sort of forensic evaluation of claims for fraud, waste, and abuse; sometimes they'll have a vision vendor that they use to administer vision benefits under the plan. But, on the pharmacy side, they will often contract. But, they don't contract away their responsibilities to their regulators.

We heard from PCMA as to what PBMs do. The big thing that everyone talks about is the price negotiation, but the value to the health plans is more, and I think to consumers is more, is that they're negotiating price discounts is one thing; they're administering claims, which is not an easy task to administer claims for the millions and millions of claims that are done. They manage the pharmacy networks. They have safety programs like medication and therapy management programs to try to say like, "Well, somebody is on seven complicated drugs, how do--" you're going to different doctors, how do you sort of resolve all those drug needs? And, then, there's adherence programs they'll do. So, task one is negotiating price discounts, but the value of propositions is broader than just those rate negotiation benefits.

Turning a little bit to the pharmacy side, if I can talk a little bit about that. New Jersey has what's called a-- Well, let me-- Let's take one step back. Insurance companies are regulated based on the network of providers that they do. There's an evaluation for network adequacy to evaluate various components of your network. Pharmacy is one of those. There are clearly challenges, and we're facing more challenges moving forward, in some areas. If you're looking for a pediatric oncologist in Cape May County, there's just not that many of them. So, there are challenges with different provider classes and building a network, and most of that is driven by how many providers we have.

In terms of pharmacies, I'm not hearing from our members that there are challenges in terms of the development of the pharmacy networks based on the number of pharmacists we have today. I think the PCMA folks testified it's about a 1-1 ratio; there are a couple thousand pharmacies in the state. I think it's something to keep an eye on, to look forward, but right now I'm not aware of any pharmacy challenges.

Part of that, too, is driven by a New Jersey law that's -- I *think* -- the only law in New Jersey that's like this for this class of providers. It's an any-willing-provider requirement. These started to crop up in the '80s or '90s, and they were laws that would say, "Insurance company, you don't get to contract with necessarily who you want to." As long as that provider is willing to accept the terms of your contract, you *have* to accept them in your network. It's the only provider class in New Jersey where we have an Any Willing Provider Law. There's been a-- You don't see many of these laws anymore, and there's a pushback; they're seen as anti-competitive. The FTC and others kind of push back on this notion of forced contracting. But, we still have it in New Jersey -- any pharmacy that is willing to take the standard terms and conditions is eligible under state regulated plans to accept that.

So, on the regulatory climate for PBMs, I think it's been discussed a fair amount. It's not like the Legislature has been idle in the past 10 years. I tried to list out in my testimony; I thought it might be a useful tool for you to see all the things that you've already done in New Jersey to help regulate PBMs. There are a lot, including one very recent one that was enacted in 2023, we have-- DOBI has a whole section of its regulations that deal with this. Carriers are required to report a lot related to their PBMs, and there's a lot of regulation around PBMs. There is a bill in the Legislature;

it's been heard in the Assembly. One of the components was to seek to set a fiduciary standard for health plans. It's not something that my members have; it's a protection, I guess, designed for health plans. It's not something our members have sought as part of a legislative package, so I did want to just relay that concept.

Also, in my testimony, I did put in -- just to give you an example of the cost savings in Medicaid. I mean, Medicaid is a *really* big payer in New Jersey. We've got 1.8 million people in New Jersey; it's about close to 20% of the population. Our Medicaid managed-care organizations partner with the State to serve a range of services. Almost everything is carved in at this point, including pharmacy. There was a report done by the Menges Group that looked at pharmacy savings in New Jersey. We are very good -- let me just take a -- fourth-lowest cost in Medicaid pharmacy nationwide, and third of dispensing rate for generics. So, we're producing some very good outcomes in terms of Medicaid costs. But, the scope of these drugs is changing over time, and it's playing a larger and larger portion of the health-care dollar. Just as an example, our organization used Medicaid data in 2011. The outpatient pharmacy piece of the Medicaid dollar was around, I think, 11 cents per -- of the health-care dollar. The most recent numbers are around 20-21 cents on the dollar is paid for pharmacy. And, we're doing very good on it I'd say, comparative to most of our brethren throughout the country. There's a lot of new drugs, and a lot of new costs.

I want to try to quickly -- it's not in my notes here -- but address some of the things that were commented on. New Jersey has some really strict regulations around plan design.

So, what a consumer pays -- because I know that, ultimately, that's all of your focus, really, is what's the end use to the consumer. The cost sharing that a consumer pays is determined by the plan design. And, in New Jersey, we only have three tiers -- you're only allowed to have four tiers. There are strict co-pay caps that the Department of Banking and Insurance has by regulations. There's co-insurance caps that are done by regulation. There are publication and other requirements around pharmacy changes to your -- to the formulary. We have an open-- I think we're the only state in the country that has an open formulary requirement in much of its commercial markets. And, so, I just wanted to -- because there was a lot of discussion about what that looks like. The State Health Benefits Program, and employers, and unions, and so forth, will select and demand savings around prescription drug benefits. We've talked a little bit about GLP-1s; it's sort of an interesting case. The carrier is the face of "no" in that. But, who -- whether a GLP-1 is covered or not is ultimately -- for weight loss, I should say -- is ultimately determined by the plan sponsor. So, if you're a State Health Benefits Program; if you're a Medicaid Department -- Medicaid is a little different; if you're a hospital; if you're a large manufacturer; you can say, flip the switch, do you want to cover GLP-1s for weight loss, or do you not, and under what circumstances do you want to do that? The carrier will administer the benefits according to what the employer has requested. GLP-1s -- I think it's -- I think that this view will evolve, but weight loss traditionally has been treated differently in health care than other services. Medicare, not the insurance companies, does not cover it. Medicaid traditionally has had barriers around weight-loss programs and medication.

So, again, the face of "no" is the insurer, but, ultimately, it's -- what's the breadth of benefits that are being selected by the employer or the union, whomever.

I just want to end up on a couple points, is that as you think about legislation, and as you move forward, one of the biggest payers in health care that you all are going to regulate is the State, through the State Health Benefits Program, and Medicaid. They're actually-- The 2023 legislation noted that there were cost concerns because of how pharmacists were being paid, and, so, the State carved itself out of the application of those rules to Medicaid and the State Health Benefits Program. Who paid for those higher costs was the employer and the individual market that are regulated by the State.

As you move forward, I would ask that, as a policy thought, you be really clear -- is this intended to help consumers? Is this intended to help pharmacists? Is this intended to help pharma -- pharmaceutical companies, I should say? And, if you're going to carve out the State from the application of these higher costs, what's the policy rationale? I understand the State Health Benefits Program rates are varied; there's going to be a big bump this year. The rates in the commercial markets, I think, are going to be quite high again. And, so, I just am reminded of -- there's an economist at Princeton, Uwe Reinhardt, who passed away, but I always -- to me, he was a genius. And, he used to always say, "Just remember that one person's revenue is somebody else's expense." And, when you pass these laws, most -- a lot of the expense is borne by government because government is a huge payer here.

The other maybe cautionary tale is to think really clearly about ERISA Preemption. ERISA has certain preemption provisions in it that

restrict a state's ability to regulate at the state level. A lot of people will bandy around the most recent court decision, whether it's Rutledge or whatever, saying, "Oh, you can do this or you can't do this." The jurisprudence around ERISA Preemption is *really* complicated, and I think it requires some really in-depth thought as to whether you're reaching an area that is permissible or not permissible.

And, with that, I'm happy to answer -- my team and I -- any questions you may have.

SENATOR LAGANA: Thank you, Ward.

Just a question about the plans. So, all plans are not created equal, meaning depending who your employer is -- small employers, large employers, government, unions, and whether they're self-insured or they're fully insured; whether they're ERISA based; whether they're regulated by the state -- it's a very complicated process, I think, we can kind of all understand. And, we can only regulate 30% of the market, maybe -- if that -- based upon preemption, so--

MR. SANDERS: Yes.

SENATOR LAGANA: So, I know we've had this discussion plenty of times over the past -- over the years. So, I'll just take a small employer. I think most employers in New Jersey are small employers. So, take a small employer. Let's say my law firm were 100 people, and we have-- We have an insurance broker who we go through to get us the best insurance, and they present us with a bunch of plans.

MR. SANDERS: (affirmative response)

SENATOR LAGANA: And, we review the plans, it makes sense for our employees, and that's -- this is now our health insurance. Nowhere

in that process is usually -- are we negotiating outside of our broker who is getting us the best plan for us.

So, in those situations, where were the State, for instance, or a large union, may be directly contracting with a PBM, and then using the insurer as a TPA, but essentially just managing.

Can you just explain those differences?

MR. SANDERS: Yes.

