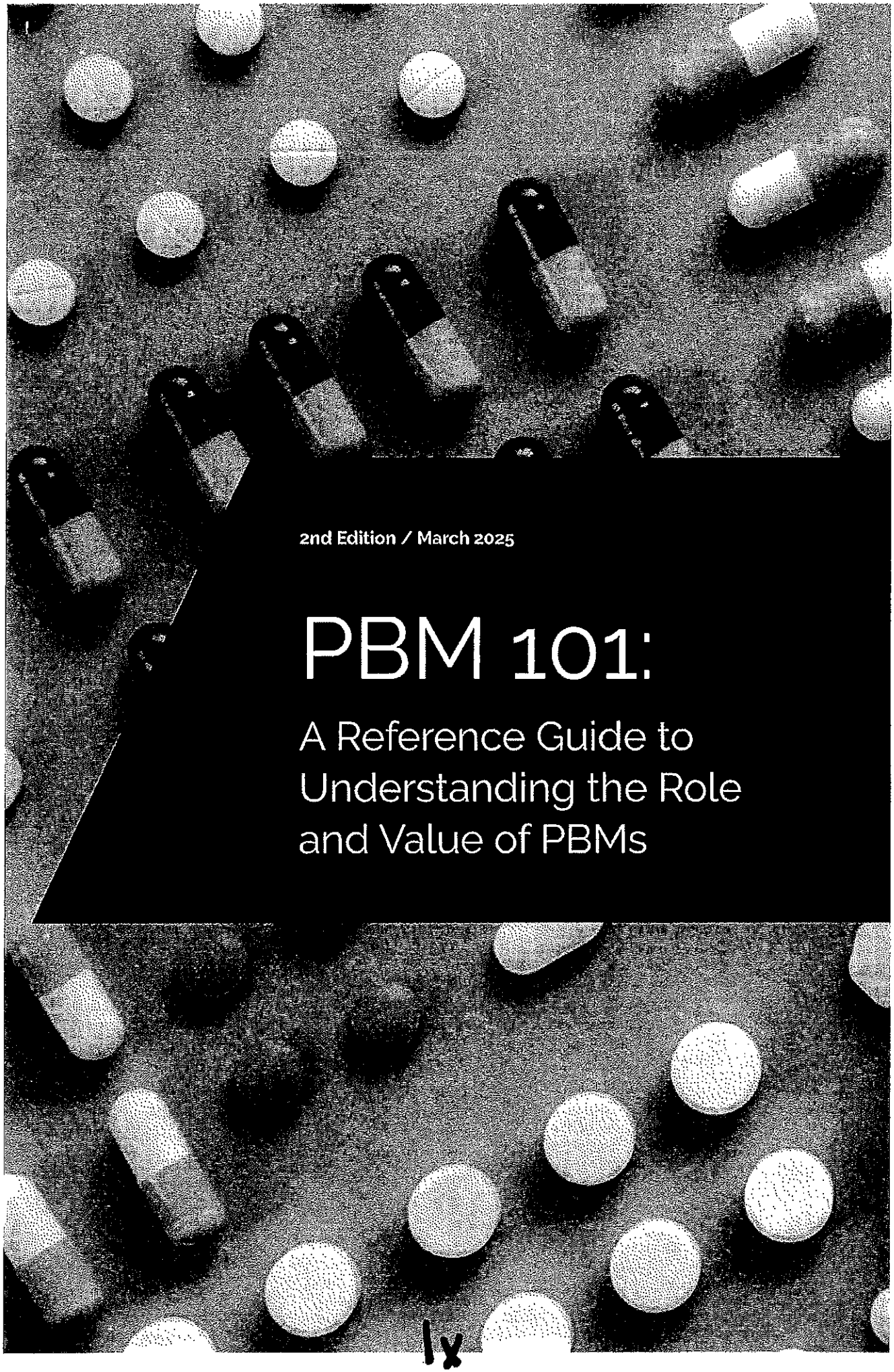
APPENDIX



2nd Edition / March 2025

PBM 101:

A Reference Guide to Understanding the Role and Value of PBMs

2x

Contents

Throughout this document you will see drug pricing terms. Click or scan the QR code to access PCMA's Glossary of Drug Pricing Terms.

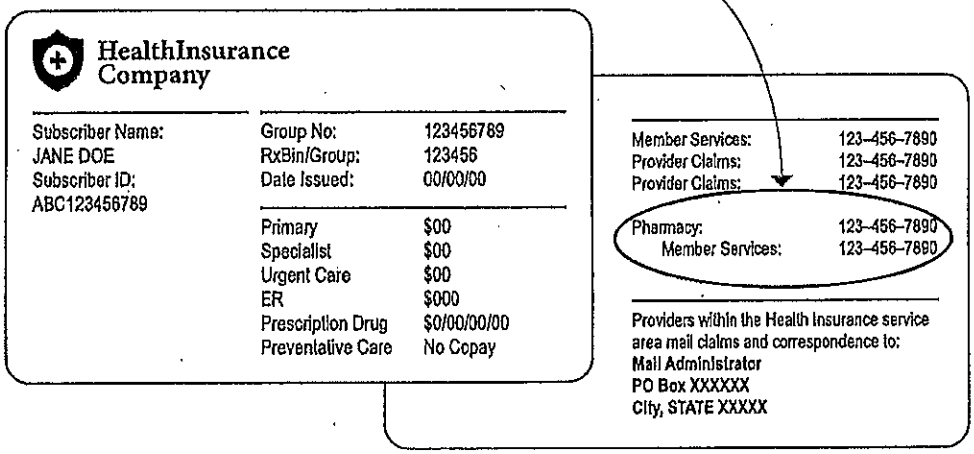
Research HUB To access the latest research from PCMA, please click or scan the QR code.

3x

The basics

What is a pharmacy benefit?

A pharmacy benefit is the part of your health insurance that covers prescription drugs. Under most health care coverage today, drug benefits are subcontracted and administered by an entity known as a pharmacy benefit manager (PBM). Typically, you can find out about your pharmacy benefit—your prescription drug coverage—by calling a number on the back of your insurance card.



What are PBMs?

PBMs are hired by health plan sponsors, including employers, unions, and government programs, to help provide prescription drug coverage to more than **289 million people** in the US.[1] PBMs help the entire health care system by driving down drug costs, saving payers and patients an average of **$1,154 per person per year,**[2] and providing **$145 billion in overall value to the health care system annually.**[3]

Click or scan the QR code to learn more.

4x

What are PBMs' core functions?

PBMs do four main things:

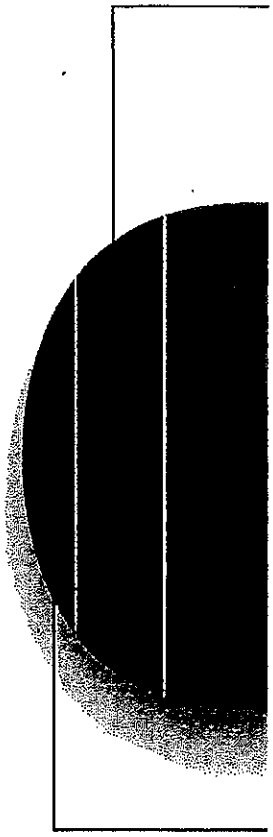
1. Negotiate savings for brand drugs from manufacturers
2. Negotiate with pharmacies to reduce costs
3. Review and settle insurance claims for prescription drugs at the time of dispensing
4. Provide tools and programs to support patients and clinicians

5x

How are PBMs paid for their services?

Employers and other health plan sponsors decide how they pay for pharmacy benefit company services.

» **Spread:** Pharmacies charge different amounts for drugs. For example, prices for a drug can vary based on whether a pharmacy is in or out of a consumer's network or whether the pharmacy purchases more or less expensive versions of a drug. To manage these fluctuating costs, an employer or health plan may ask its PBM to carry the risk that patients choose costlier pharmacies to fill their prescriptions, allowing the plan sponsor to pay a set reimbursement for each drug regardless of the pharmacy chosen. If the pharmacy charges the PBM more than the reimbursement rate agreed between the plan sponsor and the PBM, the PBM takes a loss. If the pharmacy charges less, the PBM earns a margin. Smaller employers often choose "spread contracts"[4] because of pricing predictability and potential savings.



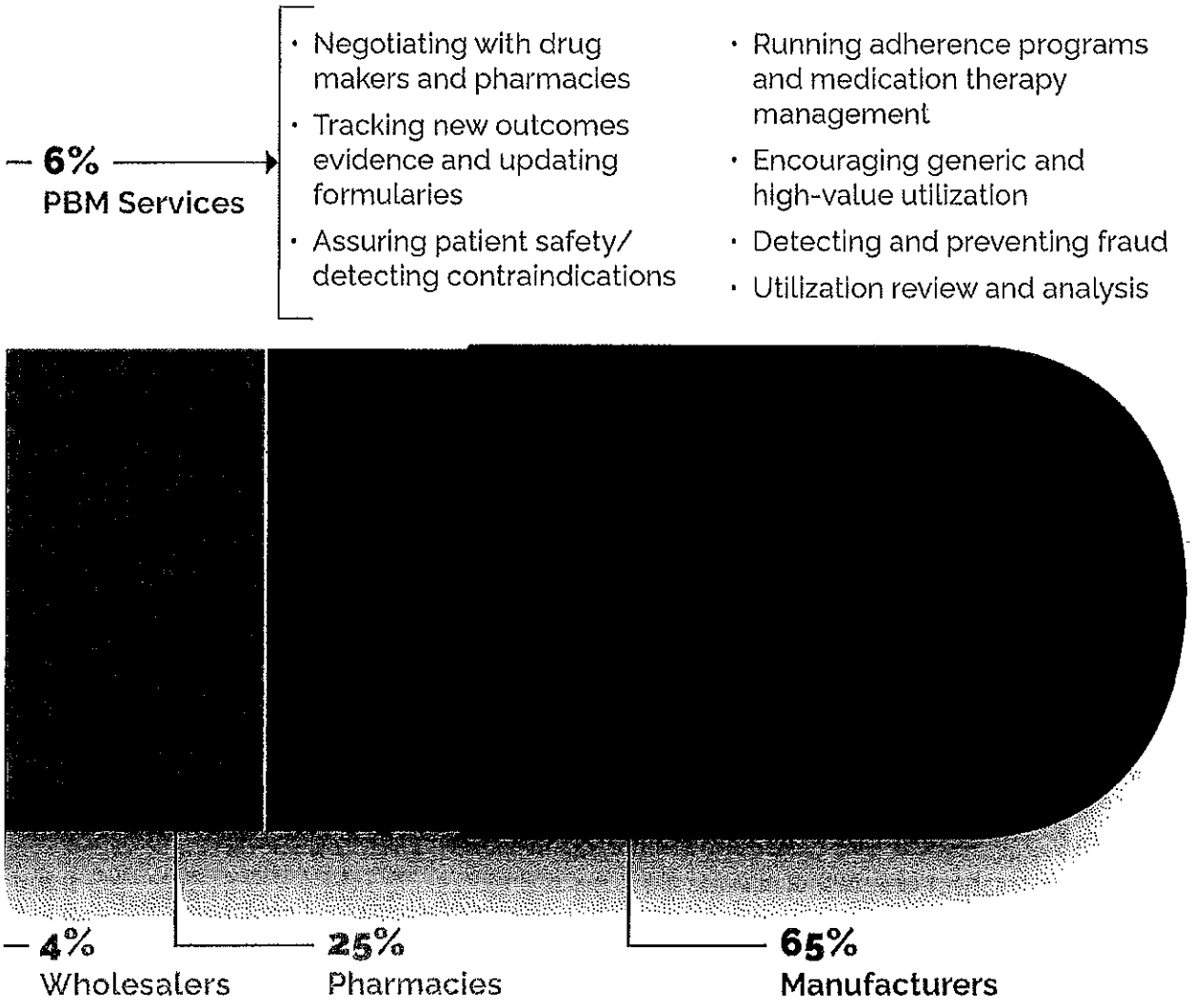
» **Rebate retention:** Health plan sponsors may choose to pay for drug benefit administration services by asking the PBM to retain a portion of drug company rebates, aligning incentives toward cost savings. This is a less common payment model among large employers. Data shows most rebates are passed through the PBM to the health plan sponsor (99.6% in Medicare and 91% in commercial health plans).

» **Administrative fee:** Plan sponsors may choose to pay the PBM a fee to administer claims and pay the PBM whatever the pharmacy charges (based on the contract between the pharmacy and PBM). Many large employers prefer this compensation model over a spread model because they have the scale to absorb the variability. Plan sponsors may also choose to pay administrative fees for rebate administration rather than allowing the PBM to keep a small portion of the rebates.

6x

Share of drug dollar retained by drug supply chain participants

90% of the Rx dollar is retained by drug manufacturers and pharmacies



Source: Visante estimates, based on data published by IQVIA, Pembroke, Altarum, USC Schaeffer, and Health Affairs. 2023. Figure displays estimated total net expenditures (after rebates), both brands and generics. Includes only traditional PBM services, and excludes prescriptions filled by PBM-owned mail/specialty pharmacies, which cost less than retail but provide added margins to PBMs who own mail/specialty pharmacies.

7x

PBM market dynamics

Are all PBMs the same?

PBMs vary in size, geographic footprint, service offerings, and focus. The PBM market is dynamic and diverse with **more than 70 full-service PBMs,**[5] which reflects the wide range of needs of the business partners that rely on PBM expertise to make robust prescription drug coverage available and accessible. While PBM business models vary, in general, PBMs do the following:

» Secure savings for plan sponsors, patients, and taxpayers.

» Enable better health outcomes for patients.

» Provide health plan sponsors with a wide range of choices for prescription drug coverage.

Is the market growing or shrinking?

» Over the most recent four years analyzed (2019–2023) there was an **18% increase in new full-service PBMs.**[6]

» New entrants are winning business and major clients are switching their PBMs, sometimes in headline-grabbing ways, demonstrating the strength of PBM competition and the numerous choices available for employers.

8x

Are customers happy?

Employers are overwhelmingly pleased with the options PBMs offer and the services provided.

Results of NORC-conducted survey of employers

96%
of respondents felt confident in their organization's ability to make decisions regarding prescription drug benefits correctly.

90%
of survey respondents expressed satisfaction with their PBMs' clarity and transparency of contract terms.

88%
of survey respondents expressed satisfaction with their PBMs' ability to provide the lowest costs for employees at the pharmacy counter.

Source: NORC. 2024. https://www.norc.org/research/projects/employers-experiences-managing-prescription-drug-benefits.html.

PBM innovation in action

PBM innovation at work: Employers and unions are grappling with pharma's extreme price setting on weight loss drugs with list prices ranging from $1,060 to $1,350 per month, combined with high patient demand. PBMs are responding by deploying their ability to negotiate discounts to bring down the cost of those treatments to help make them more affordable for employers to cover. PBMs are also using their expertise to actively support health plan sponsors that choose to add GLP-1s for weight loss to their prescription benefits by offering comprehensive programs to help the right patients gain access to these treatments, combined with services that will help maximize the chances of long-term treatment success. The programs generally consist of a behavior support component to help patients make permanent changes related to obesity, including diet and exercise in tandem with the use of GLP-1s.

Click or scan the QR code to learn more about the PBM Innovation Project. →

9x

How do PBMs support patients?

PBMs add clinical value and advance better health outcomes by:

» **Supporting patient safety** by preventing potentially harmful drug interactions and reducing medication errors.

» **Helping patients understand** how and when to take their medication. PBMs offer 24/7 customer service support, coaching and counseling services, text and phone alerts, specialized packaging to manage dosing with dates and times, and targeted services focused on adherence for the elderly, disabled, homebound, non-English speaking, and other groups in need of additional support.

» **Improving care coordination.** PBMs use technology including real-time benefit tools (RTBTs) and electronic prior authorization to benefit patients, their prescribers, and the pharmacies they use. Using PBM technology at the point of prescribing, physicians and patients can learn whether a drug is covered, what cost sharing may apply, what alternatives are available, and whether additional steps may be needed to access a drug.

PBMs help patients afford their medications.

» PBMs administer over 3.6 billion scripts annually.[7] Without the savings PBMs negotiate, patients and payers could pay much more for prescription drugs.

» PBMs design and offer programs to manage patients' cost sharing.

10x

PBMs partner with pharmacists to benefit patients.

» PBMs establish broad networks of affordable, high-quality pharmacies that patients can rely on to get their drugs.

» PBMs advocate for pharmacists' ability to practice at the top of their training to give patients more options to receive care in person or through telepharmacy.

PBMs help make drugs accessible to patients.

» PBMs and health plan sponsors recognize the challenges posed by social determinants of health and proactively explore solutions.

» PBM programs like home delivery help to improve access for patients with transportation challenges and those living in areas where pharmacies are less accessible.

11x

How do PBMs support plan sponsors?

Plan sponsors are entities—employers, government programs like Medicare and Medicaid, labor unions, health insurers, and state employee and retiree plans, etc.—**that provide health care coverage.**

Health plan sponsors choose the design of their drug benefits and participant cost sharing. PBMs offer a wide range of services and choices.