SENATOR LAGANA: Because, it's-- In the first sense, you're not really involved in that process; it's kind of what's presented to you and makes the most sense.

MR. SANDERS: Yes--

SENATOR LAGANA: So, can you just explain that--

MR. SANDERS: It's a really good distinctionary question. At a hundred employees, you'd actually be, under the law, considered a large employer, but you're a small-ish employer, and probably purchasing an insured -- maybe an insured product. There, the package of benefits is state-regulated plans -- assuming we're in a state-regulated plan. Normally, for most of those size employers -- certainly in the small employer market -- pharmacy is going to be included in there. Your broker -- who I would recommend anybody to use -- helps you shop around for coverage. They usually -- I do this for -- we have three employees in our plan. You look at the chart, and it will show different plan designs, and it will show the premium based on your -- in the small group market, it's really just based on age. And, you look at that package of benefits. It will have different prescription drug benefits options: Did you want the co-pays here; do you

want co-insurance there; what does that look like? And, then, it's going to affect the premium, obviously.

For a larger entity purchasing coverage, I think almost -- most of them will reach to a different negotiation process, which will work directly with a BPM and the insurer for the insured business.

SENATOR LAGANA: So, in the first -- in the first example, my point, essentially, is that the PBM role in that situation is almost, like, built into--

MR. SANDERS: Correct, correct.

SENATOR LAGANA: So, they're not really -- we're not negotiating directly with them, it's kind of-- So, if we were just to stick to that, that point, where does it-- Because, a little bit earlier, you mentioned about any willing provider where you don't -- you're not forced to go to a specific pharmacy. And, per my previous meetings with people in the PBM industry kind of explaining to me, their cost per pharmacy depends on their own negotiations with that pharmacy and their -- whatever organization did the negotiations are on their behalf.

So, me as an employer, I'm going and getting, based upon a specific plan, this is what I think is best for my employees. Where does-- So, my point on this is that whatever happens down the line, we're not really aware of, right? I mean, we're not really choosing what part of this is contractual, as far as me as an employer. We don't really know what they're paying this pharmacy versus this pharmacy.

I mean, I will get something in the mail--

MR. SANDERS: Yes--

SENATOR LAGANA: --saying, "If you do mail order it's way cheaper, and it's--

MR. SANDERS: Yes--

SENATOR LAGANA: --we'll give you 90 days' worth," which I'm guessing is that. But, so, there's kind of that hole -- which is more, I guess it's more or less -- I don't want to say less transparent, but it's just not -- it's just not something that's part of the negotiation. And, I think that some of the theme that we've been hearing is-- And, I know it's more complicated, and it can't just be explained away this way. But, when Senator Cryan made this point, Senator Bramnick made the point -- when we are taking, stepping back, looking at this from 30,000 feet, and we have so much of the marketplace controlled by a couple groups, and then you look at this insurance company owns this PBM and they own this.

For us, we-- This is something Senator Cryan kept saying, "We work for our constituents." So, when they ask us these questions, and the question posed to you -- how do we look at this scenario, look at this -- what could-- I'm not going to call it a monopoly, I'm just going to call it, just the way it's been integrated according to law; there's nothing illegal about it. How do we-- How do we look at that and assure ourselves that there are enough protections in place that you're not just going to have everybody looking out for their own you-know-what's and such as controlling 80-plus percent of the market. Would you just explain that as, like, an insurer?

MR. SANDERS: Yes, so, for the insurer and its members, there are a lot of protected mechanisms in place today. So, the Department of Insurance requires the addition of PBM having a -- a P&T committee, a pharmacy and therapeutics; the health plan does as well.

The Department of Insurance is regulating what-- You can't have a class of services, or a class of drugs, for which you don't cover anything. If there is multiple drugs in a class, you would -- you could try to negotiate brand name drugs, and so forth.

I think that part of it is the market, so if you're buying an integrated benefit, it's the cost. So, what-- However good that PBM is, whether it's internal or external, it's passing along the cost of the -- to the insurance company, which passes it along to the premium payer. So, there is a competitive component to this, is that you want to have premiums that you put forth--

SENATOR LAGANA: So, are there situations where -- and, I'm not sure if you even would have any stats as far as how often this happens or doesn't happen. Because, I was told that oftentimes, you may have Optum Rx, and Optum the PBM, and they may not contract with each other because they don't have the best prices.

How often does it happen that that's not the case, where it's just down the line, it's bang, bang, bang; where it always happens to come out as being the best benefit in every circumstance, just because of who is at the top?

MR. SANDERS: Yes, and this -- somebody else previously mentioned this -- that the contracting dynamics, a trade association generally is a little bit blind to, for anti-trust reasons, you want to sort of stay clear of that. So, I don't get to see the contracting dynamics.

I would just offer two points, is that, one -- and, Senator Cryan, you were getting into this a little bit -- a small PBM is going to have a challenge in negotiating discounts nationally. I do think that there is a lot of

new entrants into the market from what my reading around the PBM space is, and different models of payment, to the extent that a big PBM is not driving value for its members well. Like any industry, if you're not making T-shirts well and somebody else can make it better, if you have shoddy workmanship, you'll have somebody else move in. So, I do think there's space for new PBMs to come in if the market is not being served well.

But, I do think that the size of the purchasing power does matter, because you're an aggregated purchaser for the most part.

SENATOR LAGANA: Thank you.

Senator Cryan.

SENATOR CRYAN: Thanks.

Thanks, Ward.

Just a couple.

So, in the-- You talked about the fact that insurance companies contract with PBMs. Is there a standard length, or how long are those contracts?

MR. SANDERS: Again, I don't see the contracts. My understanding is just from reading is that there tend to be a couple of years, and there's provisions for getting out of them, too, as I understand it. But, I never see those contracts. But, they tend to be a couple years, I think.

SENATOR CRYAN: So, for the consumer, the ultimate consumer, who-- Clarify for me, who makes the final decision on what drug I'm allowed to have?

MR. SANDERS: It's a really good question.

So, the-- In the insured marketplace, the-- It will be determined by a couple of factors. Number 1, is there an exclusion? So, there are

insurance contracts that exclude drugs for weight loss. So, do you have access as a consumer? That's driven by plan design and maybe, whether it's a -- whomever the employer or plan sponsor is, or whether it's a state-regulated plan, it's driven by the contract. And, a lot of times, that's the plan sponsor or regulation.

If it's a service, or it's a condition for which there is coverage; carriers have formularies that are regulated. They need to publish those and provide notice of changes, while we have -- in the commercial market, anyway -- an open formulary. I would say most states allow a closed formulary. It's a cost containment measure, but we don't allow closed formularies for the most part in the commercial markets. And, part of this analysis will be, frankly-- Well, part of it is safety, so the carrier is going to do safety edits -- there's five different doctors that's treating this patient, and doctor -- the doctor may not know that this other doctor has prescribed a medication that's going to interact horribly with the drug that you have. So, there's a safety edit that's in place so you can say that the PBM or the carrier, if it's retained that responsibility, will determine who -- in some case, if there's a safety edit, whether you have access to that drug.

The other is that there are -- prior auth is done in some cases for cost containment. So, you can have a $1,000 and a $100 drug. It may be that the $100 drug works for 95% of the people. You could have a health-care system that's completely agnostic as to cost, but, generally, I think there's an acknowledgement that we can't afford that, and you have to have some process in place to determine whether there is access to the more expensive drug. New Jersey has lots of rules around, "Oh, this person has been on this drug for five years, they tried that other drug and it didn't work."

There is a workaround to make sure that those folks can get access to the drug that's (indiscernible) not on the preferred tier of the formulary or off the formulary. So, that's another way in which the drug could be changed.

And, the last one is a mandatory generic substitution law, where the carrier is not really involved, per se, is that the drug has been prescribed, the physician has not said dispense as written, and we have a law that you all -- some of you passed -- a long time ago that said you have to substitute the generic. Again, it's not -- there's not necessarily an insurer involvement. So, it's a complicated answer; there's lots of ways in which drug-- But, I would completely agree with you about your concern about people walking away, with the pharmacy, without a drug. That's not the way this should happen. And, to say that the world is perfect is -- it clearly isn't right.

We do have high hopes for real-time prescription drug tools, so the pharmacist -- a physician has the tools -- not at the point of prescribing -- to say, "There's 15 drugs in this class, these two are going to require prior auth; these 13 aren't. Here's the cost to the consumer." Giving those tools to physicians and encouraging electronic transmission of claims rather than fax machines is the way to go.

You all did a very good thing, I think, in encouraging in the recent prior authorization law a stepping towards to encourage that electronic transmission of claims that we hope will help alleviate a lot of that problem. It's harder when you get to the pharmacy to fix these kinds of problems, but people should get prompt access to drugs, and that's certainly something to look at.

SENATOR CRYAN: You do realize that answer is why people just hate every part of this process, right?

MR. SANDERS: Yes.

(laughter)

MR. SANDERS: And, yes, and it's-- Understand that the State, and employers, and unions, say, "We need the drug spend to come down, and we'll ask that--" If all drugs cost the same, or are priced low, we wouldn't have this challenge. It's just-- It's an odd space especially because you have patent protection and only one drug and it's -- it creates weird market dynamics.

SENATOR CRYAN: Well, I'll tell you, 25% of people have to walk away because it's $75 or more, when the big three who control this market are reaping billions and billions and billions a year. Say what you want, it's in the kitty, and the idea that we've lost focus on that leaves me with just my last question for you as each -- as the insurance piece.

So, in your view, why do prices continue to increase?

MR. SANDERS: Like all answers in health care, it's complicated, and there's a lot--

SENATOR CRYAN: There was a movie, wasn't it--

MR. SANDERS: (laughter)

And, I think that there is probably some blame to go around. I heard people in health care say that the one thing that everybody in health care is good at is blaming somebody else for the reasons.

SENATOR CRYAN: And, by the way, on display today--

MR. SANDERS: Yes, I'm sure it is; I'm sure it is.

I think that -- to me, there are groups that are -- show a path forward in this, and insurance companies don't always like them. But, there is a group called ICER, for example, that looks at the value of drugs, and the

access rules that the carrier has, and looks at the price of the drugs and says, "That's priced according to its value in the system," or, "It's not priced according to the value in the system."

There are-- Unfortunately, the prices aren't reflective of the value, necessarily, and you have wild differentials and costs. It happens all throughout health care, honestly. You can have a hospital with massively different pricing for the same knee replacement surgery. You have to ask your sales, "Why is that?"

But, I think that some of it is direct-to-consumer advertising for drugs; we're among a few countries that do that. There's billions of dollars spent on trying to influence physician practices as to what they should be prescribing. And, that's-- It's probably part of it.

On the rebate piece, I will say, in New Jersey, we have passed a law that requires the entire rebate for PBM to be passed through either to lower premium or to lower cost-sharing at the pharmacy. So, that rebate should be--

SENATOR CRYAN: We'll see how it works, right? We'll see, we don't--

MR. SANDERS: I'm not convinced it's going to solve the problem of the unaffordability of drugs, but it does -- it is a New Jersey law.

SENATOR CRYAN: (indiscernible) sorry, Chair, only because of your comments.

Is there a state or a legislation out there in terms of value pricing that if, say one had a mic in front of him on this side and wanted to take a look at it, is there anything out there that really would be a benefit for this Committee?

MR. SANDERS: I don't know. I was definitely off script on that one, but I'll have to--

SENATOR CRYAN: Could I ask, through the Chair, if you happen to come across--

MR. SANDERS: Sure.

SENATOR CRYAN: Thank you.

Thanks.

SENATOR LAGANA: Thank you.

Senator Johnson, did you have a question?

SENATOR JOHNSON: Chair, just one -- just one question.

I was away; I had to step away for a meeting.

But, can you define open formulary to me--

MR. SANDERS: Yes, that's a good question--

SENATOR JOHNSON: --versus closed?

MR. SANDERS: Yes, so a closed formulary will allow that certain drugs are just not covered. You have to cover in a class, so if you have whatever -- diabetes -- you have to have diabetes drugs in your formulary. But, you could have certain drugs that are off the list, and you don't have access to. State Health Benefits Program has closed formulary components.

Our State insurance laws, for the most part, do not allow a closed formulary. Every drug has to, essentially, have ultimate access to it.

So, you would have-- You could have a formulary where there's a preferred drug and a non-preferred drug--

SENATOR JOHNSON: (affirmative response)

MR. SANDERS: --and, they're on different tiers, and there's different cost-sharing--

SENATOR JOHNSON: And, then the tiers come into--

MR. SANDERS: Pardon me?

SENATOR JOHNSON: Then the tiers come into play--

MR. SANDERS: The tiers do come into it. But, you-- In a closed formulary, there's drugs that are just-- You just don't have access to, and it's a cost containment to--

SENATOR JOHNSON: But, we don't have closed formularies in New Jersey?

MR. SANDERS: Oh, you have them all over the place in New Jersey. But, in the State-regulated markets that DOBI regulates, which is drastically shrinking, is you have an open formulary requirement for the--

SENATOR JOHNSON: OK.

MR. SANDERS: Yes, the-- We've got 9.5 million people in New Jersey now; I think that the DOBI-regulated markets are, I would guess, around 1.1 million people.

SENATOR JOHNSON: Oh, OK.

Thank you.

Thank you, Chair.

SENATOR LAGANA: Thank you, Senator.

Senator Bramnick.

SENATOR BRAMNICK: First, I wish Joe Cryan was a trial lawyer, because I would hire him at any price. I don't know where he developed that cross-examination skills, but it's pretty damn good.

SENATOR CRYAN: Debating you.

(laughter)

SENATOR BRAMNICK: So, PBMs-- I didn't realize until you said it. Did they actually handle the claims process for an insurance company -- correct?

MR. SANDERS: Pharmacy piece -- or, most of the pharmacy piece, yes.

SENATOR BRAMNICK: OK.

So, if I get that seven-page denial letter, or whatever it is, that could technically be something done by a PBM, correct?

MR. SANDERS: Uh--

SENATOR BRAMNICK: I'm not asking about the policy, but they would be the out-front entity dealing with that claim?

MR. SANDERS: It's a good question, and I should know the answer, but I don't. Through the Chair, I will certainly get you an answer as to how the -- a claim denial would come through. I mean, ultimately, the carrier retains responsibility if it's an insured market, but -- yes.

SENATOR BRAMNICK: I understand that, but I'm getting this sense -- because, when I first walked in here, I was confused about PBMs. I'm a *little* less confused. But, technically, the insurance company, which advertises under its name of whatever -- we'll call it the ABC insurance company. They could be outsourcing a lot of these technical -- not decision-making, but they could be outsourcing a lot of these things to a PBM, such as claims management?

MR. SANDERS: Yes, I believe that's true. I mean, ultimately the plant -- there's two different -- you can contract separately with a PBM, but if you're talking about the integrated benefit where I'm a small employer, I buy a plan and it's got a pharmacy billed into the plan, and it's one -- I'm

contracting with one entity, the carrier, then there's certain functions that the plan has like what's the cost-sharing; how many tiers are there; what drugs are on the formulary? The carrier does that, but the administration of the claims can be done by the PBM if it's, that's the--

SENATOR BRAMNICK: But, I'm saying, it's possible to conclude that an insurance company could hire a PBM to do a lot of these different things, such as--

MR. SANDERS: Yes.

SENATOR BRAMNICK: OK.

The reason I'm saying that -- I'm getting this sense that there could be insurance companies out there that, even though technically the insurance company retains the final decision-making, that the PBM could be running the show in a lot of ways. If they're doing the claims, they're doing everything; if they're negotiating -- if they're negotiating the costs of things, or whether a drug should be in and out of a plan, they're doing that as well. And, now I can see how the industry has grown out -- up.

The reason I'm asking this question is the same issue that's been raised by my colleagues, and that is, who is running the show? Because we have frustration now, and by us understanding-- Some of the-- I see the ad for the insurance company, but maybe that's not who is really running the show here. They are an entity, but less likely to be in the weeds in terms of making those decisions.

So, that's something that could or could not have an effect on patients' frustrations, and the role of the PBM seems to be growing. And, I can understand they run an insurance company; if you can outsource this but

also make money, I would get rid of the tough stuff, too. So, that's just an observation.

MR. SANDERS: If I could just--

SENATOR BRAMNICK: Yes. I'm trying to understand how powerful the PBMs have become. Because, I'm always thinking I'm dealing with that insurance company, and maybe I'm not.

MR. SANDERS: As, like, who is making -- who is in charge, who is making the calls, it's -- again, health care is complicated. What plan design you purchase is going to be driven by the options that the carrier makes available. Some of it is going to be driven by state regulations.

So, like, what your cost-sharing is for drugs and how many tiers you have, and whatever -- is it an open or closed formulary -- is determined by the carrier, into the constraints of the regulatory climate in that market.

The claims handling process--

SENATOR BRAMNICK: Sure, and I understand that; they have to follow the rules.

MR. SANDERS: Yes.

SENATOR BRAMNICK: I'm just saying that it seems as if the PBMs are getting bigger, and the insurance company's role seems to be somewhat smaller. Or, at least that's the appearance from what I'm seeing. That's all.

MR. SANDERS: Well, certainly the pharmacy piece of your health-care dollar is growing in all markets. So, the role of pharmacy as your benefit package is bigger. The cost of drugs is a significant driver of the importance and the need for PBMs, too.