PBMs help employers, unions, and other plan sponsors by:

- **Negotiating with drug companies and pharmacies to lower drug costs.** PBMs also encourage the use of generic drugs, push pharmacies for high-quality performance, and negotiate value-based purchasing programs.
- **Providing business and operations expertise.** PBMs provide plan sponsors with a variety of coverage choices and flexibility in benefit design and payment structure.
- **Providing coverage recommendations.** PBMs help plan sponsors navigate coverage options, beginning with recommendations based on analyses performed by independent pharmacy and therapeutics (P&T) committees made up of clinical experts who review and evaluate clinical evidence.

Click or scan the QR code to learn how PBMs determine what drugs they will recommend for coverage.

12x

» **Developing networks of high-quality pharmacies.** PBMs help select the right mix of brick-and-mortar, home delivery (mail order), and specialty pharmacies for plans' networks to ensure broad access.

  - PBM programs like home delivery help to improve access for patients with transportation challenges and those living in areas where pharmacies are less accessible.

» **Recognizing and addressing health equity concerns.** Among other things, PBMs work with health plan sponsors to recognize the challenges posed by social determinants of health and proactively explore solutions to address health disparities and advance heath equity.[8]

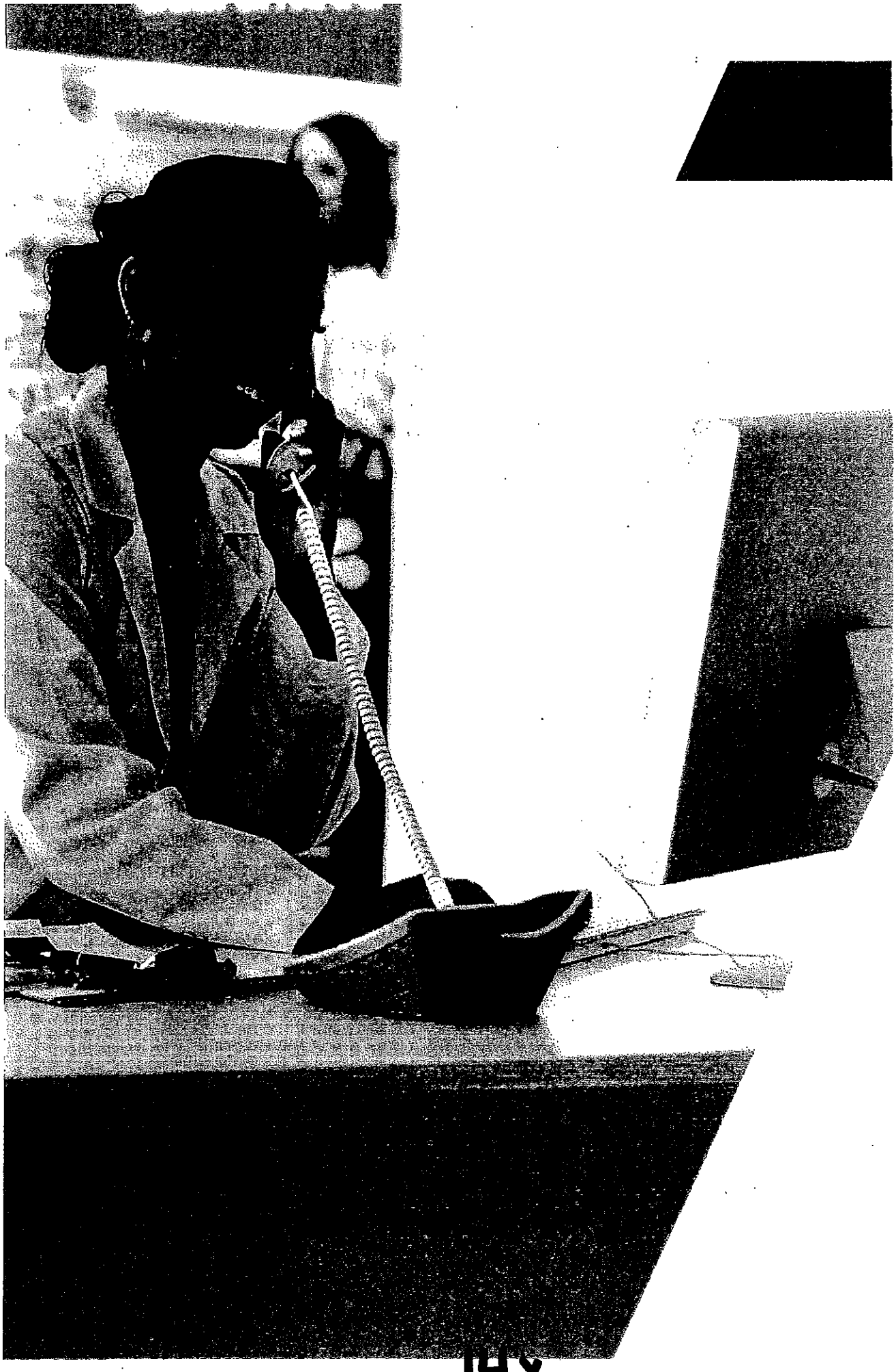
Click or scan the QR code to download the PCMA Members Health Equity Progress Report.

How do health plan sponsors choose their PBM?

Plan sponsors solicit PBM bids. Plan sponsors typically shop for PBMs using benefits consultants and requests for proposals (RFPs), which include hundreds of requirements and questions that PBMs must respond to in order to be considered for selection. PBMs compete hard for business and tailor their offerings to meet plan sponsors' needs.

What obligations does the PBM have in relation to the health plan sponsor?

Following contractual requirements. PBM contracts are comprehensive and include everything the PBM is required to do to fulfill its obligations to the plan sponsor. Plans can choose their preferred level of transparency, payment method, plan design, and more, and PBMs must administer the benefit exactly as the sponsor desires. Plan sponsors have the right to audit their PBMs, and PBMs also audit pharmacies on behalf of plan sponsors to ensure plan resources are used appropriately.



PBMs partner with pharmacies

PBMs partner with pharmacies to benefit patients.

» PBMs establish broad networks of affordable and high-quality pharmacies that patients can rely on to get their medications.

» PBMs facilitate patient access by helping plan sponsors to select the right mix of brick-and-mortar, mail-order, and specialty pharmacies for their networks.

- As of 2024, there are 23,384 independent pharmacies and 36,209 chain pharmacies for a total of 59,593.
- **Over the last 10 years (2014–2024), the number of independent retail pharmacies nationwide increased by 1,287 stores or 5.8%. In contrast, the number of retail chain pharmacies decreased by 4,149 stores or 10.3%.**

Mail-service and specialty pharmacies will generate more than $274 billion in savings over the next 10 years

Over the next 10 years, savings from mail-order pharmacies are projected to be **over $23.5 billion.**

Pharmacy benefit managers are projected to generate more than **$250 billion in savings** on specialty medications over the next 10 years.

Source: PCMA 2023. https://www.pcmanet.org/wp-content/uploads/2023/11/Mail-Order-and-Specialty-Savings_FINAL-1.pdf.

15x

PBMs strive to maintain pharmacy access in rural communities.

» PBMs offer innovative programs in rural communities to support increasing pharmacy reimbursements including expanding reimbursements for clinical services performed at independent pharmacies.

» A strong relationship between PBMs and rural pharmacies improves affordability and access for patients.

» PBMs have programs designed to identify and assist patients living in rural areas who may have specific needs, including connecting them to available pharmacies and other sources of clinical and social resources—for example, diaper banks and food banks—to help them lead healthier lives.

PBMs partner with and support rural independent pharmacies and their patient populations by:[9]

16x

How do PBMs generate value?

PBMs help secure lower health care costs for their customers and patients.

PBMs help save payers and patients 40–50% of their annual drug and related medical costs compared to what they would have spent without PBMs.[11] Recent research shows that for the vast majority of prescription drugs, patients pay less by having and using their health insurance.[12]

What would the world look like without PBMs?

Pharmacy benefit companies provide critical services that make drugs affordable for patients, saving $148 billion each year.

Click or scan the QR code to learn more about a world without PBMs.

PBMs help the entire health care system by driving down drug costs, saving payers and patients an average of **$1,154 per person per year.**[13]

18x

PBMs provide value and achieve savings in part by:

» **Negotiating with drug companies for rebates**—empowering the private market to drive down drug costs.

Four facts about rebates

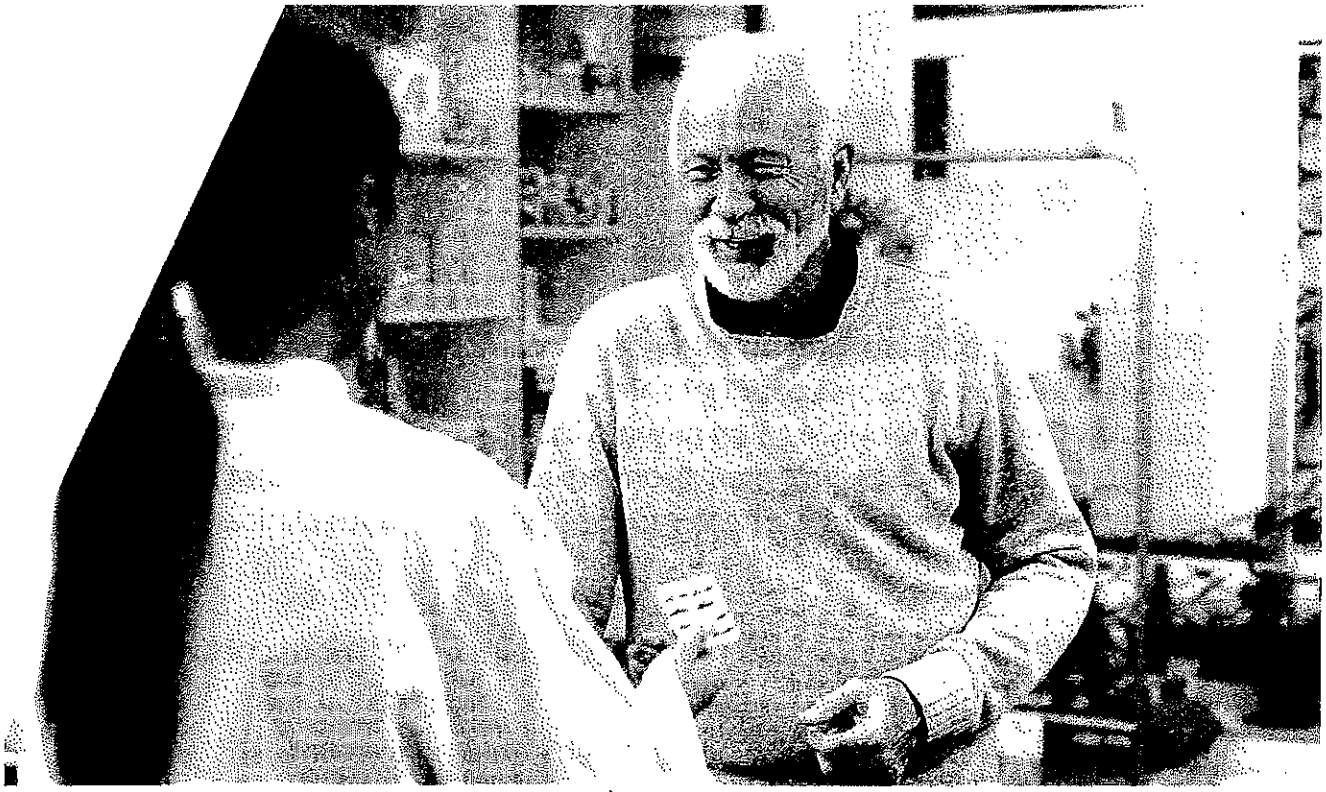
Statistical analysis of the top brand drugs found no correlation between rising list prices set by drug manufacturers and the change in rebate levels negotiated with PBMs.[14]

The Health and Human Services (HHS) Office of Inspector General (OIG) found that PBM-negotiated rebates led to lower prescription drug costs in the Medicare prescription drug program.[15]

For more than a third of the brand-name drugs it reviewed, OIG found that rebates declined as costs increased. The same report also found that the majority (95.6%) of Medicare Part D brand-name drug costs increased regardless of rebates over the five-year period examined.[16]

Pharmaceutical manufacturers take enormous price increases for Part D drugs without rebates and for Part B drugs, for which PBMs do not negotiate rebates.[17]

19x



PBMs improve drug adherence:

» Research indicates that non-adherence is largely attributable to financial barriers. The term "financial toxicity" was coined to reflect the adverse financial strain of medication non-adherence.[18]

» By improving patient affordability, reviewing claims for indicators of non-adherence, providing clinical and other patient support programs, and providing targeted services focused on adherence for groups in need of additional support, PBMs improve drug adherence.

PBMs provide additional value by:

» Encouraging pharmacies to elevate quality and reduce costs.

» Preventing fraud, waste, and abuse through pharmacy audits.[19]

» Increasing efficiency with shorter claims processing times and reducing the need for paper claims.

» Providing a plethora of real-time coverage and cost information to patients and prescribers.

PBMs provide clinical value

PBMs support patients by using their expertise to provide medication adherence programs and conduct safety checks on prescriptions. Clinicians working for PBMs also provide tools and support to providers, pharmacists, and plan sponsors to help increase safety and access to medications. These processes involve both clinical and operational components.

PBMs hire clinicians to help support better health outcomes for patients.

PBM clinicians improve health outcomes by helping to establish medication therapy management (MTM) programs, which target patients who are on multiple medications and can benefit from improving the use of medications. These patients are then partnered with a pharmacist to have a one-on-one discussion about their medications, look for common problems with taking the medications, and make recommendations for changes to a medication or create a list of things for the patient to try.

Clinicians in the PBM setting also focus on patient adherence and safety by:

- Recommending plan sponsors allow patients to get a 90-day supply on most medications through retail or mail order.
- Having a pharmacist available 24/7 to answer questions about medications or coverage.
- Evaluating the appropriate and safe use of medications by conducting a drug utilization review (DUR) for all drugs billed to the PBM regardless of source pharmacy.
- Working with mail-order pharmacies to improve access to medications.
- Creating adherence or patient assistance programs to help patients afford their medications.
- Developing care coordination for patients with complicated diseases and therapies, such as partnering with home infusion services, social or behavioral therapists, and others.

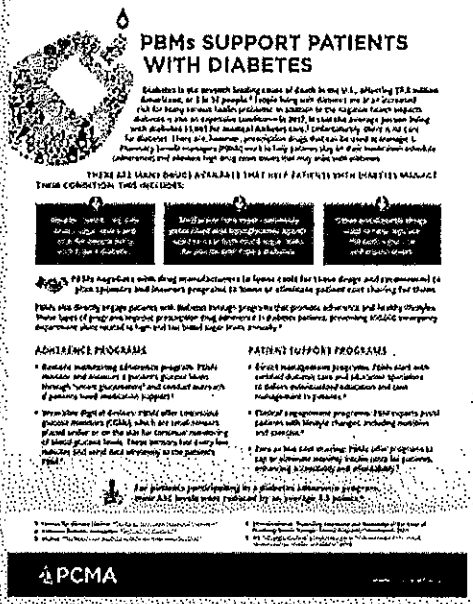
22x

PBM clinical programs support patients

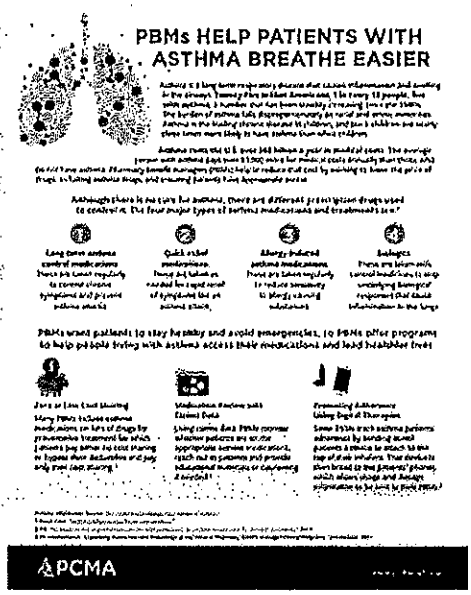
Availability of care coordination can be illustrated by looking at PBMs' efforts with pre-diabetic patients and the related efforts to manage co-morbidities for both diabetics and pre-diabetics (e.g., hypertension and obesity).

Click or scan the QR code to listen to the PBMs and Diabetes Care podcast.

Click or scan the QR code to learn more about PBM involvement in care coordination.



Click or scan the QR code to learn more about how PBMs make a difference in medication adherence for diabetics taking insulin.



Click or scan the QR code to learn more about how PBMs make a difference in medication adherence for asthmatic patients.

23X

PBM clinicians help other clinicians maneuver a complicated pharmacy system.

- PBMs encourage providers to use RTBTs that interface directly with electronic medical records to help providers understand the patient's drug benefit. This tool helps providers ensure safety by analyzing the clinical data provided by PBM clinicians for drugs that require additional information or laboratory values.
- PBM clinicians engage with providers to discuss duplicate or suboptimal therapies.
- PBMs are constantly reviewing drug interactions or other drug-related concerns and providing the information to the pharmacist or providers.
- Many PBMs coordinate drug regimens with other health care services the patient is receiving, including from specialists.
- PBMs help providers gain access to medications that may be hard to get from traditional pharmacies or wholesalers.

24x

PBMs provide clinical support to employers and other plan sponsors by:

» Overseeing medication utilization, managing formularies, and ensuring cost-effective pharmacy services.

» Evaluating new drugs entering the market.

» Monitoring and communicating clinical trends, reviewing relevant pharmacy data, and providing recommendations/supportive rationale for clinical management strategies.

» Designing clinical programs to optimize how drugs work to improve outcomes and adherence and reduce overall health care expenses.

» Restructuring pharmacy benefits as necessary to comply with new or changing laws.

PBMs provide clinical value through operations and compliance support.

» PBMs conduct audits to ensure the plan sponsors' costs, care, and quality are appropriate.

» PBM clinicians may also include forecasting and modeling services to help plan sponsors with financial reports to help guide decisions on which drugs the plan sponsor covers and which programs to implement.

» Pharmacists and other clinicians within the PBM monitor the changes to state and federal laws. New laws impact pharmacy benefit design, and plan sponsors are then faced with new decisions on the programs and offerings they want for their plan participants. PBM clinicians support plan sponsors as they make these decisions.

What do PBMs do for your state?

This map indicates savings by state across all insurance markets over 10 years (2025–2034)

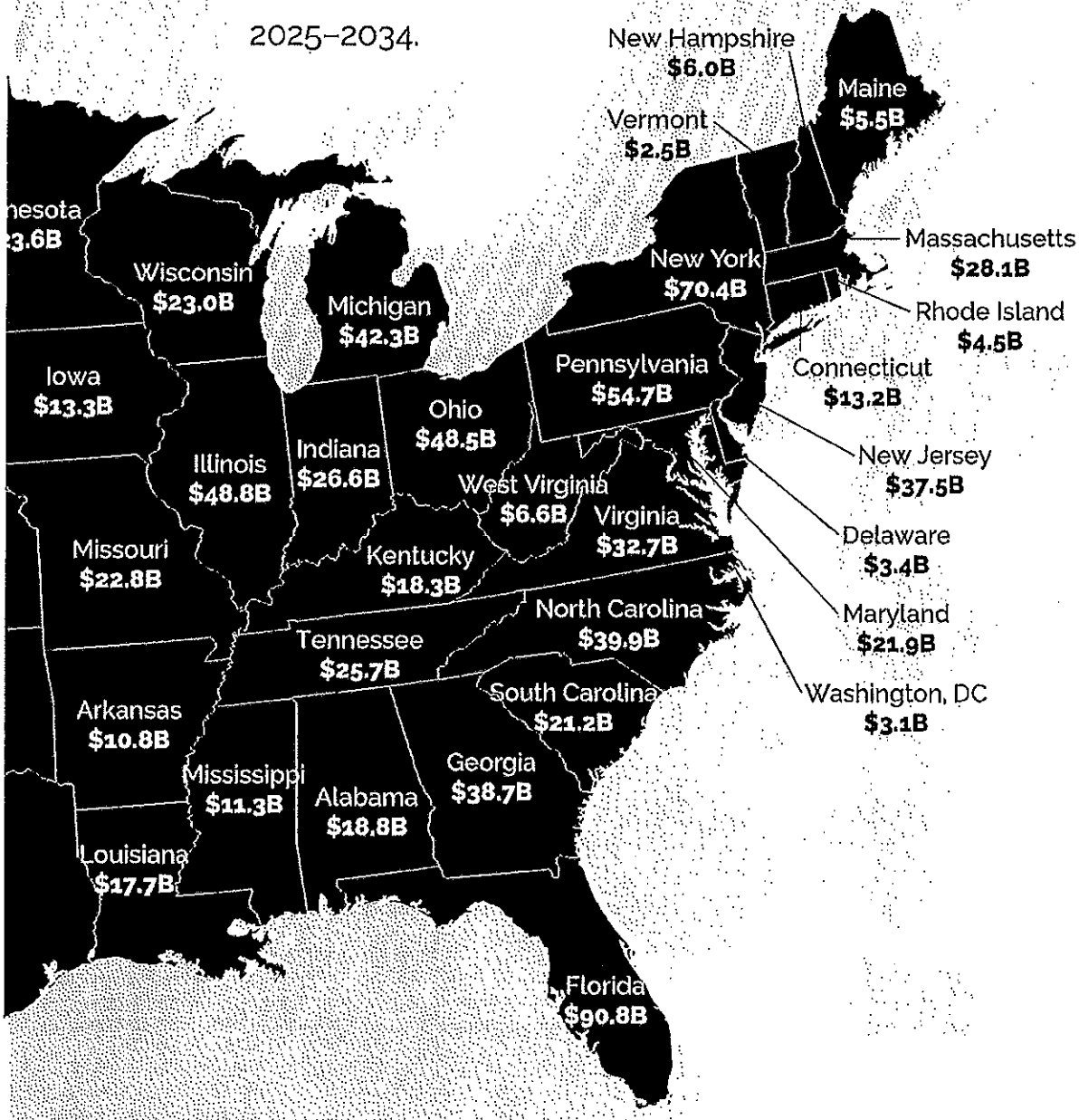
Source: Visante/ECSD Consulting. February 2025.

26x

The use of PBM tools will save payers and patients nationally more than

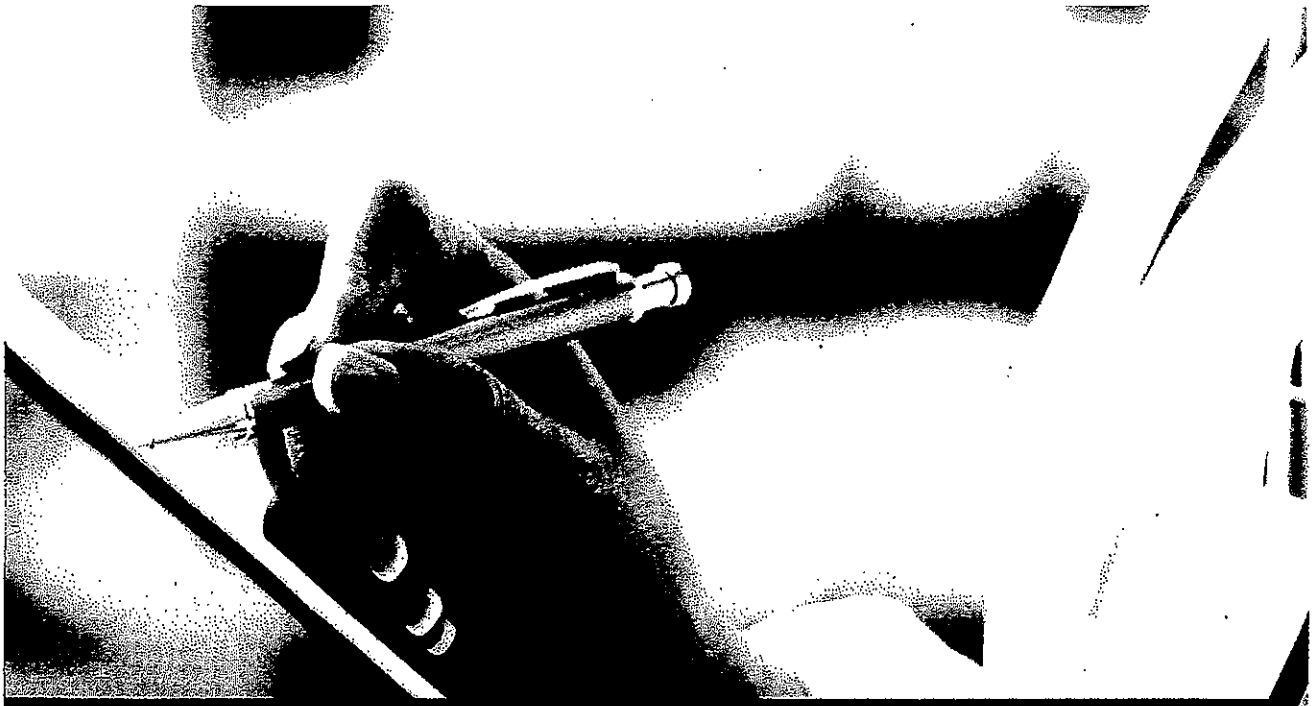
$1.2 trillion

2025–2034.



Across the United States, PBMs employ **more than 28,000 clinicians,** including **more than 9,500 pharmacists.**

27x



Endnotes

1 Visante/ECSD Consulting. 2025. https://www.pcmanet.org/wp-content/uploads/2025/02/ROI-on-PBM-Services.pdf.

2 Ibid.

3 National Bureau of Economic Research. 2022. https://www.nber.org/papers/w30231/.

4 PCMA. 2020. https://www.pcmanet.org/wp-content/uploads/2020/06/PCMA-Infographic-How-Risk-Mitigation-Spread-Pricing-Helps-Drive-Lower-Drug-Costs_final.pdf.

5 PCMA. 2024. https://www.pcmanet.org/rx-research-corner/the-pbm-marketplace-is-more-competitive-not-less/05/08/2023/.

6 Ibid.

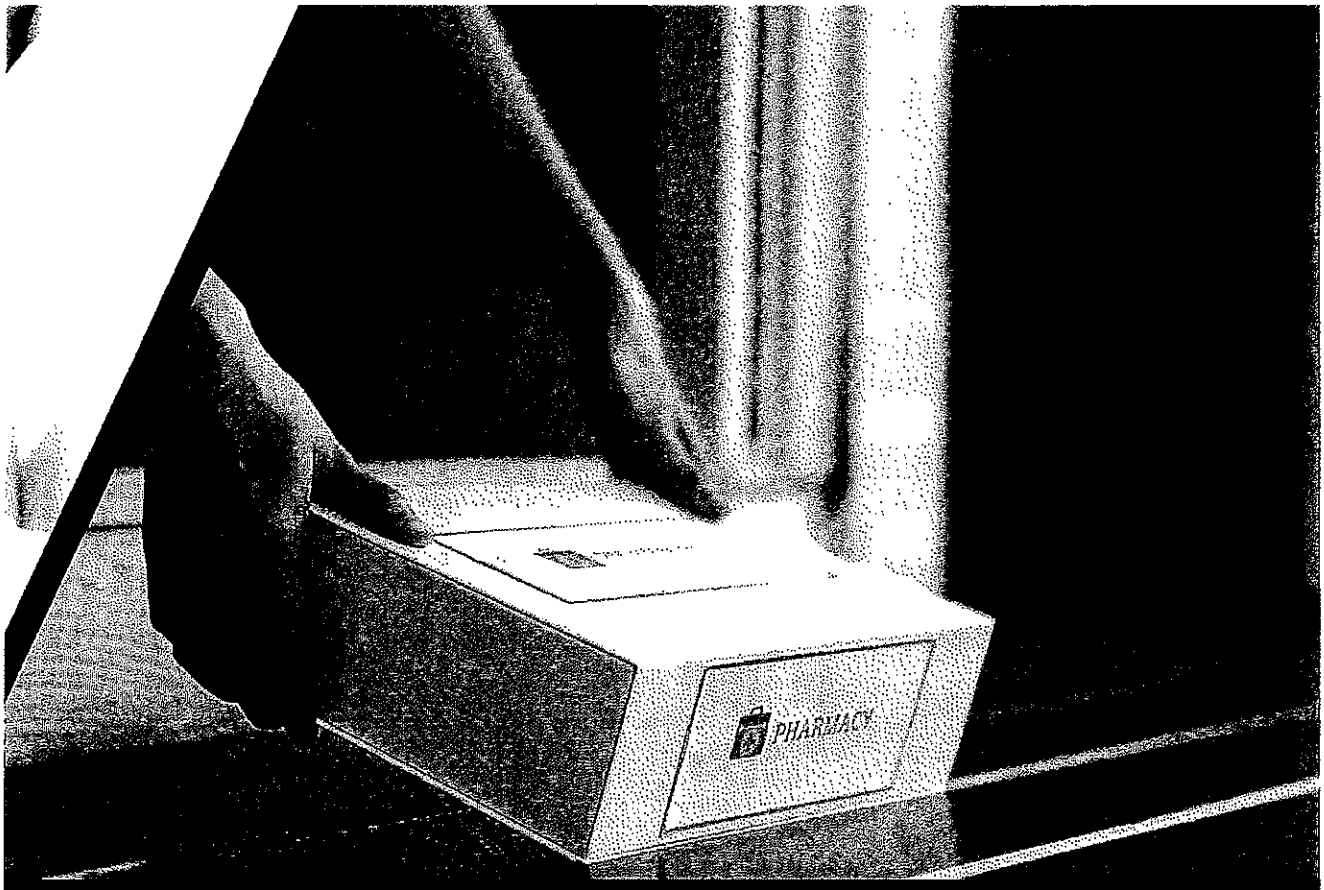
7 KFF. 2019. https://www.kff.org/health-costs/state-indicator/total-retail-rx-drugs/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

8 PCMA. 2023. https://www.pcmanet.org/wp-content/uploads/2023/11/PCMA_Health-Equity-Progress-Report-.pdf.

9 PCMA. 2024. https://www.pcmanet.org/wp-content/uploads/2024/04/Pharmacy-Benefit-Companies-Support-Rural-Independent-Pharmacies_r538.pdf.

10 Top Pharmacy Services Administrative Organizations (PSAOs) based on Pharmacy Count by State. Milliman 2024.

28x



11 Visante/ECSD Consulting. 2025. https://www.pcmanet.org/wp-content/uploads/2025/02/ROI-on-PBM-Services.pdf.

12 JAMA. 2024. https://jamanetwork.com/journals/jama-health-forum/fullarticle/2819897.

13 Visante/ECSD Consulting. 2025. https://www.pcmanet.org/wp-content/uploads/2025/02/ROI-on-PBM-Services.pdf.

14 Visante. 2024. https://www.pcmanet.org/wp-content/uploads/2024/07/Price-Increases-Not-Correlated-with-Rebate-Changes47-1.pdf.

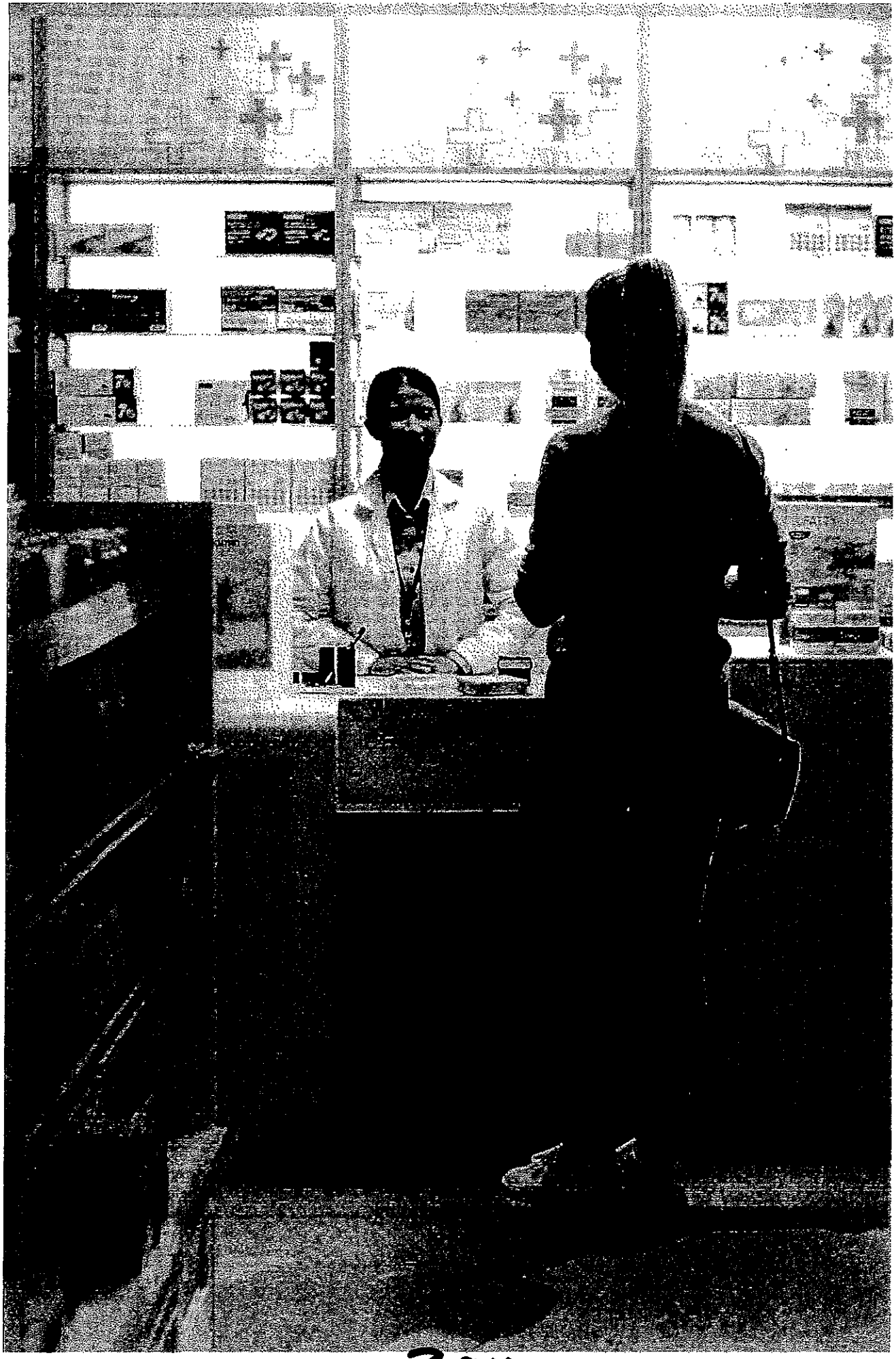
15 HHS OIG. 2019. https://oig.hhs.gov/oei/reports/oei-03-19-00010.pdf.