So, I don't think you're wrong to say that there's a growing-- The interest around pharmacy is completely different. It used to be that health insurance didn't cover pharmacy benefits; Medicare didn't -- it was like, 2003 or whatever when they first included drugs in Medicare. So, it's been an evolution, but its place and role and the size of the health-care dollar is changing over time.

SENATOR BRAMNICK: So, just real quick. So, if I have an issue, I am always reaching out -- am I talking to my insurance company, or am I talking to -- these companies that answer the phones for the car companies, or for whatever? They're just an outside entity? So, I could be calling -- thinking I'm calling the insurance company, but I'm really talking to the PBM, maybe?

MR. SANDERS: Yes, I mean, I think your -- I'll have to double check this -- but on your card, there's normally, like, there may be a behavioral health center, too; there may be a pharmacy vendor--

SENATOR BRAMNICK: All right--

MR. SANDERS: And, there's a separate number to talk to because they're the ones who have a role in sort of assisting you.

SENATOR BRAMNICK: All right, thanks.

MR. SANDERS: I expected a longer deposition by the way, so.

SENATOR BRAMNICK: Well, here's what I think is gonna happen. This is so -- this is so in-the-weeds complicated--

MR. SANDERS: Yes--

SENATOR BRAMNICK: --in a lot of ways, and there's so many different levels to it. I can see why it's difficult to find the culprit.

So, it might take a few more hearings, Mr. Chairman.

MR. SANDERS: I look forward to our dialogues.

SENATOR LAGANA: Thanks, Senator.

And, not to complicate things even worse, because we're on the cusp of our last witness coming up, but we also -- and, the hospital association isn't here, but we also have pharmacies owned by hospitals, and that's a whole other layer of this that we haven't even touched upon.

So, maybe at a later date we'll get to that. I know it's much to the chagrin of the health insurers--

MR. SANDERS: Yes, exactly, Senator--

SENATOR LAGANA: So, we'll talk about it another time.

But, thank you, Ward; appreciate it.

MR. SANDERS: Thank you.

MS. ACKERMAN: For the fourth panel: Brian Pinto, Registered Pharmacist, Trustee with the Garden State Pharmacy Owners; Anthony Reznik, Director of Government Affairs, Independent Pharmacy Alliance; Dr. Alan Oustaev with the -- the Chief Operating Officer of Invictus Pharmacy; and, Ritesh Shah, CEO and Managing Partner of Legacy Pharmacy Group.

SENATOR LAGANA: I don't believe Mr. Shah is here, so we can begin with the first panel.

Anthony, do you want to begin?

A N T H O N Y R E Z N I K: My name is Anthony Reznik; I am the Director of Government Affairs for Independent Pharmacy Alliance. In my previous life, I was the Chief of Staff for former State Senate Budget Chair.

And, I want to concentrate my testimony -- because I know PBMs are complicated, and we heard a lot of complex testimony here. But,

I think Senator Bramnick's question is really on point: Who is running the show here, in terms of PBMs and insurers?

So, in the PBM market, you have three PBMs that are called, "The big three." You have CVS, which owns Caremark, which is the largest PBM; they are the largest payer of pharmacies. You have UnitedHealth Group, which is an insurance company, and they own Optum Rx, which is also one of the largest payers for pharmacy. And, then you have Cigna, which bought Express Scripts, which is also one of the largest PBMs as well. These companies are in the *Fortune* 500 list, but not where you'd expect. They're not way down in the *Fortune* 500 list -- they're right in the top 10. You would have to look for Disney in the middle of that list before you reach these companies that I just mentioned.

Now, what do these companies do? These companies decide how how much pharmacists and pharmacies get paid. These are take-it-or-leave-it contracts that are too big to negotiate with. So, the pharmacies, in order to be in-network -- and, yes, we do have an "any-willing-pharmacy" law in New Jersey. But, pharmacy owners have to accept all terms and conditions, otherwise they cannot participate. And, if they do not accept those terms and conditions, they are out of network.

On the other side of the coin, you also heard a lot of talk about employers and clients. The State of New Jersey is also a client -- PBM client and insurance client -- for State Medicaid Program. They, in many cases, are being overcharged for prescription drugs in the State Medicaid Program. So, one of the things that I wanted to bring up in relation to that is how the State of New Jersey is being overcharged in the Fiscal Year 2026 State Budget on prescription drugs. Let me start off with the Federal Trade Commission

report that came out last year. According to the Federal Trade Commission, PBMs overpaid their affiliated pharmacies over $7.3 billion above the average cost for specialty generic drugs in Medicare Part D. So, what that means is the Federal Government keeps an average cost of specialty generic drugs. They say it costs this much for a pharmacy to purchase it from a wholesaler.

What the Federal Trade Commission said last year is that the PBMs and the insurers that own them are overpaying the pharmacies that they own -- that's what affiliated pharmacies are. Affiliated pharmacies are pharmacies that have a special contract with PBM, or they just own them outright -- that they are actually overpaying them in Medicare Part D by $7.3 billion. That's Federal Trade Commission. On the employer side of it, the Federal Trade Commission also found that they are also overcharging employers in the benefits plan by similar amounts -- we're talking hundreds of million to billions of dollars.

So, come back to the State of New Jersey. We're dealing with a very difficult budget, and I -- when I used to work for the Senate Budget Chair, I used to be on that side of the room when the negotiations were happening. But, I still followed the budget. If you take a look at New Jersey State budget, Medicaid for the last five fiscal years, you will see a nearly billion dollar increase in prescription drug spending in New Jersey. Specifically, the FTC found that those increases are with specialty drugs, because there are more and more drugs -- generic drugs -- that are termed specialty. And, you know who terms those drugs specialty? The insurers and the PBMs. They decide what a specialty drug is. And, when a drug is classified as specialty, all of a sudden it becomes more expensive. So, what's happening?

So, we decided, when the FTC -- we saw what the FTC came out with -- the Federal Government is getting overcharged for drugs. We wanted to see, is the State of New Jersey getting overcharged for prescription drugs? We surveyed -- New Jersey Pharmacists Association did a study and surveyed 68 independent pharmacies in-network in Medicaid, versus affiliated or owned pharmacies in New Jersey Medicaid. Now, keep in mind these managed care organizations -- these are companies contracted by the State of New Jersey; they are insurers and PBMs that I mentioned before. So, that is what an MCO is -- they're vendors, pretty much, for the State of New Jersey.

The study that we have from NJPHA surveyed the 10 most top prescribed drugs in New Jersey Medicaid. They're all specialty drugs. High-cost HIV cancer drugs. If you take a look at how much the MCOs and the PBMs they own pay the pharmacies that they're affiliated with, or that they own, it's hundreds to thousands of dollars higher for the same drug, for the same milligram, than what the pharmacies paid -- the independent pharmacies paid. The independent pharmacies in New Jersey pay closer to NDAC -- which is the National Drug Acquisition Cost that I told you about. It's publicly available online; you can see it. So, the pharmacy on the HIV cancer drug is paid $50-60; the Medicaid-- The PBMs reimbursing their affiliated pharmacy, or pharmacy they own -- hundreds to a couple thousand dollars above the national average drug acquisition cost price right in New Jersey.

If we took the difference between what those independents were paid -- which is closer to the average -- and what the affiliated pharmacies were paid, just on those top-10 drugs, that's a $20 million difference right there. Depending where we believe, based on the information that we're

seeing, many -- or, a giant amount of drugs in New Jersey Medicaid -- are now classified as specialty drugs. Some charts that I've seen show that specialty could be nearly half of the amount of drugs that are dispensed within Medicaid. If what we found with these top-10 drugs, if you equalize it to just expand it within the universe of Medicaid drugs, that's $700 to a billion dollars, in terms of what the budget increase within the last five years.

2019, the budget in New Jersey was $2.1 billion for prescription drug spending. This year, OLS came out with an analysis that said you're going to have the biggest prescription drug price increase this year that they've ever seen -- a 9.2% increase due to specialty drugs, they say. But, what's interesting about the OLS report is they don't know why; they actually say they don't know why the specialty drugs have gone up this much. But, if you look at the FTC report, and you look at the findings that NJPHA found, it is clear that they are taking money that's provided to them through the budget and overpaying their own pharmacies.

Thank you for giving me an opportunity to testify.

SENATOR LAGANA: Do you want to run through the panel first, and then--

SENATOR CRYAN: Whatever you want. I just-- My only ask is can you define how does a specialty drug get (indiscernible)

SENATOR LAGANA: Let's go through everybody, and then we'll deal with that whole issue.

Alan, if you want to.

A L A N O U S T A E V, PharmD: I want to thank you all.