16 Ibid.

17 Visante. 2018. https://www.pcmanet.org/wp-content/uploads/2018/08/Reconsidering-Drug-Prices-Rebates-and-PBMs-08-09-18.pdf.

18 Valero-Elizondo, J., Javed, Z., Khera, R. et al. 2022. https://doi.org/10.1186/s13690-022-00987-z.

19 Health Evaluations. 2023. https://www.pcmanet.org/wp-content/uploads/2024/12/PBM-Pharmacy-Audit-White-Paper-1.pdf.



30x

SIX

PCMA

ABOUT PCMA

PCMA is the national association representing America's pharmacy benefit companies. Pharmacy benefit companies are working every day to secure savings, enable better health outcomes, and support access to quality prescription drug coverage for more than 289 million patients. Learn more at www.pcmanet.org.

2nd Edition / March 2025

www.pcmanet.org

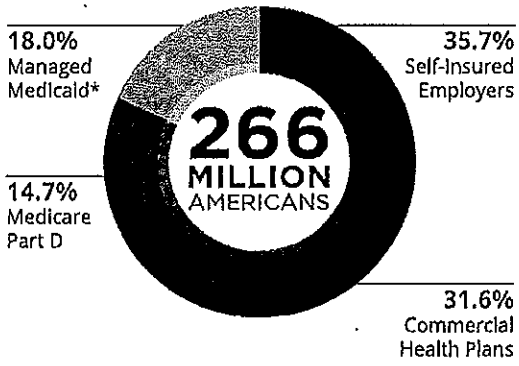
32x

ABOUT PCMA

The Pharmaceutical Care Management Association (PCMA) is the national association representing America's pharmacy benefit managers (PBMs). PBMs administer prescription drug plans for more than 266 million Americans who have health coverage from a variety of sponsors. PCMA continues to lead the effort in promoting PBMs and the proven tools they utilize, which are recognized by consumers, employers, policymakers, and others as key drivers in lowering prescription drug costs, increasing access, and improving outcomes.

PBMs serve consumers across plan types

Americans With Drug Benefits Managed by PBMs, by Type of Coverage



* Excludes "Medicare/Medicaid Dual Eligibles" where drugs are covered by Medicare Part D

How PBMs reduce drug costs

- Encouraging the use of generics and affordable brand medications
- Reducing waste and increasing adherence to improve health outcomes
- Offering home delivery of medications and creating networks of affordable and high quality pharmacies
- Negotiating rebates from drug manufacturers and discounts from drugstores
- Managing high-cost specialty medications

PBMs promote pharmacy access

PBMs work with health plans, employers, and government programs to ensure that their members and employees have access to necessary medications through a variety of pharmacies, including retail, community, mail order, and specialty pharmacies.

PBM savings

PBMs are projected to save employers, unions, government programs, and consumers $654 billion — up to 30 percent — on drug benefit costs over the next decade, according to research from Visante.

$654 BILLION SAVINGS

Source: Visante, estimates prepared for PCMA. (2016).

PCMA MEMBERS

ABARCA
CastiaRx
Cigna
CVSHealth
envolve Pharmacy Solutions
Humana Pharmacy Solutions
MagellanRx MANAGEMENT
MAXORplus
MedImpact
meridianRx
OPTUMRx
PERFORMRx Next Generation Pharmacy Benefits
PRIME THERAPEUTICS
RXSENSE
SERVE YOU Rx
WellDyneRx

JUST THE FACTS

Patient Savings and Independent Pharmacy Access in New Jersey

PBMs are advocates for patients and payers in the fight against high drug costs

PBMs cover
8,390,000
New Jerseyans.[1]

PBMs will save New Jerseyans
$37.5B
across all New Jersey insurance markets over ten years (2025–2034).[2]

PBMs processed
101.2M
prescriptions in New Jersey in 2023.[3]

PBMs save payers and patients an average of $1,154 per person per year.[4]

PBMs drive prices down by forcing manufacturers to compete with one another.

SAVINGS ARE REALIZED THROUGH:

- Encouraging the use of generic and lower cost brand drugs
- Reducing waste and increasing adherence
- Negotiating price concessions with drug manufacturers
- Creating networks of affordable, high quality pharmacies
- Providing clinical support to patients taking specialty medications

Nationwide, the independent pharmacy marketplace is stable.[5]

In New Jersey, between 2015 and 2025, **the number of independent pharmacies grew from 845 to 969, a 14.7% increase.**[6]

Nationally, the number of chain pharmacies decreased by 14.1% over the last 10 years.[6]

50.5% of pharmacies in New Jersey are independent pharmacies.[6]

Independent pharmacies say they're getting squeezed out of business, but according to the National Council of Prescription Drug Programs (NCPDP) data and the National Community Pharmacists Association (NCPA), the number of independent pharmacies has generally been stable. Adam Fein's Drug Channels also found that the independent pharmacies' financials have also been steady. From 2019 to 2023, the average per prescription gross profit margin for independent pharmacies fluctuated slightly between about 20% and 21%.[7]

94% of independent pharmacies in New Jersey use a Pharmacy Services Administrative Organization (PSAO) to negotiate with PBMs on their behalf.[8]

1 Visante analysis of US Census state population data, CMS enrollment data, and Kaiser Family Foundation data, see The Return on Investment (ROI) on PBM Services, 2025.

2 Visante, "PBMs: Generating Savings for Plan Sponsors," 2025.

3 PCMA acquired 2023 IQVIA data. The statements, findings, conclusions, views, and opinions contained and expressed in this report are based in part on data obtained under license from the following IQVIA Institute information service: IQVIA PayerTrak data for PCMA, 2022, IQVIA Inc. All rights reserved.

4 Visante, "The Return on Investment (ROI) on PBM Services," 2025.

5 PCMA, The Independent Pharmacy Marketplace is Stable.

6 Quest Analytics analysis of NCPDP pharmacy data, 2025. Pharmacy count data is from January of a given year.

7 Drug Channels, "The 2025 Economic Report on U.S. Pharmacies and Pharmacy Benefit Managers," March 2026.

8 Milliman, "Pharmacy Services Administrative Organization (PSAO) Landscape," 2024.

ABOUT PCMA

PCMA is the national association representing America's pharmacy benefit companies. Pharmacy benefit companies are working every day to secure savings, enable better health outcomes, and support access to quality prescription drug coverage for more than 289 million patients. Learn more at www.pcmanet.org.

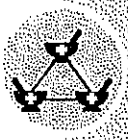
PCMA

www.pcmanet.org

34x

PHARMACY BENEFIT MANAGERS: INNOVATIVE TOOLS AND TECHNIQUES

All PBMs offer a core set of services to manage the cost and utilization of prescription drugs and improve the value of plan sponsors' drug benefits. Some offer additional tools, such as disease management, that can target specific clinical problems for intervention. It is up to the client of the PBM, however, to determine the extent to which these tools will be employed. **Such tools include:**



Pharmacy networks — PBMs build networks of more than 60,000 retail pharmacies to provide consumers convenient access to prescriptions at discounted rates. PBMs monitor prescription safety across all of the network pharmacies, alerting pharmacists to potential drug interactions even if a consumer uses multiple pharmacies.

Formularies — PBMs use panels of independent physicians, pharmacists, and other experts to develop lists of drugs approved for reimbursement in order to encourage clinically appropriate and cost-effective prescribing for their clients.

Plan design — PBMs advise their clients on ways to structure drug benefits to encourage the use of lower cost drug alternatives — such as generics — when appropriate.

Manufacturer rebates — PBMs pool purchasing power to negotiate substantial rebates from pharmaceutical manufacturers in order to lower benefit costs for clients. PBMs pass back 90 percent of total rebate dollars to their employer clients.[1]

Clinical management — PBMs use a variety of tools such as drug utilization review and disease management to encourage the best clinical outcomes for those individuals with coverage through PBM clients.

Mail service pharmacies — PBMs provide highly efficient mail-service pharmacies that supply home-delivered prescriptions with great accuracy and safety and at a substantial savings. Consumers use mail-service pharmacies once they are stabilized on a medication, after having finished several 30-day prescriptions from their local drugstores. According to recent studies, mail service pharmacies will save consumer as much as $60 billion over the 2015-2024 period.

Specialty pharmacies — PBMs own and operate specialty pharmacies that perform a wide range of clinical activities as well as dispense very costly specialty drugs. The quality and continuity of the care patients receive is improved, while ensuring that they derive the greatest value from their medications. Specialty pharmacies can serve an entire region or the whole nation using sophisticated information technology and logistics to dispense medications directly to the patient's home or physician's office.

1 http://www.drugchannels.net/2016/01/solving-mystery-of-employer-pbm-rebate.html

BioNJ
Because Patients Can't Wait

NEW JERSEY SENATE COMMERCE COMMITTEE
BIONJ TESTIMONY ON PHARMACY BENEFIT MANAGERS
6-23-2025

Chairman Lagana, Vice-Chair Cryan, and members of the Senate Commerce Committee,

Thank you for the opportunity to be here. I am Debbie Hart, President & CEO of BioNJ, and I represent the life sciences ecosystem in New Jersey. Our 450 members include the full continuum of companies from biotechnology start-ups to the world's largest biopharmaceutical companies, Patient advocacy organizations and other research-based institutions across the State.

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. However, for all that incredible productivity by our companies, unfortunately, due to the practices of pharmacy benefit managers, Patients are having difficulty accessing those 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, and neurodegenerative conditions to rare, autoimmune, and genetic diseases. And without fail, those Patients tell us that PBM practices are one of their main sources of stress, struggle, and unaffordability.

PBMs manage prescription drug benefits on behalf of health insurers, Medicare Part D drug plans, large employers and other payers. They negotiate discounts with drug manufacturers and have significant decision-making power over which drugs are included on a formulary.

They 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 prevent the progression of disease, medicines to treat these conditions are frequently excluded from PBM formulary lists.

While PBMs are able to profit from discounts they have negotiated with pharmaceutical companies, they rarely share 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 nonadherence can lead to a host of higher medical costs down the road for Patients and New Jersey's health care system. Patients are also likely to miss work and experience lower productivity, decreased quality of life, short-term side effects and complications and negative long-term health impacts.

New Jersey Patients and their families struggle to afford their prescriptions. About 3 in 5 New Jersey adults reported 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 manage their symptoms. Medications that treat these conditions, such as diabetes, cardiovascular disease, cancers and mental health conditions, are frequently excluded from PBM formularies.

In 2023, the three largest PBMs each excluded roughly 600 medications from their formularies thereby limiting Patient access to critical therapies.

PBMs instead include higher-priced brand medications on formularies over generics or biosimilars, which typically have lower list prices, forcing Patients to manage higher copay costs and limiting their access to certain treatment options. My colleagues on this panel will 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 a key factor in Patients being unable to afford their medications. And in some cases, their health is being compromised.

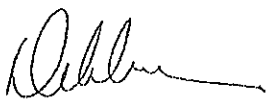
In one recent case, a change in his insurance formulary forced an epilepsy patient to switch from a medication that had been successfully managing his condition. As a result, he began experiencing over 20 seizures a day, leading to a substantial rise in his medical expenses and negatively affecting his quality of life. In what universe does that make sense?

In closing, this is a significant challenge to the cost of healthcare, to Patient access and 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 that and for the opportunity to be here. I will be happy to answer any questions.

Sincerely,



Debbie Hart
President & CEO
BioNJ
Dhart@BioNJ.org
609-510-4481

37x

Pharmacy Benefit Managers: The Middlemen Getting In Between You & Your Medications

Pharmacy benefit managers – or **PBMs** – are companies that manage prescription drug benefits on behalf of insurers, Medicare Part D drug plans, large employers, and other payers.

Meet the middlemen impeding Patient access

Most PBMs are owned by for-profit insurance companies.

80%

The three largest PBMs control 80% of the prescription drug market.

PBMs operate with little to no transparency or oversight.

PBMs often fail to pass on savings they negotiate to consumers at the pharmacy counter, leading to higher out-of-pocket costs.

Higher out-of-pocket costs for medicines can lead to:

Less treatment adherence

More treatment abandonment

Worse health outcomes

Learn more about the role of PBMs and efforts to help you access the right medicine at the right time.

NJPhA New Jersey Pharmacists Association | est. 1870

BioNJ Because Patients Can't Wait

38x

Who are the middlemen increasing your medication costs?

Pharmacy benefit managers – or **PBMs** – are for-profit companies that negotiate discounts with drug manufacturers, create drug formularies, and reimburse pharmacies for prescriptions.

How PBMs increase your costs at the pharmacy counter:

- PBMs **fail to pass on discounts** they negotiate with drug companies to you.
- PBMs are incentivized to include **more expensive drugs** on the list of drugs covered by your insurance plan to increase their profits.
- PBMs **operate with little to no transparency** within the healthcare system.

Are you having trouble accessing your medications? Contact the New Jersey Department of Banking & Insurance (DOBI) for help.

New Jersey DOBI Consumer Hotline: 1-800-446-7467

NJPhA New Jersey Pharmacists Association | est. 1872

BioNJ Because Patients Can't Wait

39x

HINJ®
HealthCare Institute of New Jersey
ADVANCING GLOBAL HEALTH • LEADING NEW JERSEY'S ECONOMY

10 W. LAFAYETTE STREET • TRENTON, NJ 08608 • TEL: 732.729.9619 • WWW.HINJ.ORG

To: Chairman Lagana, Vice-Chairman Cryan & Members of the Senate Commerce Committee

From: Chrissy Buteas, HINJ President and CEO

Date: June 23, 2025

Re: Testimony regarding the impact of pharmacy benefits managers in New Jersey

---

Chairman Lagana and members of the Senate Commerce Committee:

The HealthCare Institute of New Jersey (HINJ – www.hinj.org) is the leading trade association representing New Jersey's life sciences community, including our biopharmaceutical and medical technology companies that are saving lives around the world by developing new treatments and cures here in New Jersey.

We thank you for the opportunity to submit testimony regarding pharmacy benefits managers (PBMs) and how they undercut efforts to make prescription medicines more affordable while limiting access to lifesaving and medically necessary treatments for patients.

Background:

New Jersey is a world leader in discovering and developing new medicines, therapies, diagnostics and technologies that save and improve patients' lives while driving the state's economy. The life sciences sector is responsible for generating roughly 16% of the state's Gross Domestic Product (GDP) and provides nearly 360,000 direct and indirect jobs for workers across the state.

New Jersey is home to eight of the top 10 pharmaceutical companies in the United States, and 8 of the top 10 medical technology companies.[1]

This is why we are called the "Medicine Chest of the World." And it is also why we find it even more appalling when residents living in this "medicine chest" cannot access the medicines they need, or that their doctor has determined is the best course of treatment for them, due to middlemen like PBMs.

To be clear, concerns regarding the role of PBMs and their impact on patients is not limited to life sciences companies – these concerns are also the result of multiple independent reports from

[1] See Choose NJ "2024 New Jersey Life Sciences Report: Market Access, Affordable Real Estate, World-class Talent."

4ox

journalistic and governmental agencies including the New York Times,[2] Wall Street Journal,[3] U.S. House Energy and Commerce Committee, and the Federal Trade Commission.[4] Not to mention from the patients who interact with them when trying to navigate their pharmaceutical benefits.

The result of which has been a growing recognition that PBMs artificially but significantly increase the cost of prescription medicines.

This is due to several key factors:

- **PBMs' customers are insurers and employers, not patients**. This means their financial incentives are tied to their performance from the perspective of these entities, not the people who depend on timely, affordable access to medications.
- **The three largest PBMs now control up to 80% of the prescription drug market**. They are owned by major conglomerates that also own insurers, retail pharmacies, mail order and specialty pharmacies, and, increasingly, doctors' offices.[5]
- 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 costs and limited access for patients.
- PBMs are also responsible for collecting and directing roughly $200 billion in rebates awarded by pharmaceutical manufacturers. Those rebates could be used to offset a patients' cost-sharing requirements **but are more often used to offset premiums for the entire insurance pool rather than to offer assistance to patients struggling to afford their medication**.

These and other factors create an environment in which PBMs have extraordinary power over how and where patients can access the medications they need and what those medications will cost. And because their incentives are tied to the price of drugs and the utilization of those tied to higher rebates rather than lower prices, the result for patients is often higher out-of-pocket costs, limited pharmacy options, and restricted access to more affordable medicines.

Fact vs. Fiction:

PBMs make a lot of claims to try and escape responsibility for the role they play when it comes to access and affordability. Let's start with drug pricing:

---

[2] Abelson, R. & Robbins R. (2024, June 21). *The opaque industry secretly inflating prices for prescription drugs*. The New York Times.

[3] Whyte, L. (2024, July 9). *Big pharmacy benefit managers increase drug costs, FTC says*. The Wall Street Journal.

[4] *See Federal Trade Commission. (2024, July). Pharmacy benefit managers: The powerful middlemen inflating drug costs and squeezing main street pharmacies. FTC.GOV.*

[5] See Drug Channels. (April 2025). Mapping the Vertical Integration of Insurers, PBMs, Specialty Pharmacies, and Providers: DCI's 2025 Update and Competitive Outlook. DrugChannels.net.

41x

Pricing: PBMs claim that they are powerless when it comes to drug pricing and try to circumvent culpability for their role in patient affordability by pointing at pharmaceutical 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 the medicine. This process typically results in substantial price decreases in the form of rebates and other discounts.

The manufacturer is essentially out of the picture following these negotiations. On the other hand, the PBM still gets to determine what the dispensing pharmacy will be reimbursed for the drug, what the insurer of the covered patient will be billed for the drug, and what the patient will pay at the pharmacy counter.

Misaligned incentives: PBMs claim their job is to lower drug costs, but their fees are often tied to the price of medicines or to the size of any rebates or discounts they negotiate. This results in a perverse incentive structure in which the PBM is financially rewarded not when patients pay the lowest cost possible, but when they are able to show more "savings" on paper.

"Savings" means a reduction to the list price, but it does not represent savings to the patient or in comparison to a cheaper alternative. Given this revenue scheme, it is not difficult to understand why a PBM would prefer to cover a $10 medicine versus a $1 alternative – the potential for "savings"-based fees is 10x higher for the $10 drug than the $1 drug, even if the patient ultimately winds up paying more when they pick up their prescription.

It is also not difficult to understand how this dynamic contributes to increasing drug prices.

Who Benefits: PBMs claim 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 brand name medicines. The rest goes to middlemen, like PBMs, that play no role in the research, development, or manufacturing of those medicines.

That means that when you see a headline figure of how much Americans pay for prescription medicines, only half of that is going back to the companies that actually made the discovery and produced the drug – only half of that goes to the same companies that are putting that revenue toward funding the next generation of life-saving cures and treatments.[6]

This also ignores the fact that the net prices for products from large manufacturers often decrease or remain flat even when list prices appear to be increasing.

Conclusion:

Thankfully, the role that PBMs play when it comes to how patients access and afford the medicines that they need is finally receiving the attention that the scope of their impact deserves. For that

[6] Carpenter, E. (January 7, 2025). New study: Entities that don't make medicines get half of what is spent on those medicines. PhRMA.

42x

reason, we again express our appreciation for the opportunity to weigh in on this important discussion.

We look forward to working with the Chairman and members of the Committee to continue to seek meaningful reforms that will benefit the patient community we serve.

If you have any questions, please contact me by emailing buteas@hinj.org. You may also contact Kyle Sullender, Director of Government and External Relations, by emailing sullender@hinj.org.

Sincerely,

Chrissy Buteas
President and CEO
HealthCare Institute of New Jersey

43x

PhRMA

RESEARCH • PROGRESS • HOPE

Follow the Dollar

How the Pharmaceutical Distribution and Payment System Shapes the Prices of Brand Medicines

February 2025

PhRMA
RESEARCH • PROGRESS • HOPE

Table of Contents

45x

Introduction

The path of a prescription medicine from a manufacturer to a patient involves a series of transactions among multiple stakeholders, all at varying and typically confidential prices. Each transaction plays a role in determining the amount patients, employers, and plan sponsors ultimately pay for brand medicines.

In the commercial market, prices are determined through private negotiations between stakeholders with varying degrees of negotiating power. Large pharmacy benefit managers (PBMs), which administer benefits for tens of millions of patients, leverage substantial rebates and discounts that lower the cost of brand medicines. However, these savings may not be reflected in what patients experience at the pharmacy counter. That's because patients' out-of-pocket costs are set by PBMs and plan sponsors, who often require patients to pay a percentage of a medicine's full, undiscounted list price. As a result, patients rarely benefit directly from the cost savings negotiated on their behalf and, in some instances, pay more for a medicine than their PBM or health plan.

Understanding who pays what for prescription medicines requires a baseline understanding of the pharmaceutical supply chain, including the distribution system and flow of payments, many of which occur behind the scenes. This paper seeks to arm researchers, policymakers, patients, and other interested parties with that baseline knowledge, along with information about recent and emerging trends in the pharmaceutical marketplace.

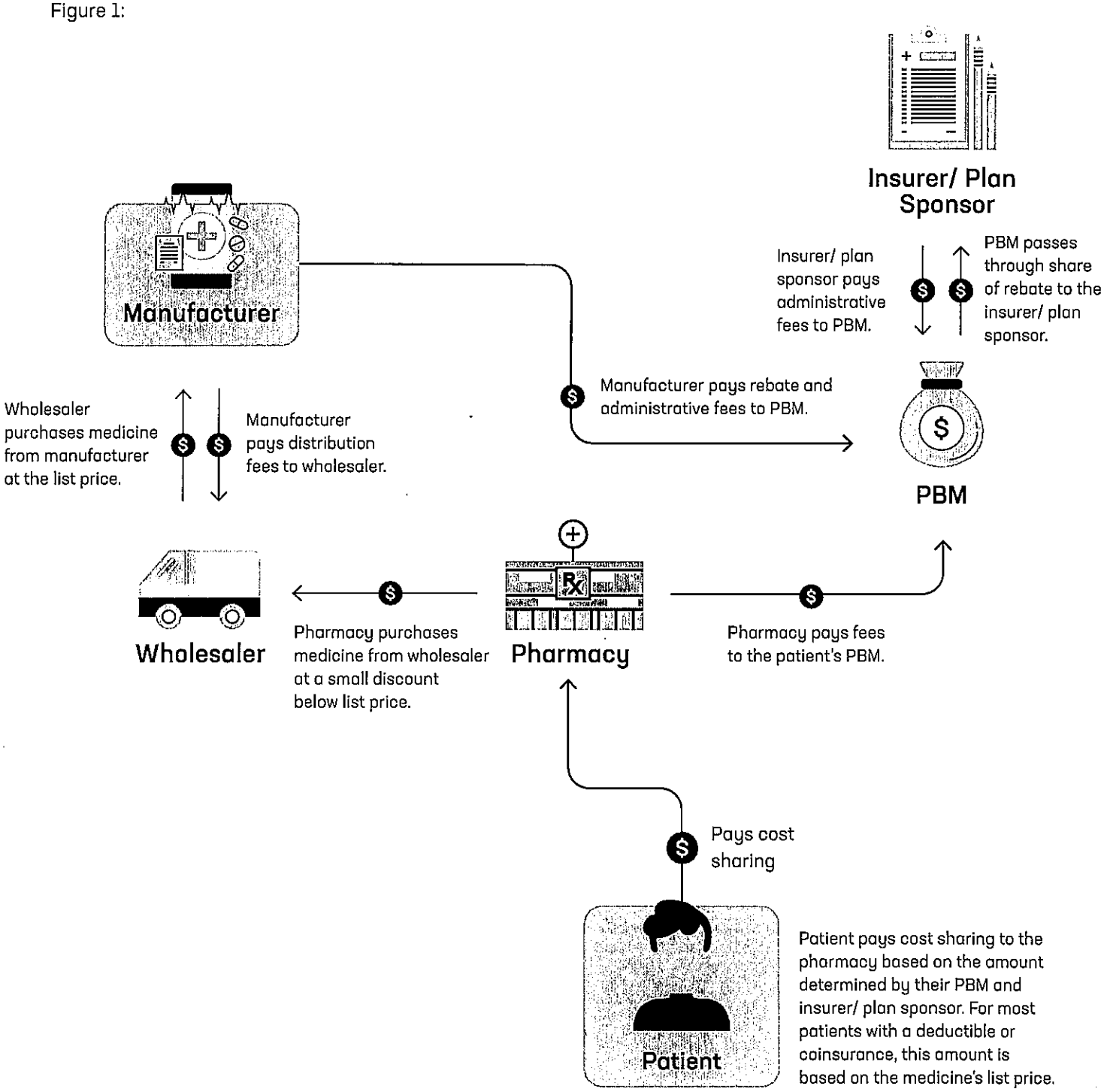
We focus on the supply chain for brand medicines dispensed through retail channels for commercially covered patients. An assessment of the supply chain for generic drugs or for non-retail channels (i.e., medicines administered to patients by a health care provider), or prescriptions provided to patients covered by public insurers, like Medicare and Medicaid, is outside the scope of this paper. The information presented was gathered from public research and interviews with supply chain experts. Many prices in the supply chain are confidential; therefore, the hypothetical transactions depicted in this paper may vary from real-world actuals.

An analysis published by the Berkeley Research Group (BRG) in January 2025 found half of what the US spends on brand medicines goes to stakeholders other than manufacturers, including supply chain entities, providers, the government, and others.[1] BRG's analysis incorporates factors outside of the scope of this paper, including brand spending for all patients regardless of insurance type, spending on non-retail brand medicines, and the statutory rebates, fees, and other discounted pricing provided by manufacturers on prescriptions for patients outside the commercial market. As a result, the final share of spending received by manufacturers and supply chain entities in the BRG analysis is not analogous to the hypothetical transactions presented here.

46x

Pharmaceutical Supply Chain: Key Stakeholders

Figure 1:



47x

From Factory to Pharmacy

Before a patient can pick up their prescription, the medicine must make its way from the pharmaceutical manufacturer to the pharmacy.

Manufacturers typically rely on wholesale distributors **(wholesalers)** to take physical possession of medicines and distribute them to pharmacies. As of 2022, 95 percent of all retail pharmaceutical sales went through a wholesaler.[2] The wholesaler industry is highly concentrated among a small number of companies. McKesson, Cencora (previously AmerisourceBergen), and Cardinal account for 95 percent of the wholesaler market.[3]

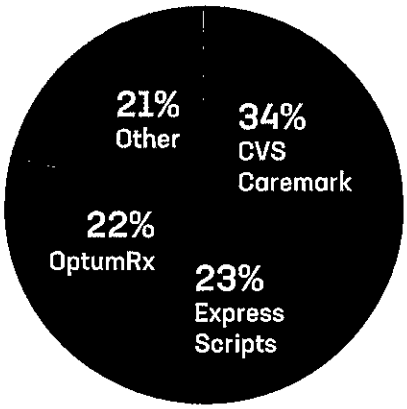
Wholesalers typically purchase drugs from manufacturers at the list price, or Wholesale Acquisition Cost (WAC), and charge distribution service fees to the manufacturer in exchange for providing certain services or achieving certain performance benchmarks. These fees, often structured as a percentage of WAC, serve to lower the wholesaler's net purchase price. Discounts manufacturers offer for prompt payment or volume further lower the net price paid by the wholesaler.

Pharmacies purchase drugs from wholesalers. Competition for each pharmacy's business leads wholesalers to pass through a portion of the discounts and distribution fees they receive from manufacturers in the form of lower prices. As a result, pharmacies typically purchase brand drugs from wholesalers at a net price below WAC. Larger pharmacies with more purchasing power can negotiate the steepest discounts. There are many types of pharmacies in the US, including retail drug stores, specialty pharmacies, mail order pharmacies, and pharmacies embedded within grocery stores, doctors' offices, or hospitals.

When a pharmacy dispenses a drug to a patient, it is reimbursed by a **pharmacy benefit manager (PBM)** working on behalf of the patient's **insurer**, who often is hired by a **plan sponsor** to administer the health benefit. In the commercial market, the plan sponsor is most often the patients' employer or labor union.

PBMs perform several roles, including managing formularies, establishing a network of pharmacies, and negotiating reimbursement rates with pharmacies across covered drugs on behalf of the insurer and plan sponsor. These reimbursement rates are typically structured as a percentage of a drug's Average Wholesale Price (AWP).[i] Like the wholesaler industry, the PBM industry is highly consolidated among a few large companies. As of 2023, the big three PBMs, Express Scripts, CVS Caremark, and OptumRx, accounted for nearly 80% percent of the market.[4]

PBM Market Share, 2023



Source: Drug Channels Institute, 2024.

i. For brand drugs, AWP is typically 20 percent of WAC. *See*[5]

48x

Patient Out-of-Pocket Costs

At the time a prescription is filled, the pharmacy collects the patient's cost sharing and the PBM pays the pharmacy the remaining amount of the negotiated reimbursement rate for the medicine.

Cost sharing is the amount the patient must pay out of pocket at the pharmacy, as determined by the plan sponsor and/or the PBM, and typically takes one of the following forms:

Deductible: The amount that a patient must pay before the insurer/ plan sponsor begins to pick up a share of the costs of their medicine.

Coinsurance: The amount that a patient pays out of pocket calculated as a percentage of the medicine cost.[ii]

Copayment: Fixed amount that a patient must pay per prescription.

Payers typically do not use the rebates they negotiate with manufacturers to directly lower costs for patients at the pharmacy counter. This differs from all other types of health care where plans typically base patient out-of-pocket spending for care received from doctors and hospitals on the discounted rates negotiated with in-network providers. Instead, patients with deductibles and coinsurance are usually required to pay a percentage of the full, undiscounted price for their medicines, rather than the net price that reflects the rebates and discounts paid to the PBM by the manufacturer.

Once a patient has reached their deductible, the coinsurance percentage or copayment amount is often determined based on a drug's "tier" assignment within a PBM's formulary (i.e., the list of drugs covered). PBMs group drugs into different tiers, often depending on their net cost to the PBM and/or plan sponsor.

Patients taking drugs on lower, or "preferred," tiers often have low fixed copayments, while medicines on higher tiers are more likely to require coinsurance or a higher copayment. This can create affordability issues for patients, and many manufacturers offer commercially insured patients cost sharing assistance to help defray these costs. As of 2023, this manufacturer assistance totaled $23 billion.[6]

ii. The reimbursement rate negotiated between the PBM and the pharmacy is similar to the wholesale acquisition price (WAC), and often referred to as the "list price."

49x

Flow of Payments After a Prescription is Filled

Once a prescription is dispensed to a patient, the physical journey of that medicine through the pharmaceutical supply chain is complete. The funding flow, however, is not.

PBMs subsequently collect payments from plan sponsors, manufacturers, and pharmacies, including administrative fees and retrospective rebates.

After reimbursing a pharmacy for a patient's medication, the PBM seeks to recoup the cost of the medicine from the plan sponsor or insurer. The amount the PBM requests from the plan sponsor or insurer sometimes exceeds the amount the PBM actually paid to the pharmacy. This phenomenon, known as **"spread pricing,"** allows the PBM to retain a share of the reimbursement as profit. PBMs operating under "pass-through" models without spread pricing typically charge a higher administrative fee to the plan sponsor or insurer as an alternative source of compensation.