New Jersey is one of the most -- I'd say it's a leader in this field of regulating PBMs and increasing transparency to ultimately help the people. Because that's what we're all here for.

I'm a pharmacist; I've been in pharmacy since I was 16 years old. I started out as a stockboy and a delivery boy and worked my way up the chain. I love what I do, I just-- I really hate to see what's happened to this industry. When I started out, I remember when it was a simple situation. New York Medicaid was direct with pharmacies, as it is now again, but there was a period where they gave that away to PBMs. And, in that 16-year span, I saw PBMs start to dominate the market; exert their power over pharmacies; get merged with insurers. And, they started out as a pharmacist-run organization in the '60s to lower the cost of prescription drugs, because drugs were paid out of pocket at the time. It had a good intent.

My question is, if that's what they do and that's what the testimony here that we heard from PCMA is about, why is it that nothing works? Why is it that pharmacies are getting paid less, while patients are paying more, and manufactured drug price has gone up, and premiums have gone up? What exactly do they do? They are a middleman. There's a lot of middlemen in America for various industries. In real estate, if you want to buy a house, you need a real estate agent; they're there to facilitate that transaction and make it smooth and painless between the buyer and seller. If we look at the table of what's actually happening here, you have an employer who needs to provide coverage for their employee. They need to make sure that they're taken care of so they can work; there's laws in place for that.

You have a manufacturer that's innovating and creating a product that is needed by the public -- for public health. You have a pharmacy that is providing a valuable service in facilitating that drug and helping that patient accordingly to that therapy. And, then you have the end consumer -- the patient -- who ultimately just needs the medication. Where, then, does the PBM come in? They have their tentacles around every single facet of this, but if I just illustrated exactly what I told you, in that simple design, they're not needed. They are simply not needed.

In my time as a pharmacist, me and my partners, we came to understand that 90% of the drugs in America are generic. And, most of them don't cost us more than $10 I'd say -- $20. So, then, why is the drug spend so high? We had an opportunity after COVID -- we were the pharmacy that helped Union City and Weehawken run their COVID site, testing the residents. And, after that, we earned the trust of a large employer based -- headquartered in Jersey City. And, the ownership group there was interested in lowering their prescription benefits. They were self-insured, so they had a broker who was going to find them the health insurance side and the PBM side, and just ultimately try to lower how much they're spending for their employees. And, so, we devised -- we took a look at the data, we contracted the brokers, we got their data, the identified, and we looked -- OK, out of the 5,000 lives that are on this employer roll, how much is actually being spent here? OK, 90% generic. OK, simple -- we'll charge all of these patients a tiered structure. If it costs us below $5, we'll charge them $10; if it costs us about $10, we'll charge them $15. Simple, simple model.

For brands, we don't have rebates; we don't have rebate agreements in place. We said, OK, we'll just charge them what it costs us.

We're not here to -- sorry, a couple of dollars on top; a fixed fee. At the end, when we proposed our package to the broker, we estimated $1 million in savings to the employer over the course of the year. And, we're a pharmacy; we don't have rebates. No rebates. One million dollars in savings. The broker then said, "Well, we've got to check this." "Well, I don't know about this." "You know what? We're not comfortable. We're going to go with who we've been going through." Whether the broker has some kind of affiliations, I don't know; I'm not going to speculate on that. But, what it did for me, just kind of peering into this industry, is it kind of just opened the veil a little bit. OK, we can save people money.

In my course as a pharmacist, and what we do at Invictus Pharmacy is, we actually work with manufacturers directly. I have multiple relationships with various drug makers and various products. Because, ultimately, they make a drug; they market it; they have to sell it; they have to get it to their patients. We have patients who need that drug. There's a natural alignment there. Where there is a problem is, you have PBMs that come to these manufacturers and say, "Hey, you want access to this list of patients we have? You want this to be covered? Give us 40%; give us 60%; give us 80%." Racketeering, it sounds like to me; I'm not going to say it, but it's what it sounds like.

So, essentially, we then negotiate with these manufacturers directly, because they don't want to play the rebate game; they don't want to play it. They'd rather just say, "OK, Alan, your pharmacy can buy it from us at 20% off." And, you do with it what you want. And, because they don't play the rebate game, they're non-formulary, or they're excluded, and so they have to -- they have to jump through hurdle after hurdle to get the patients

the prescriptions; prior authorizations; step therapies. And, these are some of the tools that the PBMs put in place so that you play their game. You have to play their game if you want to sell.

Let's examine -- and, this is just me theoretically speaking -- but, if you were to pull them out of the market, if you were to just say PBMs didn't exist, here's what would happen. Ninety percent of drugs are generic. They're cheap. And, the way it works is, you have 10 wholesalers that make Rosuvastatin -- generic Crestor. Rosuvastatin is very cheap -- why? Because you have 10 makers of that same generic, so they've got to compete with each other. I'm going to lower my price; you're going to lower your price, and we're going to see who ends up selling the most. The same thing would happen for branded manufacturers, especially when you're talking about a disease state that has multiple brands.

In diabetes, for example, there's a type -- there's type 2 -- type 2 diabetes runs rampant in the United States. So many Americans are influenced, and so many people from New Jersey. There are multiple manufacturers that make, for example, a particular diabetes type 2 drug -- SGL2 inhibitors. They essentially help you -- when you go to the bathroom, you're pushing out glucose through the excretory system. There's multiple manufacturers of that. If you were to pull PBMs out, what they'd naturally do is they'd compete with each other. And, how would they compete? Who has got the lowest price? Because in America, it's the lowest -- it's the best product for the lowest price that wins in standard economics, and that's what would happen, 100%.

Conversely, what happens in our pharmacies and what I see -- that same drug class that I mentioned, there's a drug name: Farxiga. Farxiga

went generic a year and a half ago, for about half the price that it's currently listed at. I have pharmacies that submit claims for generic Farxiga, get denied at the point of sale by the PBM, and are told to substitute for the brand name because they get a rebate. There's an adverse incentivize in almost all areas of this system. And, if the manufacturers are blaming the PBMs, the pharmacies are blaming the PBMs, the legislators understand that it's the PBMs. It's indefensible to me.

I just want to say a couple things as it relates to pharmacies, and some of the things that are happening to us every day. I would estimate that 90% of brand name drugs are paid below cost. Pharmacies acquire brand name drugs from wholesalers. The wholesalers are also -- there's only -- there's also a big three in that category: Cardinal, Amerisource, and McKesson. But, essentially, most independent pharmacies are buying their brand name drugs at WAC -- which is wholesale acquisition cost -- minus 3%. So, as an example, if a brand name drug costs $100, you're buying them at $97. We analyzed our reimbursements over a period of a year, and what we found is PBMs are reimbursing brand name drugs at independent pharmacies an average of WAC minus 5%. So, that means that every brand name drug, I'm losing $2. In this example, if that drug is five times that price, I'm losing five times that amount, and so on and so forth.

So, that puts a financial strain on the pharmacies. Now, we have to try to get volume. We need to get more generics out. We need to find different things that we can do to stay alive. I have to negotiate directly with manufacturers, for example, in our case. But, we have to get creative; whereas, they pay their own pharmacies substantially more and profit off of the integration that they've created. If they claim that their integration is

helping the system, why is it at every end that it's become more difficult and more expensive?

A few more examples of some of the things they do. We have claims for patients that have been with us for years, where their employer suddenly switches a different plan under the PBM, that they'll come back to us, they'll try to fill a prescription for the Crestor they've always been on, and suddenly we'll get rejection. "You can't fill a 30-day supply; it's got to be a 90-day supply." OK, no problem with that, we'll give three months, it's better; sure. You give three months -- "Oh, sorry, rejected. You're not in the 90-day network. Good luck getting in." Is there a phone number to call for the network? No. Is there an email? Maybe. Good luck finding it, and good luck getting a response. And, then when you finally do get the contract, good luck going through all the steps and the accreditations they need to finally get into that network. It's a joke.

Another thing that they've been doing in the last couple of years, because it's been such a push on them, and the spotlight is finally on them -- thank God -- is I now have patients coming to me that have been with me for years. "Alan, we want to stay with you, but if I get this brand name drug with you, my out-of-pocket is $150. But, if I get it with the mail-order plan that my PBM owns, it's zero." How does that happen? That means that they're paying me less, they're subsidizing the full cost. I tell the patient, "Go, I don't want you to spend more with me, I don't want you to do that. You need your drug, you need to not go into debt for this; this will make sense." But, that's not a fair and competitive system.

If they claim that their integrated pharmacies are so great -- beautiful. Open the veil, let's compete. I'll beat you on service; I'll beat you

on quality. And, most of my independent brothers and sisters out there will do the same, because that's competition. But, they steer. They actively steer and manipulate the market, because that's how they win. Their pharmacies, in my opinion, not that great from what I've heard from patients. But, again, happy to compete with them. But, they don't let us.