One of PBMs' primary roles is negotiating with manufacturers for retrospective rebates that lower the net cost of medicines. PBMs also typically charge manufacturers administrative fees for a variety of services, including formulary management and data access. Retrospective rebates and the administrative fees PBMs charge to manufacturers are typically structured as a percentage of a medicine's list price.[7]

Manufacturers are incentivized to offer rebates to PBMs in exchange for inclusion and a favorable placement on the PBM's formulary.[8] PBMs can elect not to cover drugs by excluding them from their formularies. More than 1,150 medicines were excluded from at least one of the three largest PBMs' standard commercial formularies in 2022.[9]

In addition to formulary exclusions, PBMs can influence which medications patients use by subjecting medicines to **utilization management** restrictions, like prior authorization, step therapy, or placing products on a higher cost sharing tier.[10]

PBMs may also retrospectively claw back additional payments and fees from pharmacies, including network access fees, performance fees, and reconciliation payments such as effective rate guarantees. These post-sale adjustments may occur weeks or months after prescriptions are dispensed, creating complexity and financial uncertainty for pharmacies.[11]

Depending on contractual arrangements with their plan sponsor clients in the commercial market, PBMs often retain administrative fees and a share of rebates as compensation and pass along the remainder to the plan sponsor. The fees that PBMs charge to plan sponsors, manufacturers, and pharmacies account for a substantial and rapidly growing share of PBM profits, while the share of profits attributable to retained rebates has declined.[12]

50x

Illustrative Examples of Financial Flows within the Pharmaceutical Supply Chain

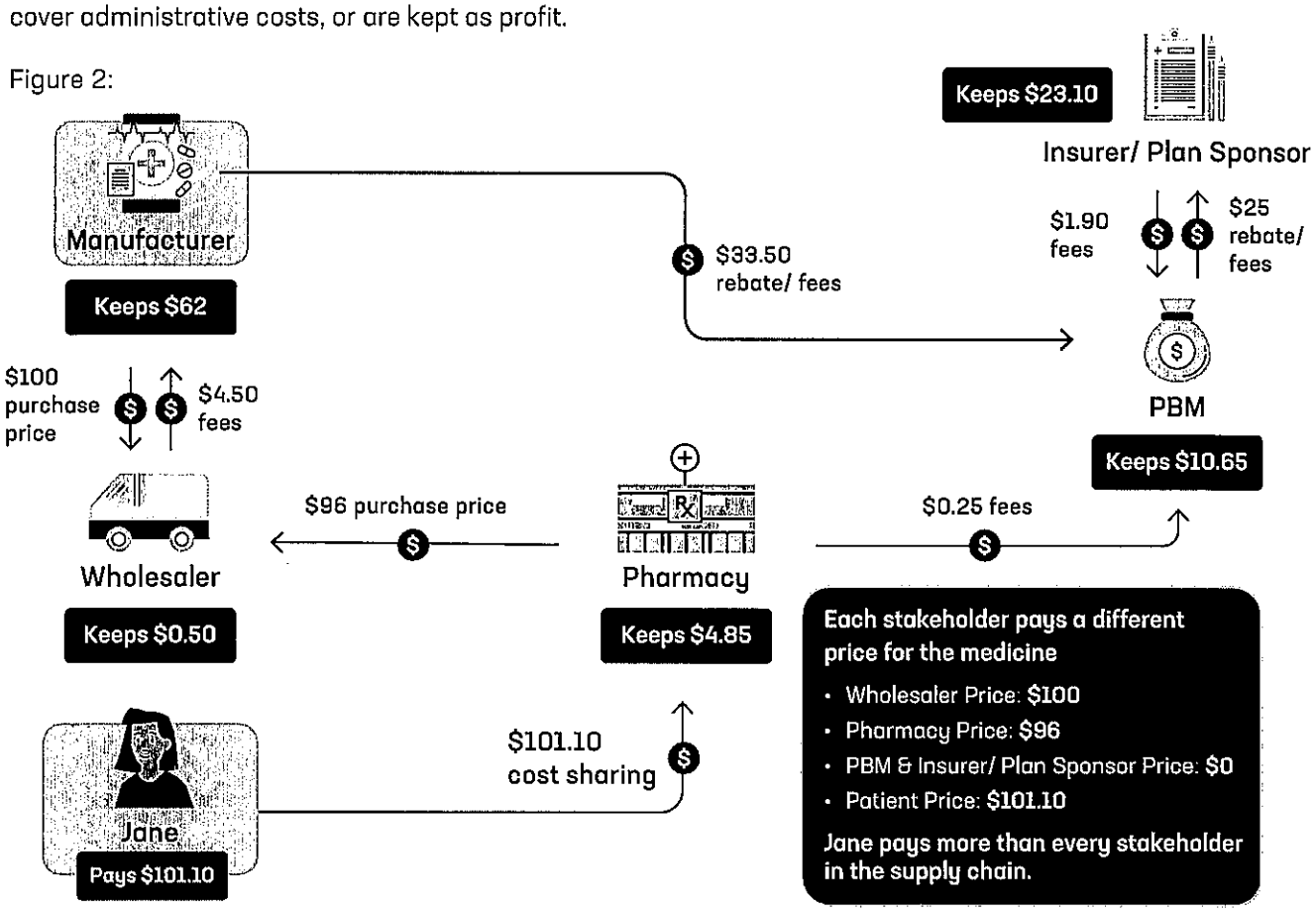
To illustrate the financial role of each major stakeholder within the supply chain, the following examples walk through a few hypothetical payment flows for a medication with a **list price of $100**. The details underlying each payment flow are included in the appendix to this report.

Deductible

In this example, Jane has not yet met her deductibles, meaning that neither their PBM nor plan sponsor contributes anything toward the cost of the medication. Jane must pay the entire reimbursement rate negotiated by the PBM with the pharmacy: $101.10.

In this instance, because neither the PBM nor the plan sponsor contributes to the cost at the pharmacy counter, but the PBM still collects a rebate from the manufacturer, both the PBM and the plan sponsor emerge net positive from the transaction. The amounts retained by PBMs, insurers, and plan sponsors in commercial market transactions like these may be used to reduce the premiums paid by patients and their employers, cover administrative costs, or are kept as profit.

Figure 2:



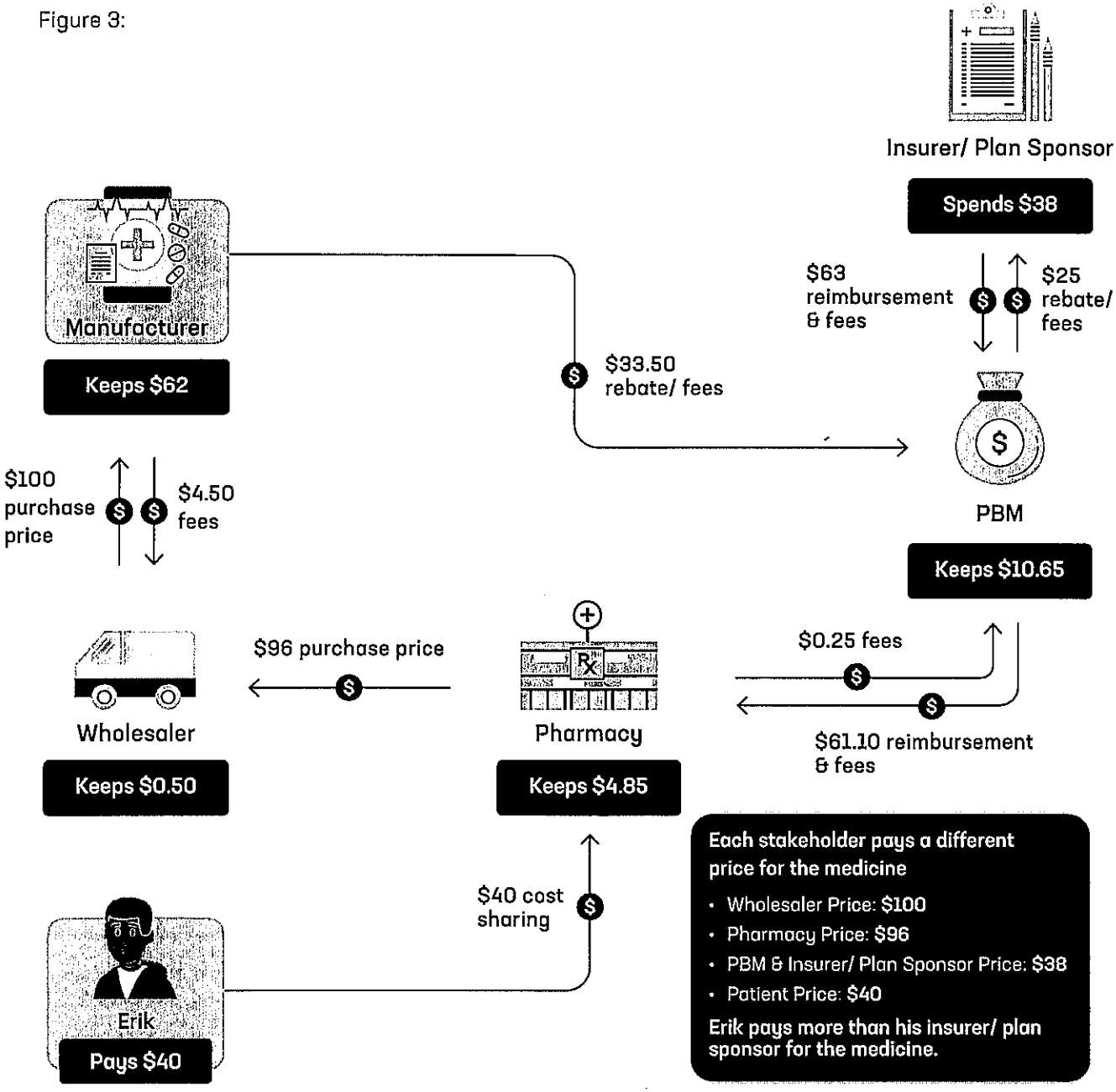
Hypothetical example of a commercially insured patient filling a prescription with a deductible. Final amounts retained or spent by stakeholders do not reflect the market-wide average for all prescriptions filled, including those dispensed to Medicare and Medicaid beneficiaries. The final amount spent by patients and retained by manufacturers may be lower if the patient utilizes a manufacturer cost sharing assistance program.

51x

Copayment

In this example, Erik has already met his deductibles and is required to pay a $40 copayment. The rebates paid by the manufacturer to the PBM reduce the net amount the plan sponsor pays for this medication to $78, most of which is borne by the patient through the copayment. Of that $78 in net spending, $62 is ultimately retained by the manufacturer with the remaining $16 going to others in the supply chain.

Figure 3:



Hypothetical example of a commercially insured patient filling a prescription with a copayment. Final amounts retained or spent by stakeholders do not reflect the market-wide average for all prescriptions filled, including those dispensed to Medicare and Medicaid beneficiaries. The final amount spent by patients and retained by manufacturers may be lower if the patient utilizes a manufacturer cost sharing assistance program.

52x

340B Program

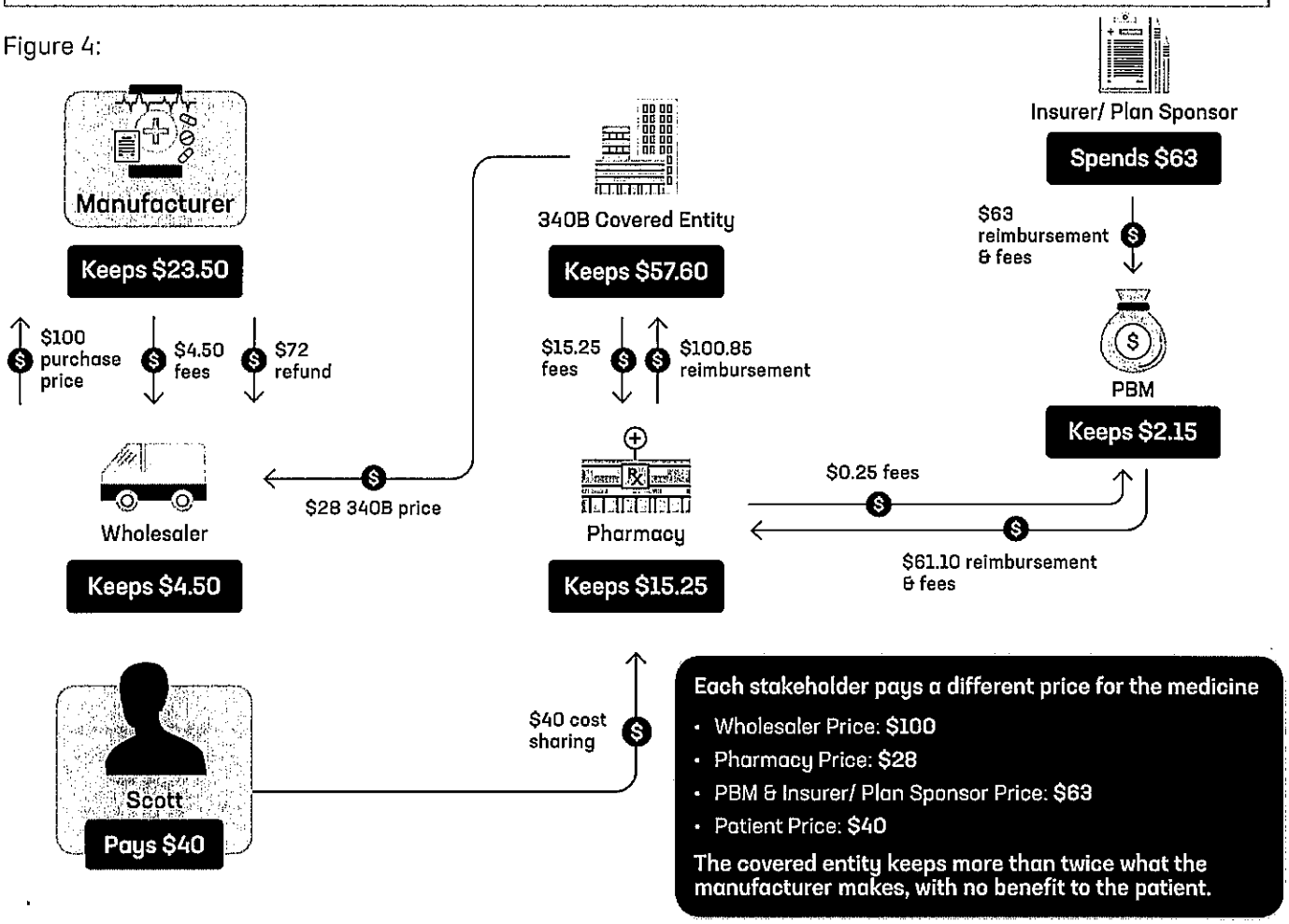
The third example is identical to the second, except that Scott happens to fill a 340B eligible prescription at a 340B contract pharmacy.

The 340B Program

The 340B program allows certain types of hospitals and clinics, known as **covered entities**, to purchase drugs at significantly lower prices. When these drugs are dispensed at the discounted 340B price, insurers typically reimburse at the standard negotiated rates. The difference between reimbursement and the discounted acquisition cost, often referred to as "spread" or "340B margin" is retained by the covered entity.

340B prescriptions can be administered to patients in an outpatient setting at a hospital or clinic, filled at a hospital or clinic pharmacy, or filled at an external, unaffiliated pharmacy (**contract pharmacy**). Today, half of US pharmacies act as contract pharmacies for at least one hospital or clinic in the 340B program. When a 340B prescription is dispensed, the contract pharmacy transfers the reimbursement that it receives from the patient and their insurer to the covered entity in exchange for a share of the 340B margin. As a result, pharmacies typically earn higher revenues from filling 340B prescriptions than non-340B prescriptions.

Figure 4:



Hypothetical example of a commercially insured patient filling a prescription purchased at the 340B price. Final amounts retained or spent by stakeholders do not reflect the market-wide average for all prescriptions filled, including those dispensed to Medicare and Medicaid beneficiaries. The final amount spent by patients and retained by manufacturers may be lower if the patient utilizes a manufacturer cost sharing assistance program.

53x

In this example, the covered entity purchases the drug from the wholesaler at the discounted 340B price of $28. The wholesaler then receives a $72 payment from the manufacturer to make up for the difference between the WAC and the discounted 340B price. The wholesaler ships the discounted medicine to the pharmacy, which dispenses it to the patient and collects a total of $100.85 in reimbursement from the PBM and patient, net of fees the pharmacy is required to pay to the PBM. The pharmacy transfers the majority of this reimbursement to the covered entity but retains $15.25 as a fee for acting as the covered entity's contract pharmacy.

Unlike the two previous examples, absent from this payment flow are any rebates or fees paid by the manufacturer to the PBM. This is because most contracts between PBMs and manufacturers prohibit the payment of negotiated rebates and fees for medications sold at the 340B price.[iii,13]

Without those rebates and fees, the plan spends an additional $25 on the prescription. Even though the manufacturer does not pay rebates and fees to the PBM in this instance, it still retains less revenue than in the prior example, due to the magnitude of the 340B discount. While the covered entity retains the largest share of the revenue, the wholesaler and the pharmacy also benefit financially from the 340B transaction.

When manufacturers' contracts with PBMs do not prohibit the payment of negotiated rebates and fees for medicines purchased at 340B prices, or manufacturers lack the data necessary to determine whether PBMs are requesting rebates on 340B priced medicines, manufacturers could end up paying rebates on medicines already purchased at a steep discount.

These "**duplicate discounts**" further erode manufacturer net revenue from the sale of a medicine and, depending on the magnitude of rebate and the lower 340B price, could ultimately leave manufacturers paying out more in rebates and other price concessions than they are bringing in from selling 340B priced medicines.

iii. Although paying rebates in addition to providing 340B pricing on the same unit of a medicine (often referred to as a "duplicate discount") is typically contractually prohibited under commercial and Medicare Part D contracts and statutorily prohibited in certain circumstances, it still commonly occurs. The hypothetical example shown here assumes that no duplicate discount is paid.

54x

Evolution of the Pharmaceutical Supply Chain and Emerging Trends

By capitalizing on changes in the insurance, regulatory, and business landscapes, PBMs, insurers, and other supply chain stakeholders have found new and profitable ways to increase their influence over the distribution and reimbursement of prescription medicines.

Increased consolidation and vertical integration among PBMs, insurers, and other stakeholders creates downstream impacts that further influence the cost of medicines for patients, employers, and plan sponsors.

Consolidation and Vertical Integration of Supply Chain Stakeholders

Following decades of **horizontal consolidation**—which occurs when entities providing the same services acquire or merge with their competitors—parts of the pharmaceutical supply chain are now controlled by a small number of very large companies. This is especially true in the PBM and wholesaler industries, where just three companies control nearly 80% and 95% of their respective markets.

PBMs and other stakeholders are also increasingly engaged in **vertical integration**, where entities that perform different functions along the pharmaceutical supply chain join together under a single corporate umbrella. Each of the three largest PBMs now owns or is owned by an insurer, forming a large parent corporation that also owns pharmacies (e.g., specialty, mail order, etc.) and provider groups.[14] Rounding out these vertically integrated entities, the three largest PBMs have each created a new type of subsidiary they refer to as **"group purchasing organizations,"** or PBM GPOs, and have acquired a private label distributor to commercialize biosimilar medicines on their behalf. (see Figure 5)

55x

Figure 5:

Vertical Integration of Pharmaceutical Supply Chain Stakeholders

Parent Company	The Cigna Group	CVS Health	UnitedHealth Group
Insurer *administers the health benefits, often on behalf of a plan sponsor*	Cigna Healthcare	Aetna	United Healthcare
PBM *manages pharmacy benefit, including pharmacy networks and formulary, on behalf of the insurer*	Express Scripts	CVS Caremark	OptumRx
Pharmacy(ies) *dispenses prescription medicines to patients, can include retail, specialty and mail order*	• Accredo • Freedom Fertility Pharmacy • CarepathRx	• CVS • CVS Specialty	• Optum Specialty • Pharmacy
Provider Group(s) *physicians and other health care personal that directly provide patient care, including writing prescriptions*	• Evernorth Health Services • Alegis Care • MDLive • VillageMD	• CVS Minute Clinic • Oak St. Health • Signify Health	OptumCare
PBM GPO *negotiates, collects and disburses manufacturer rebates for their affiliated PBM and smaller PBMs or other health care entities*	Ascent Health Services	Zinc	• Emisar Pharma • Services
Private Label Distributor *produces, or contracts with manufacturers that produce, biosimilars*	Quallent Pharmaceuticals	Cordavis	Nuvaila

56x

Vertical integration enables organizations to profit at multiple points along the pharmaceutical supply chain and creates new opportunities to leverage one line of business to increase revenue for another.

Vertical integration financially incentivizes PBMs to "steer" patients toward the pharmacies they own, either by requiring or incentivizing patients to use PBM-owned pharmacies or by implementing narrow pharmacy networks that exclude a large number of non-affiliated pharmacies.[15] Similarly, a PBM or insurer may instruct providers owned by the parent company to electronically transmit prescriptions to the PBM-owned pharmacy or incentivize their providers to prescribe medications that are most profitable to the PBM.[16]

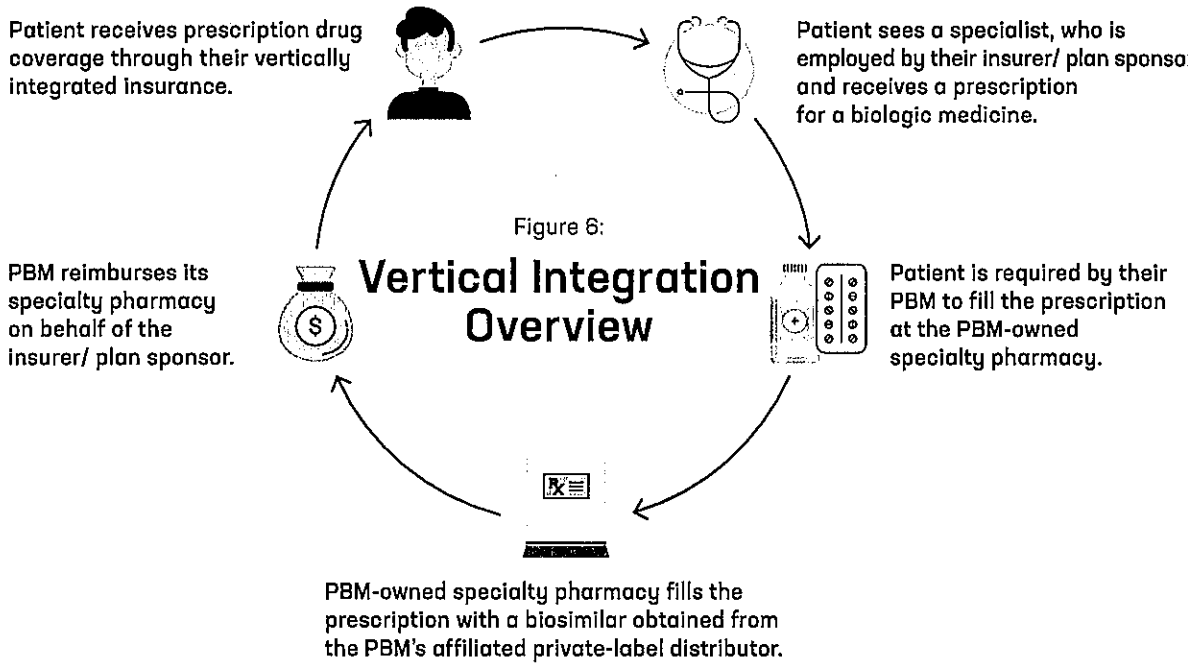


Figure 6:
Vertical Integration Overview

Pharmacies typically earn a profit when the reimbursement they receive from PBMs exceeds the price at which the pharmacy acquired the drug. When the PBM and pharmacy are part of the same parent company, the PBM can increase corporate profits by reimbursing its own pharmacy at a higher rate than an independent pharmacy, knowing that the higher cost will ultimately be borne by an unaffiliated insurer. Because pharmacy acquisition costs are typically confidential, the insurer may not recognize the magnitude of the markup that it is absorbing. When the PBM, pharmacy, and insurer are all part of the same parent company, inflated reimbursement rates are ultimately funded by the plan sponsor or patient through higher premiums and/or out-of-pocket costs.[17,18]

57x

Consolidation and vertical integration enable other problematic PBM incentives and conflicts of interest that may increase pharmacy costs for patients, employers, and plan sponsors.

Ownership of vertically integrated pharmacies also enables PBMs to implement strategies that mitigate or undermine the impact of manufacturer provided cost sharing assistance. As previously mentioned, many manufacturers offer financial assistance for commercially insured patients to offset the cost sharing requirements established by their PBM and/or plan sponsor, including deductibles, copayments, and coinsurance. In recent years, PBMs and insurers are increasingly implementing **accumulator adjustment programs (AAPs)** and **copay maximizers**, which allow PBMs to retain some or all of the cost-sharing assistance offered by manufacturer assistance programs as profit. AAPs prevent payments made by a manufacturer cost sharing assistance program from counting toward the patient's deductible or out-of-pocket maximum.[19]

Copay maximizers increase patients' cost sharing limits to amounts higher than their standard annual cost sharing limits. Patients are then enrolled in a manufacturer copay assistance program to cover their new out-of-pocket costs, which are often set at the maximum amounts manufacturers offer under their financial assistance programs. This assistance does not count towards their deductible or annual cost sharing limits. AAPs and copay maximizers have become so widespread that as of 2023, nearly $5 billion of manufacturer cost sharing assistance funds were absorbed by PBMs, plans, or third-party vendors, rather than benefiting patients.[20]

A large share of compensation received by vertically integrated PBMs is tied to the list price of medicines, which experts say can incentivize PBMs to prefer higher cost medicines over lower cost alternatives and may dissuade manufacturers from lowering list prices.[21] For years, the three largest PBMs blocked patient access to lower-cost biosimilars, but this dynamic is changing now that each PBM has acquired a private-label distributor to commercialize biosimilars on the PBM's behalf.[22] Vertical integration between the PBM and the private-label distributor incentivizes the PBM to provide preferential coverage for biosimilars in which they have a financial stake, regardless of whether the PBM's biosimilar is the lowest cost option for patients or employers.[23,24]

58x

The 340B Drug Pricing Program

Under the 340B program, contract pharmacies increase their dispensing margins by obtaining medicines at significantly discounted prices, with no requirement to share any portion of those margins with patients or their plan sponsors. The average profit margin for a brand 340B prescription dispensed at a contract pharmacy is 72 percent, compared to 3-4 percent for non-340B brand prescriptions.[25,26] The profit margin generated on 340B prescriptions is typically shared between the contract pharmacy, the covered entity, and any other third parties involved in operations and administration, with industry estimates suggesting that contract pharmacies keep as much as 25-35 percent of 340B margin.[27]

The ability to earn larger profits on brand prescriptions has attracted large, for-profit contract pharmacies to the 340B program, including those owned by PBMs. Overall, 44 percent of all contract pharmacy relationships are between a 340B covered entity and a pharmacy associated with one of the three largest PBMs, and over half of total 340B profits retained by contract pharmacies are concentrated in just four for-profit corporations, two of which are vertically integrated with two of the largest PBMs (CVS Health and Express Scripts).[28,29] These profits are largely driven by prescriptions filled through PBMs' mail order and specialty pharmacies, which represent the fastest growing segment of the contract pharmacy dispensing channels.[30]

Research shows that the 340B program can increase costs for patients, public and private payers, and employers. As shown in the hypothetical flow of funds earlier in this paper, the net cost to the plan sponsor is often higher when a patient receives a 340B medicine due to forgone manufacturer rebates. These additional costs may then translate into higher premium payments for employers and patients. One recent study found that drug costs for employers and their workers was $7.8 billion higher than it otherwise would have been in 2021 due to forgone rebates as a result of the 340B program.[31]

59x

Conclusion

Brand medicines make their way to patients through a complex process involving multiple stakeholders, including manufacturers, wholesalers, pharmacies, PBMs, insurers, and 340B covered entities. Transactions between these stakeholders shape the amount that patients pay at the pharmacy counter and the net costs paid by employers and plan sponsors. A large share of what the US spends on brand medicines goes not to the manufacturers that researched and developed them, but to stakeholders along the supply chain in the form of manufacturer rebates, discounts, fees, and other payments. Through consolidation and vertical integration, PBMs, insurers, and pharmacies increasingly profit from the distribution and reimbursement of prescription medicines. Along with the sizable growth of the 340B program, this consolidation and vertical integration has increased the share of brand medicine spending received by non-manufacturer stakeholders. Vertically integrated PBMs are often compensated based on the list price of medicines, raising questions as to whether their incentives are aligned to achieve the lowest costs for patients, employers, and the health care system.

Cox

Appendix

The amounts retained by each stakeholder in these transactions reflect typical marketplace trends but do not necessarily reflect all transactions.

Flow of Payment for a $100 Blood Pressure Medication

Patient is in Deductible Phase

		Item	Amount	Composition
[WAC]		Wholesale acquisition cost	$100.00	[WAC] (set by manufacturer)
[AMP]		Average wholesale price	$120.00	[WAC] * 1.2 (determined by pricing publications)
Wholesaler	[1]	Buys product from manufacturer	$100.00	[WAC]
	[2]	Collects distribution fee from manufacturer	$4.50	[1] * 4.5%
	[3]	Sells product to pharmacy	$96.00	[1] - 4.0%
	Wholesaler retains		**$0.50**	**[2]-[1]+[3]**
Pharmacy	[4]	Collects cost sharing from patient	$101.10	Estimate
	[5]	Reimbursed by PBM for ingredient cost	$-	No payment made by PBM
	Pharmacy retains		**$4.85**	**[4]+[5]-[3]-[11]**
PBM	[6]	Collects base rebate from manufacturer	$25.00	[WAC]*25%
	[7]	Collects administrative service fee from manufacturer	$4.50	[WAC]*4.5%
	[8]	Collects price protection rebate from manufacturer	$4.00	[WAC]*4.0%
	[9]	Collects and retains administrative fee from insurer/ plan sponsor	$1.90	Negotiated with insurer/ plan sponsor. Per claim fee
	[10]	Collects and retains transaction and E-prescribing fees from pharmacy	$0.25	Transaction($0.10)+E-prescribing ($0.15) fees
	[11]	Retains share of base rebate and price protection rebate	$5.13	[6]*12.5%+[8]*50%
	[12]	Retains share of manufacturer administrative fee	$3.38	[7]*75%
	[13]	Reimbursed for ingredient cost by insurer/ plan sponsor	$-	No payment made by insurer/ plan sponsor
	PBM retains		**$10.65**	**[10]+[11]+[12]+[13]-[5]**
Insurer/ plan sponsor	[14]	Payment to PBM	$1.90	[9]
	[15]	Receives share of rebates and fees	$25.00	([6]+[8]-[11])+([7]-[12])
	Final insurer/ plan sponsor cost		**$23.10**	**[16]-[15]**
Patient cost sharing amount			$101.10	[4]
Manufacturer-retained payment			$62.00	[WAC]-[2]-[6]-[7]-[8]

GIx

Flow of Payment for a $100 Blood Pressure Medication

Patient Pays a Copayment

		Item	Amount	Composition
[WAC]		Wholesale acquisition cost	$100.00	[WAC] (set by manufacturer)
[AMP]		Average wholesale price	$120.00	[WAC] * 1.2 (determined by pricing publications)
Wholesaler	[1]	Buys product from manufacturer	$100.00	[WAC]
	[2]	Collects distribution fee from manufacturer	$4.50	[1] * 4.5%
	[3]	Sells product to pharmacy	$96.00	[1] - 4.0%
	Wholesaler retains		**$0.50**	[2]-[1]+[3]
Pharmacy	[4]	Collects cost sharing from patient	$40.00	Determined by plan
	[5]	Reimbursed by PBM for ingredient cost	$1.50	Estimate
	[6]	Collects ingredient cost reimbursement from PBM	$59.60	([AWP] - 17%)-[4]
	Pharmacy retains		**$4.85**	[4]+[5]+[6]-[3]-[11]
PBM	[7]	Collects base rebate from manufacturer	$25.00	[WAC]*25%
	[8]	Collects administrative service fee from manufacturer	$4.50	[WAC]*4.5%
	[9]	Collects price protection rebate from manufacturer	$4.00	[WAC]*4.0%
	[10]	Collects and retains administrative fee from insurer/ plan sponsor	$1.00	Negotiated with insurer/ plan sponsor. Per claim fee
	[11]	Collects and retains transaction and E-prescribing fees from pharmacy	$0.25	Transaction($0.10)+E-prescribing ($0.15) fees
	[12]	Retains share of base rebate and price protection rebate	$5.13	[7]*12.5%+[9]*50%
	[13]	Retains share of manufacturer administrative fee	$3.38	[8]*75%
	[14]	Reimbursed for ingredient cost by insurer/ plan sponsor	$62.00	([AWP] - 15%)-[4]
	PBM retains		**$10.65**	[10]+[11]+[12]+[13]+[14]-[6]-[5]
Insurer/ plan sponsor	[15]	Payment to PBM	$63.00	[10]+[14]
	[16]	Receives share of rebates and fees	$25.00	([7]+[9]-[12])+([8]-[13])
	Final insurer/ plan sponsor cost		**$38.00**	[15]-[16]
Patient cost sharing amount			$40.00	[4]
Manufacturer-retained payment			$62.00	[WAC]-[2]-[7]-[8]-[9]

62x

Flow of Payment for a $100 Blood Pressure Medication

Patient Purchase at 340B Contract Pharmacy

		Item	Amount	Composition
[WAC]		Wholesale acquisition cost	$100.00	[WAC] (set by manufacturer)
[AMP]		Average wholesale price	$120.00	[WAC] * 1.2 (determined by pricing publications)
Wholesaler	[1]	Buys product from manufacturer	$100.00	[WAC]
	[2]	Collects distribution fee from manufacturer	$4.50	[1] * 4.5%
	[3]	Sells product to covered entity	$28.00	[WAC]*28%
	[4]	Wholesaler 340B refund	$72.00	[1]-[3]
	Wholesaler retains		**$4.50**	**[2]-[1]+[3]+[4]**
Covered entity	[5]	Collects reimbursement from pharmacy	$100.85	[6]+[8]+[9]-[14]
	Covered entity retains		**$57.60**	**[5]-[3]-[7]**
Pharmacy	[6]	Collects cost sharing from patient	$40.00	Determined by plan
	[7]	Collects fee from covered entity	$15.25	Estimate
	[8]	Collects dispensing fee from PBM	$1.50	Estimate
	[9]	Collects ingredient cost reimbursement from PBM	$59.60	([AWP] - 17%)-[6]
	Pharmacy retains		**$15.25**	**[6]+[7]+[8]+[9]-[5]-[14]**
PBM	[10]	Collects base rebate from manufacturer	$-	No rebate paid
	[11]	Collects administrative service fee from manufacturer	$-	No fee paid
	[12]	Collects price protection rebate from manufacturer	$-	No rebate paid
	[13]	Collects and retains administrative fee from insurer/ plan sponsor	$1.00	Negotiated with insurer/ plan sponsor. Per claim fee
	[14]	Collects and retains transaction and E-prescribing fees from pharmacy	$0.25	Transaction($0.10)+E-prescribing ($0.15) fees
	[15]	Retains share of base rebate and price protection rebate	$-	No rebate paid
	[16]	Retains share of manufacturer administrative fee	$-	[11]*75%
	[17]	Reimbursed for ingredient cost by insurer/ plan sponsor	$62.00	([AWP] - 15%)-[6]
	PBM Retains		**$2.15**	**[13]+[14]+[15]+[16]+[17]-[9]-[8]**
Insurer/ plan sponsor	[17]	Payment to PBM	$63.00	[13]+[17]
	[18]	Receives share of rebates and fees	$-	([11]-[16])
	Final insurer/ plan sponsor cost		**$63.00**	**[17]-[18]**
Patient cost sharing amount			$40.00	[6]
Manufacturer-retained payment			$23.50	[WAC]-[2]-[4]-[10]-[11]-[12]