SENATOR LAGANA: I'll open up for questions now, if we want, and-- Are there any questions?

I know Anthony brought up a couple points that you wanted to discuss.

SENATOR CRYAN: Can you talk about how the process is to define a drug as a specialty drug? You brought it up; the numbers were stunning. How does the process actually work?

MR. REZNIK: Well, the process is even more stunning than the numbers, because in New Jersey in 2018, the New Jersey Department of Banking and Insurance issued a bulletin, and it said in that bulletin that there were certain drugs that were being labeled as specialty drugs that were not -- that would not adhere to Federal statute. There's a Federal statute that defines what a specialty drug is. The bulletin was specific. It said that the PBMs and insurers had to provide some sort of evidence to show that this drug meets the Federal requirement.

I could tell you without a shadow of a doubt that that bulletin and that statute was never followed. We also heard some discussion here about other statutes in New Jersey. We actually have some good laws on the books that may have been able to correct some of the problems that we have. But, just like what Senator Cryan brought up, just like with this statute where the Department of Banking and Insurance has to make sure that the drugs

that are specialty are actually specialty, the other laws that we have in New Jersey -- while they're well-intentioned -- the Department has not really enforced the law. Not because they don't want to, I think it's just, based on my experience, pharmacy is very complicated; they don't have a lot of staff over there. They've had a hard time wrapping their hands around it.

SENATOR CRYAN: OK -- I get it. I think I do, anyway.

What -- another -- just a quick question for you, and then one for you, sir, if that's all right.

I heard about the firewall today, more than once, and your comments reflect the fact that there would not be a firewall. Would you care to expand upon that?

MR. REZNIK: Yes, so, there is no firewall. This is a PBM and insurance talking point that I've heard for the last decade. The last decade, let's say a company like CVS -- which owns Aetna; which owns Caremark -- the talking point to all the times that we have a firewall in our company where the two don't influence each other. But, clearly, they do. Clearly, they influence each other, because Rite Aid just filed for bankruptcy, right here, down the street. Walgreens is going private, because they've been losing money as well.

The only chain that's doing well and surviving is CVS, because they own Aetna, which is a managed care organization here in New Jersey, and they own Caremark -- the largest payer of pharmacies. Who do you think they're paying more? (laughter)

This firewall is fantasy; it doesn't exist.

SENATOR CRYAN: Your example is -- I'll just say very illustrative, and very much appreciated. And, I think we've got a little work to do on those budget numbers that we're going to take a look at.

I have a follow-- And, thank you very much for the -- I mean, really, top notch.

But, we heard continuously today that it was difficult, if not impossible, for an independent to communicate or to do, frankly, the things that you spoke about, being able to work with a manufacturer and being able to price and to purchase.

Could you just-- I mean, when you said that, I'll tell you, it was mind-blowing, to be candid, given the rest of the conversation we've had here today. Could you just expand upon that? Is it immensely difficult to depend on years relationships, or is it a process?

DR. OUSTAEV: I'll tell you how it started for us; it was very simple.

We-- I was the pharmacist, just opened up our first store in Rochelle Park, and we had sales reps coming in all the time. Like, "Hey, we're talking to these doctors in the neighborhood, and they said that they like you guys. Patients who need this drug, they'll send them over this way, and you can help these patients out; we'd appreciate it." So, we had a good track record of helping patients navigate the complicated insurance process. We have staff on hand that will work with the office; help them submit the prior authorizations in an organized fashion; help the patients walk through any other step therapies they may have; and, we deliver upon success.

But, to answer your question, it's not immensely difficult. They're making it sound like it's extremely hard, and it's not. There are

PSAOs. There are these organizations that essentially aggregate all these independent pharmacies and say, "We're going to go contract on your behalf, because individually you don't have any leverage, but together we can go to the big bad PBMs and get a better deal for you."

SENATOR CRYAN: OK.

DR. OUSTAEV: In reality, it's not the way it really works. It's a nice thought, and I'm sure they had the right intention, but they really don't get a good deal for us.

And, the reason that happens is because the PBMs can always just say, "You know what? We don't like your PSAO. We're going to work with the other one." And, that's exactly what happened to a PSAO called Arete. They no longer exist. But, they did, and they were big just a few years ago. I believe it was Express Scripts that said, "You know what? We're no longer going to be working with Arete --" I believe. And, shortly thereafter, all of Arete's members left and went to the wholesaler-owned PSAOs, like LeaderNET, and Health Mart; McKesson; Cardinal.

SENATOR CRYAN: OK.

DR. OUSTAEV: So, if these PSAOs exist, which prove the concept that you can aggregate independent pharmacies to create the pharmacy network that they were saying it's super hard to do, these networks exist. Then, all you need is just somebody to transmit claims. OK, there's a software for that; I've seen it; it costs $50,000 a year. That's all it is. You transmit a claim; it says paid or rejected based on the design. OK. So, then, you just need to negotiate with manufacturers. Well, that can be done. Manufacturers want to sell their product, and they want to sell it for cheaper; they want to drop their price. If you think about what is going on with the

rebate system, they're already selling it for much lower than they're trying to list it at, but they have to play this game.

A good example is the GLPs -- and it's all I'll say on this. They mentioned the GLPs high list price. The list price is $1,200. But, Eli Lilly themselves, on their website, you can buy it from them directly right now for $499. That's where this market is going. Manufacturers want to lower their prices because they want to compete, and they don't want to be the bad guys. And, pharmacies want to help patients, but there's something standing in the way.

SENATOR CRYAN: OK.

And, your opening comments were also immensely illustrative on all that's happening around us here; prices still go up. It's very well done.

DR. OUSTAEV: Thank you.

And, if there's time at the end, there's a couple points that I left out that I think would also be helpful, in terms of what the pharmacies deal with. If there's time.

SENATOR LAGANA: Sure, why don't we just finish the last two witnesses, and then we can just do some follow-up questions.

Thanks.

R I T E S H S H A H, RPh: Thank you, Chairman.

My name is Ritesh Shah; I am a pharmacist and a CEO of Legacy Pharmacy Group, which represents 700-plus pharmacies.

And, also, I have extreme honor on my personal mission as a founder of New Jersey's first and only charitable pharmacy called Ritesh Shah Charitable Pharmacy, where we provide life-saving medications to those who are underserved and uninsured.

Chairman and Committee, I would like to be short; very specific. I will focus on savings on taxpayers, and protecting small businesses against the big corporations and PBMs.

This state -- in three large states, if you see -- Minnesota, Nevada, and Virginia -- they have passed the Medicaid Managed Care Rx Reform, in line with Senator Gopal's bill. That now makes 33 states that either have a Medicaid Rx fee for service corralled in a cost space payment passed through the mandated Medicaid Management Care Rx Program. Additionally, the five states this year -- Colorado, Iowa, Montana, New Mexico -- has passed similar mandating bills. So, all the states are doing these reforms to fix the economic problems of pharmacists in that (indiscernible).

I have successfully practiced 20-plus years with the love of my life, who is also a pharmacist -- an independent pharmacist -- owning seven drug stores. And, how PBMs now putting us -- how Invictus Pharmacy, and Anthony, and Brian would say -- how they -- in telling us, "Whether you take it or leave it." And, those (indiscernible) how PBMs have destroyed the community pharmacy; the desert that they have created in patients. I heard in testimony, they said, "Well, they can reach out in a community, and go on a computer, and reach out to us, and we'll do the things that we're supposed to do." I also heard, "Hey, there is a pharmacy knowledge we provided." We as a community pharmacist, we are doing this. We've been taught to do this in a pharmacy school. We have students right now saying it, and they're -- "How come they're not asking us questions on the medications, and they're asking on why my co-pay is this, and if I go to this pharmacy my co-pay will be this?" This is where we are ended.

Now, low reimbursement rates. Pharmacy benefits managers offer reimbursement rates that are below the cost of independent pharmacies, squeezing their profit margins and threatening the financial viability. They'll tell us, "This is the cost, this is the contract, and we're going to pay you this below the $30-40 cost of my drug." We are happy to provide you those invoices. The three big that we mentioned -- Cardinal, or ABC, or McKesson -- "Oh, no, no, no. This price is available in this state." Well, show us. This is what is available in New Jersey. I can afford it.

Second thing that I would like to focus: The open pricing practices of PBM lack transparency in their pricing and fee structures, making it very difficult for independent pharmacies to predict revenue or negotiate their fair contracts. Direct and indirect reintegration the DAR fees -- we often heard about that. The restrictive pharmacy networks created by PBMs. It was just mentioned, something about specialty. If aspirin, a $1 medication, becomes a thousand dollars, determined by PBM, they will put that into PBM. There is nothing about that drug that is specialty but the price. Their motive constantly is about the price, how to make them big, fat, and make their profit at the cost of patients.

So, my humble request on this testimony is considering the economics, why small pharmacies are going out of business and CPS data rates every third day, second day; one community pharmacist closing. Let them -- they want to serve. They're in a community; they want to do this. If you'd be providing the fair contracts and fair economics, what would we be closing when we saw the entrepreneurs we saw; that if you want to open up the drug store and be one and do the business.

So that being said, I just wanted to bring it out, they do not play by equal -- level playing fields.

Thank you.

SENATOR LAGANA: Thank you, Mr. Shah.

Please.

B R I A N P I N T O, RPh: Good afternoon, at this point.

(laughter)

MR. PINTO: My name is Brian Pinto; I am Mr. Bramnick -- or, Senator Bramnick's -- pharmacy and pharmacist, and I have the honor of being that. Today, I am here as a member of the Board of Trustees of the Garden State Pharmacy Owners. I also currently serve as the President of the New Jersey Pharmacists Association this year. And, I have been a pharmacy owner for the last 20 years in Westfield, New Jersey.

Just going to read a quick prepared comment.

So, pharmacy closures are called a lot of things. Most apropos among them is that they're a wake-up call that we are on the precipice of a pending public health emergency for New Jersey residents. Rural and urban areas now share similarities -- they are disproportionately affected by the lack of local pharmacy services, leaving fewer pharmacies to which patients can turn for care. Patient disruption is real -- longer waiting times; farther distances to travel; reduced access to care; and trusted advice. Time and again, studies have shown that pharmacy benefit managers use their muscle to impose below-cost contracts on non-affiliated pharmacies, while reimbursing their location to better rates.

In a recent Congressional hearing, these tactics were categorized as a reverse Robin Hood scenario, with the riches going to the PBMs. But,

one thing is certain: Unrelenting financial pressures on independents and chains alike have caused store closures, and more are inevitable. Corporations are not immune to disputes. Just a few blocks away at the Federal Courthouse, Rite Aid bankruptcy proceedings went ahead a couple of weeks ago, and while there may be a solution in the works for some of those New Jersey Rite Aid stores, that isn't the case across the country, and that doesn't mean that the situation in New Jersey is any more stable.

I'm not going to go into anything further, because my colleagues here have done a really, really good job of touching on a lot of the points that I would have already touched on. What I will just use is I'll give one specific example that I had, especially with the State health benefits.

So, there is a medication called Spravato; it's a nasal spray that's a physician-administered medication that is used for treatment-resistant depression. I've worked with several doctors offices in the state; we typically have a courier service that will deliver it directly to them so that it can be delivered to patients. At the beginning of the year, January 1, all of a sudden Optum Rx had put in notice that they were no longer going to allow pharmacy -- any other non-affiliated or owned pharmacies -- to be able to act to dispense those services. Their claim was because it's a specialty drug. The only thing that I would say makes it specialty -- it does have a REMs program, which any pharmacist who goes, does the training, gets certified with the program should be able to dispense it. But, for no other reason -- I'm not saying that -- I'm not saying I didn't have the knowledge necessary to dispense it.

Touching on what Alan said, and even touching on what Ritesh said -- we went to pharmacy school for five, six, whatever number of years, depending on what level of degree you got. A lot of these functions that the

PBMs claim to do for their members are things that we went to school for and do every day. So, those services are not exclusive to a PBM. Those are what pharmacists and chain, retail, independent do on a day-to-day basis to help serve their patients.

I would say that, when it comes to MAC lists, or the way that pharmacies are reimbursed, these lists that we are reimbursed off of -- especially on the generic side, MAC lists -- they're exclusive to each of these PBMs. It's not the same for Express Scripts; it's not the same for Optum; it's not the same for Caremark. They each come up with their own list. We've been told on numerous occasions that we can appeal a reimbursement if we don't agree with it, but, as we've seen in multiple attempts with DOBI, that when we do appeal, we're told, "You should be able to buy it from these providers in the state," and ultimately we're not able to find what wholesaler or what provider is able to provide it at the reimbursement that they're dictating.

I'm going to leave it there and just leave it up to questions.

SENATOR LAGANA: Sure.

Senator Bramnick.

SENATOR BRAMNICK: So, the PBMs were here; maybe we should have had them last.

(laughter)

SENATOR BRAMNICK: The question that I have is, so, when I walk into a pharmacy -- as you said, sir, and I want my drug, and you say, "You can get it a lot cheaper online or by mail order by a PBM that owns the mail order house," correct? OK. So, they're doing more than simply

negotiating and helping the consumer. In essence, they create their own business.

So, we could do legislation that would prohibit them from selling the same drug cheaper through their own mail order house, than selling it through a pharmacy, correct? We could do that? Is that something that would at least be beneficial to the consumer, knowing that the consumer can actually get advice from the pharmacist? So, it has a policy behind it; not simply a policy that would cause a consumer to pay more money, they would physically walk in.

Because, we've heard a lot of testimony today, but let's drill it down to legislation that would be helpful. It's unfair, in my judgment, for a PBM to own that company; compete with a pharmacist; and not provide the same services. What else can a legislature do? Because we heard a lot today, but I don't want to walk out of here and not be able to call OLS and put in some legislation.

But, if you would, keep it simple. I don't need a history of it; I don't need a future of it. I just want to hear the legislation.

Go ahead.

MR. REZNIK: So, our recommendation to the Legislature is to pass Senator Gopal's bill, Senate Bill 3538--

SENATOR BRAMNICK: What does it do?

MR. REZNIK: What it does is--

SENATOR BRAMNICK: We can find it--

MR. REZNIK: --it pays every pharmacy the exact same low national average drug acquisition cost price, plus a $10.92 dispensing fee. And, that way, pharmacies -- no matter who they're owned by -- are going to

be paid close to the national average, which is far lower than what the PBMs are currently paying themselves.

SENATOR BRAMNICK: OK, Senator Gopal's bill. OK.

SENATOR JOHNSON: What's the bill number?

MR. REZNIK: Senate Bill 3538.

SENATOR JOHNSON: Thirty-five thirty-eight.

SENATOR LAGANA: Just to jump in here for one second.

So, we did talk a little bit about, not every plan is the same, and we're committed to regulate. And, a lot of these bills, they exempt State health benefits -- which, I don't know why.

So, can you just talk about that? What part we're able to actually correct; what part we're not; why are these bills exempting the only thing that we can actually regulate? I mean, just give us a five-minute tutorial.

MR. REZNIK: So, this is the really confusing part. (laughter)

It's kind of hard to explain.

So, PBMs, no matter what plan you're in -- whether it's State health benefits; whether it's Medicaid; whether it's commercial -- there's really three sectors: There's State health benefits, Medicaid, commercial -- you don't have to worry about Medicare Part D, because the State of New Jersey doesn't regulate Medicare Part D.

So, Department of Banking and Insurance has the authority to regulate just the commercial space. And, what's the commercial space? That's-- I work for a private employer; my employer gets me health insurance; that's where DOBI comes in and regulates it. Medicaid is separate from the statutes that regulate commercial plans, and State health benefits are also separate as well.

The problem is that we've heard ERISA; an ERISA exemption. The one thing I can tell you about an ERISA exemption -- because that always gets in the way, say, "Well, if it's an ERISA plan, we can't regulate it." Yes and no. The Supreme Court, about two, three years ago, a case called Rutledge, ruled that yes, you cannot regulate the plan design of an ERISA plan, but you *can* regulate what the pharmacy has paid in an ERISA plan.

SENATOR BRAMNICK: Thank you.

MR. SHAH: So, Senator Bramnick, what he just said -- what's the conclusion? Patients are suffering; pharmacies are closing; we are complaining. Where are the things going?

Bottom line is this: Let's give patients an access to whoever they want to choose if state (indiscernible) pricing is installed for no matter who they are, which insurance company they are, whether it's a community pharmacy -- me -- or somebody else. I have nothing against them. So, they should not have anything against me. So, the patient can pick the pharmacy they want to go to. It will be level playing field, patients will be happy, we will be happy -- everything will be happy.

Now, there was a question--

SENATOR BRAMNICK: No, somebody's not happy. The PBM's not happy.

(laughter)

MR. SHAH: Correct, but that's the purpose of it. Health care should be given; it should be accessed to everyone. Not here to make any speech on this. Here, my son was a doctor; second-year resident at RWJ, he was a cancer doctor. When I was talking to him, when he's listening on the dinner table every day, mother and father talking about PBM fights, he never

understood. He became a doctor now and everything -- "Dad, I understand my senior doctor saying they are not covering this cancer drug. I understand your PBM fights now."

Why that has to be that level? Why do we even have charitable pharmacies, where patients are constantly coming to my drugstore and telling me that, "Hey, I can't afford the insurance companies, I can't afford the premium, and I have to rely on you?"

Thank you.

SENATOR BRAMNICK: Just a question to the Chairman.

So, an insurance company -- and, we can call it PBM -- they could actually make it cheaper for you to do an online telemed examination, if a so-called sub company owned it? But, they wouldn't be live with the doctor, but they could lower their reimbursement -- or, should they eliminate a co-pay; they can eliminate a deductible.

A similar analogy to what they're doing here, they take away the face-to-face treatment of the pharmacist for cost purposes. Sounds logical.

DR. OUSTAEV: Senator Bramnick, it's not just for cost purposes. So, the cost is the net, the same in this model where they're telling my patient, "Oh, it's $0 with the mail order, but it's $150 at the local." It's the same cost; the difference is they're paying their own pharmacy the full value, so patients gets -- has to pay $0, versus if they go to me, they're paying me $150 less and pushing that on the patient so that the patient chooses to go to them.

SENATOR BRAMNICK: No, I understand. They're arguing that the overall cost to the system would come down if -- it's not going to, obviously-- What I'm trying to do is find a policy behind the rule or behind

the legislation that people would understand, and that PBMs would have to argue, "Hey, listen, we're doing that to save cost to the system, and you're buying it online, and we're excluding the pharmacist." I'm just trying to develop the policy behind the rule, that's all.

MR. PINTO: Going with the reimbursement model of NADAC -- and NADAC is based on surveys of thousands of pharmacies across the country. So, that's an average of the acquisition cost. So, that's basically a floor. And, then, to add on the -- as Anthony said, the $10.92 dispensing fee -- you pay that across the board, and that's as transparent as you can get.

SENATOR BRAMNICK: So, just one quick -- so, when I'm at Tiffany's and I'm waiting for the prescription -- which is not very long -- and I'm buying that other stuff, like the candy and the shaving creams, that's good, right?

MR. PINTO: I think so.

SENATOR BRAMNICK: OK, good, I'll continue to do that.

SENATOR LAGANA: Thank you, Senator.

So, I think we're -- would you like to say one more thing?

MR. SHAH: Yes.

Chairman, I heard in a testimony earlier -- in the next 30 seconds -- who decides which drug? And, that question was not answered by previous -- in the testimony. A doctor who decides on a patient which drug is the one should be dispensed -- must be dispensed by the pharmacist. Not for a financial model that, hey, we can keep -- by not dispensing this medication to the patient, but giving the other medication. Those kind of DUR intervention that is happening will be prevented, what Senator Bramnick

said, gives (indiscernible) -- similar pricing and similar reimbursement to the pharmacies. So, this will be happening.

Community pharmacies are afraid. They are afraid to come and make a complaint against this, because, you know what? They're constantly afraid that they will be given -- put out of their contract, and most patients will be forced to their own pharmacy. This is what is happening right now. That's why this will prevent so many issues.

Thank you, Chairman.

SENATOR LAGANA: Thank you.

Al, and then -- (indiscernible)

DR. OUSTAEV: Thank you. Just one -- a couple things that I wanted to bring up real quick.

So, the Department of-- Thanks to the work that you guys do for your constituents and hearing the people of New Jersey, you've passed some beautiful bills that are going into effect this year, in terms of regulating PBMs and the PSAOs. And, you asked them to unveil the curtain of what they're making in rebate dollars, and for a full transparency. But, there's one thing that's missing from that bill, and that's transparency into the agreements that they have through their GPOs.

So, PBMs, when the spotlight was pushed on them for transparency, saying, "You've got to pass every rebate dollar through to the employer, they said, "No problem." And, literally the next day, they created a shell company called a GPO. Each of the PBMs owns one -- Caremark owns Zinc; UnitedHealthcare owns Emisar Health; and, Express Scripts owns Ascent -- two of the three are located in a different country. Why? Those rebates now are being negotiated with manufacturers actively. I have

manufacturer friends who tell me that they are being prompted by Zinc, for example, on behalf of Caremark, to say, "If you want coverage through Caremark, you've got to push a rebate through Zinc." So, those are going to be dollars that you are not going to be seeing under the new bill, because they created a shell company to hide it. So, that's just one thing I wanted to put out there, that hopefully you guys can address and look into.

And, then, just the last thing in terms of pharmacies, just a few other things that I think we have to think about here. Payment terms -- Mississippi passed a new legislation under the-- They passed legislation, and they created a new committee under the Board of Pharmacy that is now in charge of monitoring PBMs for fair pay. Now, what this committee does is ensures that pharmacies are paid within seven days of submitting a claim, as opposed to what's happening today, which is, we get paid in 30 to 45 days with no transparency into it. I have to pay my wholesaler within 7 to 15 -- that's a net negative.

One thing that's interesting, too, is we have no transparency into whether we got the claim paid. They can audit us; we can't audit them. The day UnitedHealthcare got announced to the DOJ investigation -- which was I think a month ago, into their Medicare Advantage plans -- was the same day I got a deposit from the Medicare Advantage plans of UnitedHealthcare, Optum Rx, for claims for four years ago. Suddenly they appeared like magic. Interesting.

And, one thing that Georgia does, that I think would be really great if we could do here, is PBMs use audits like a weapon. They use it to intimidate us; they use it to threaten us. They once withheld $7 million from my company because of an "audit." And, they completely abuse their

privileges. I had to take it to arbitration for a contract, and we won, thank God. But, nine out of 10 would have closed their doors, because that's some of the things that they do.

I would like to propose that we think about legislation to limit their audits and the scope of their audits. Georgia, for example, limits a hundred claims per audit, and the audits are one per year. Mississippi limits one per quarter. But, the point is there are limits in place. Today, they audit us with impunity -- every day, every week, every month.

SENATOR LAGANA: Anthony, you want to close it out?

MR. REZNIK: I just forgot to mention -- besides Senator Gopal's bill, which is Medicaid related -- Assemblyman Freiman, Senator McKeon, they are sponsoring a similar bill, A4953, which he is planning to move out of the Assembly Finance and Insurance Committee, which also seeks to reduce pricing in commercial plans based on paying NADAC, which is the average acquisition cost.

Thank you.

SENATOR LAGANA: Thank you to the panel; thank you for coming. We appreciate it.

DR. OUSTAEV: Thank you all.

MR. PINTO: Thank you.

MR. SHAH: Thank you.

SENATOR LAGANA: So, that being the end of testimony, I just want to make a few points of why we're here, why it's important.

And, of course, the first thing is that we are -- we're worried about patient care to our constituents, that they have access to the often lifesaving prescription drugs that they need. We care about reducing costs, especially

to our taxpayers, from what we're able to regulate through State health benefits and other State-regulated plans. And, Anthony Reznik's testimony regarding our State budget, if those numbers are correct, it's pretty staggering how much it's increased over the years. So, that's a huge concern for us. And, fair competition is also something that we, of course, I would take very seriously. We don't-- We never, in any sort of business, want one to dominate the other through unfair practices. I'm not saying that there are any here.

And, I do know, again, that bills were recently signed into law creating additional transparencies which are playing out now as the months go along. We will continue, as this issue comes before us, to speak to the stakeholders. Right now, there aren't any bills that are up for consideration -- obviously not today, and not as we break for the summer. But, if anything gets considered in the future, and the Assembly is also doing hearings -- or they're finished with their hearings -- we'll make sure that we speak to all the stakeholders to ensure that the pieces that I talked about -- fair competition; patient care; reducing cost; and saving taxpayer dollars -- is primarily the point.

Again, not trying to choose one industry over the other, as far as who is the winner and who's the loser. So, that's what everyone should take out of today.

Senator Johnson, do you have anything to add, or you're ready to go home? (laughter)

SENATOR JOHNSON: Well, Chair, we've heard a lot today. I learned a lot about this industry, and I know that some legislation will be coming out of this.

But, like you said, we'll talk to all the stakeholders when it comes down to trying to put this together, and trying to take care of our constituents, which is what we are supposed to be doing; that's what we're sworn to do.

So, I want to thank all the folks who came to testify today. I learned a lot. And, because of their dedication coming here, there could be some legislation coming out eventually -- probably this calendar year.

Thank you, Chair.

SENATOR LAGANA: Thank you, Senator.

And, yes, also, thank you for everyone who came to testify today and for sticking around and listening to the testimony and providing us with information -- again, realizing we're just scratching the surface when it comes to this industry. It's very complicated, and we certainly don't wish to make it less complicated than it is, but we'll continue to speak as we go forward.

Thank you, everyone. Thank you very much, everyone.

(MEETING CONCLUDED)