63x

References

1. Blalock E, Ferritto M, Taylor J. The Pharmaceutical Supply Chain, 2013-2023. Berkeley Research Group, January 2025. https://www.thinkbrg.com/insights/publications/the-pharmaceutical-supply-chain-2013-2023/
2. Pharmaceutical Commerce. Prescription Sales via Traditional Healthcare Distributors Increase. October 2023. https://www.pharmaceuticalcommerce.com/view/prescriptions-sales-via-traditional-healthcare-distributors-increase
3. Kim K. 3 Stocks to Watch in the Drug Distribution Industry. Morningstar, April 2024. https://www.morningstar.com/stocks/investment-opportunities-drug-distribution-industry
4. Fein A. The Top Pharmacy Benefit Managers of 2023: Market Share and Trends for the Biggest Companies—And What's Ahead. Drug Channels, April 9, 2024. https://www.drugchannels.net/2024/04/the-top-pharmacy-benefit-managers-of.html
5. Miller E, et al. Retail Drug Prices, Out-of-Pocket Costs, and Discounts and Markups Relative to List Prices: Trends and Differences by Drug Type and Insurance Status, 2011 to 2016. AHRQ MEPS, October 2019. https://meps.ahrq.gov/data_files/publications/rf44/rf44.shtml#Note1
6. IQVIA. The Use of Medicines in the US 2024: Usage and Spending Trends and Outlook to 2025, April 2024. https://www.iqvia.com/-/media/iqvia/pdfs/institute-reports/the-use-of-medicines-in-the-us-2024/the-use-of-medicines-in-the-us-2024-usage-and-spending-trends-and-outlook-to-2028.pdf
7. Percher E. Trends in Profitability and Compensation of PBMs and PBM Contracting Entities. Nephron Research, September 2023. https://nephronresearch.com/trends-in-profitability-and-compensation-of-pbms-and-pbm-contracting-entities/
8. Mulcahy AM, Rao P, Zhou A, et al. Prescription Drug Prices, Rebates, and Insurance Premiums. RAND, December 5, 2024. https://www.rand.org/pubs/research_reports/RRA1820-3.html
9. Xcenda. Skyrocketing growth in PBM formulary exclusions continues to raise concerns about patient access. May 2022. https://www.xcenda.com/insights/skyrocketing-growth-pbm-formulary-exclusions-concerns-patient-access
10. Mulcahy AM, Rao P, Zhou A, et al. Prescription Drug Prices, Rebates, and Insurance Premiums. RAND, December 5, 2024. https://www.rand.org/pubs/research_reports/RRA1820-3.html
11. Federal Trade Commission. Pharmacy Benefit Managers: The Powerful Middlemen Inflating Drug Costs and Squeezing Main Street Pharmacies. July 2024. https://www.ftc.gov/system/files/ftc_gov/pdf/pharmacy-benefit-managers-staff-report.pdf
12. Percher E. Trends in Profitability and Compensation of PBMs and PBM Contracting Entities. Nephron Research, September 2023. https://nephronresearch.com/trends-in-profitability-and-compensation-of-pbms-and-pbm-contracting-entities/
13. GAO, 340B Drug Discount Program: Oversight of the Intersection with the Medicaid Drug Rebate Program Needs Improvement, January 2020, https://www.gao.gov/assets/gao-18-480.pdf; 42 U.S.C. § 256b(a)(5)(A) (prohibiting Medicaid/340B duplicate discounts); 42 U.S.C. § 1320f-2(d) (prohibiting duplication of the maximum fair price for selected drugs and the 340B ceiling price for such drugs); 42 U.S.C. § 1395w-3a(i)(3)(B)(ii) (requiring exclusion of 340B units from Part B inflation rebates); 42 U.S.C. § 1395w-114a(b)(1)(B) (requiring exclusion of 340B units from Part D inflation rebates).
14. Fein A. Mapping the Vertical Integration of Insurers, PBMs, Specialty Pharmacies, and Providers: A May 2024 Update. Drug Channels, May 7, 2024. https://www.drugchannels.net/2024/05/mapping-vertical-integration-of.html
15. Kakani P, Navangul S, Lee Luo C, et al. Use of and Steering to Pharmacies Owned by Insurers and Pharmacy Benefit Managers in Medicare. JAMA Health Forum. 2025;6(1):e244874. doi:10.1001/jamahealthforum.2024.4874
16. PBM Accountability Project. Understanding the Evolving Business Models and Revenues of Pharmacy Benefit Managers. December 2021. https://www.pbmaccountability.org/_files/ugd/b11210_264612f6b98e47b3a8502054f66bb2a1.pdf?index=true
17. Walker J. Generic Drugs Should Be Cheap, but Insurers Are Charging Thousands of Dollars for Them. Wall Street Journal, September 2023. https://www.wsj.com/health/healthcare/generic-drugs-should-be-cheap-but-insurers-are-charging-thousands-of-dollars-for-them-ef13d055

64x

References [continued]

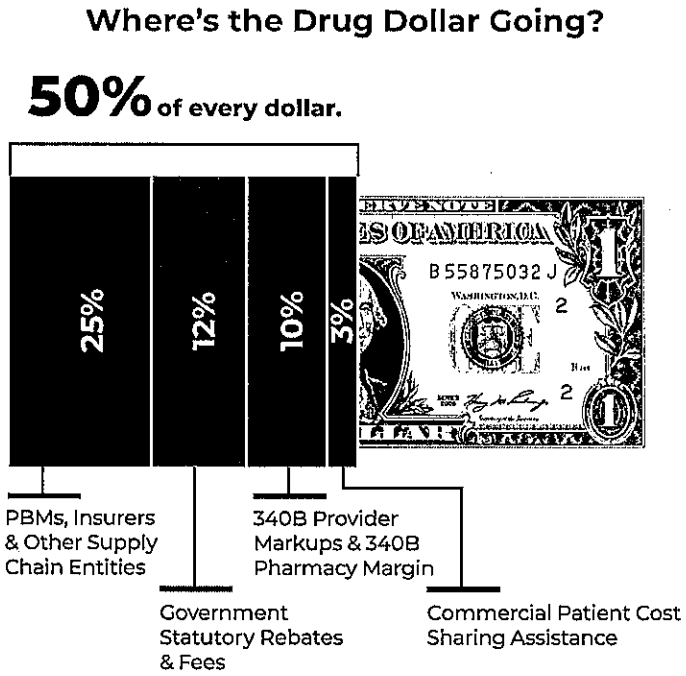
18. Federal Trade Commission. Specialty Generic Drugs: A Growing Profit Center for Vertically Integrated Pharmacy Benefit Managers, January 2025. https://www.ftc.gov/system/files/ftc_gov/pdf/PBM-6b-Second-Interim-Staff-Report.pdf
19. Mulcahy AW, Kareddy K. Prescription Drug Supply Chains: An Overview of Stakeholders and Relationships. ASPE, October 2021. https://aspe.hhs.gov/reports/prescription-drug-supply-chains
20. IQVIA. The Use of Medicines in the US 2024. April 2024. www.iqvia.com/-/media/iqvia/pdfs/institute-reports/the-use-of-medicines-in-the-us-2024/the-use-of-medicines-in-the-us-2024-usage-and-spending-trends-and-outlook-to-2028.pdf
21. Percher E. Trends in Profitability and Compensation of PBMs and PBM Contracting Entities. Nephron Research, September 2023. https://nephronresearch.com/trends-in-profitability-and-compensation-of-pbms-and-pbm-contracting-entities/
22. Fein A. Drug Channels News Roundup, June 2024: Cordavis Humira Update, OptumRx's New Biosim Biz, Generic Drugs' Wild Ride, IRA Predictions, and Dr. G on Med School. Drug Channels, June 25, 2024. https://www.drugchannels.net/2024/06/drug-channels-news-roundup-june-2024.html
23. Fein A. Humira Biosimilar Price War Update: Should We Be Glad that CVS Health and Express Scripts Are Using Private Label Products to Pop the Gross-to-Net Bubble? Drug Channels, September 4, 2024. https://www.drugchannels.net/2024/09/humira-biosimilar-price-war-update.html
24. Wyden R, Brown S. Letter to the Honorable Lena Khan. US Senate Committee on Finance, September 30, 2024. https://www.finance.senate.gov/imo/media/doc/093024_wyden_brown_letter_to_ftc_on_pbm_practices.pdf
25. E Blalock et al. For-Profit Pharmacy Participation in the 340B Program: 2025 Update. 340B Industry Roundtable, February 2025. https://roundtable.thinkmosaic.com/links/for_profit_phcy_340b_2025_update
26. Sood N, Shih T, Van Nuys K, Goldman D. The Flow of Money Through the Pharmaceutical Distribution System. USC, June 2017. https://healthpolicy.usc.edu/wp-content/uploads/2017/06/The-Flow-of-Money-Through-the-Pharmaceutical-Distribution-System_Final_Spreadsheet.pdf
27. Fein A. Exclusive: For 2023, Five For-Profit Retailers and PBMs Dominate an Evolving 340B Contract Pharmacy Market. Drug Channels, July 11, 2023. https://www.drugchannels.net/2023/07/exclusive-for-2023-five-for-profit.html
28. Drug Channels Institute analysis of OPA Daily Contract Pharmacy Database, April 2022.
29. E Blalock et al. For-Profit Pharmacy Participation in the 340B Program: 2025 Update. 340B Industry Roundtable, February 2025. https://roundtable.thinkmosaic.com/links/for_profit_phcy_340b_2025_update
30. Martin R, Hasan S. Growth of the 340B Program Accelerates in 2020. IQVIA Blog, March 2021. https://www.iqvia.com/locations/united-states/blogs/2021/03/growth-of-the-340b-program-accelerates-in-2020
31. Magnolia Market Access. Understanding the Economic Burden on Federal and State Tax Liability of Forgone Commercial Rebates Due to the 340B Drug Pricing Program. January 2025. https://www.magnoliamarketaccess.com/insight/how-the-340b-program-impacts-federal-state-tax-liability

65x

Blog

Elizabeth Carpenter January 7, 2025

New study: Entities that don't make medicines get half of what is spent on those medicines



66x

Half of every dollar spent on brand medicines goes to entities that play no role in the research, development, or manufacturing of those medicines, according to a new analysis by Berkeley Research Group (BRG).

The report's findings highlight a growing problem: spending on medicines is padding the profits of middlemen and subsidizing many parts of the health care system, often at the expense of patients.

So, where exactly is the money going? It's going to middlemen like PBMs and insurers who are aggressively consolidating their control over health care; mandatory government fees and rebates; hospitals, clinics and for-profit pharmacies in the 340B markup program; and patient assistance programs designed to help patients in a commercial insurance market that increasingly covers less while charging patients more.

WHERE'S THE DRUG DOLLAR GOING?

PBMS, INSURERS & OTHER SUPPLY CHAIN ENTITIES

PBMs, insurers, Group Purchasing Organizations (GPOs) and others in the supply chain retained the largest share of spending among non-manufacturers. In 2023, $170 billion in rebates, discounts, fees and other payments from biopharmaceutical companies went to these middlemen. While this represents 25% of all brand spending, middlemen can take up to 80% or more on some medicines. These payments lower the cost of medicines for insurers and PBMs, yet patients are often forced to pay their out-of-pocket costs based on the full undiscounted price, leading patients to pay more than they should for their medicines.

340B PROVIDER MARKUPS & 340B PHARMACY MARGIN

340B providers and for-profit companies now get 18 times more of the drug dollar than they did a decade ago while patients, taxpayers and employers are saddled with a hidden tax that inflates their costs. The largest share of 340B costs is driven by hospital markups—where big tax-exempt hospitals markup drugs up to 7x or more.

GOVERNMENT STATUTORY REBATES AND FEES

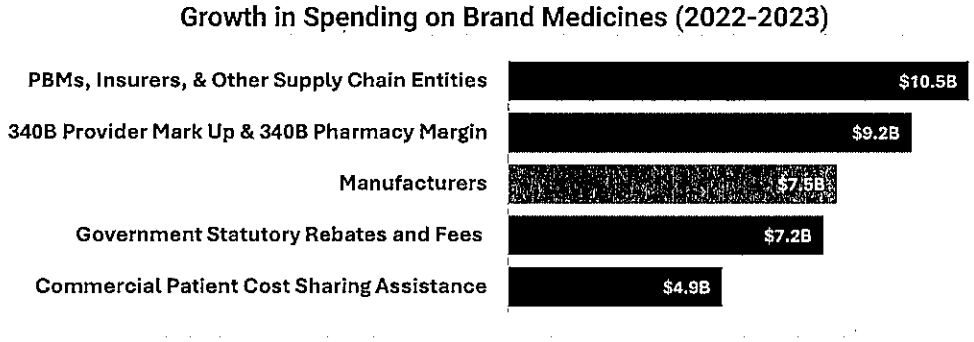
Biopharmaceutical companies paid $79 billion in rebates, discounts, and fees to government programs, including Medicaid and Medicare Part D. The Inflation Reduction Act (IRA) will further increase the amount of spending going to the government, eroding the investment in future research and development.

67x

COMMERCIAL PATIENT COST SHARING ASSISTANCE

As insurers force commercially covered patients to pay higher out-of-pocket costs, biopharmaceutical manufacturers provide billions in assistance to help them afford their medicines. This assistance represented nearly $23 billion in spending. Unfortunately, it's not all getting to patients. In fact, insurers and PBMs kept **nearly $5 billion** of cost-sharing assistance for themselves through abusive copay accumulator and maximizer programs.

WHAT'S DRIVING DRUG SPENDING GROWTH?



From 2022 to 2023, spending on medicines increased $39 billion. The rebates, fees and other payments middlemen siphon out of the system was the single largest driver of this growth in spending. The second largest contributor was the growth 340B hospital markups and 340B provider and pharmacy profit on prescription drugs. These costs continue to increase because there's no oversight or transparency. Worse, the money isn't going to help low-income and uninsured patients.

As policymakers continue to look for ways to address rising health care costs and spending on medicines, the report's findings are essential to help diagnose the right problems and pinpoint meaningful solutions. That starts with common sense reforms that put an end to insurer and PBM abuses, fix the IRA, reform the 340B markup program and ensure patient assistance goes to patients, not middlemen.

Topics: **340B, PBMs/Insurance**

68x

Vertical Business Relationships Within the U.S. Drug Channel, 2025

macy benefit manager; GPO = group purchasing organization; LTC = long-term care
erapeutics sources formulary rebates from—and has a minority ownership interest in—Ascent Health Solutions, which is part of Cigna's Evernorth segment.
s a buying group focused on medical benefit drugs. Its ownership includes the Blue Cross Blue Shield (BCBS) Association, Prime Therapeutics, Elevance Health, and other independent BCBS health plans.
erapeutics Pharmacy was previously known as Magellan Rx Pharmacy. Prime's clients have the option to use Express Scripts for mail/specialty pharmacy services.
igna invested $2.7 billion for an estimated 14% ownership stake in VillageMD. In 2024, it wrote down the full value of this investment. Walgreens Boots Alliance owns a majority of VillageMD.
egan outsourcing its PBM operations to Express Scripts in 2024. In 2023, Centene rebranded its Envolve Pharmacy Solutions pharmacy benefit subsidiary as Centene Pharmacy Services.
nark provides certain PBM services to CarelonRx business. CarelonRx also sources formulary rebates from—and has a minority interest in—Zinc Health Services, which is a subsidiary of CVS Health.
2025 Economic Report on U.S. Pharmacies and Pharmacy Benefit Managers, Exhibit 261. Exhibit does not illustrate every subsidiary business operated by each company.

Testimony of the
New Jersey Association of Health Plans
For the Senate Commerce Committee
HEARING ON PHARMACY BENEFIT MANAGERS IN NJ
June 23, 2025

Chairman Lagana and Members of the Senate Commerce Committee:

The New Jersey Association of Health Plans ("NJAHP") is a non-profit association representing the leading health care plans in the state which cover over seven million New Jersey residents. Our members include Aetna, AmeriHealth, Cigna, Fidelis Care, Horizon Blue Cross Blue Shield of New Jersey, Oscar, UnitedHealthcare, and WellPoint. Thank you for the invitation today to talk about the current state of pharmacy benefits managers (PBMs) in New Jersey.

NJAHP is a non-profit corporation created to serve its member health insurance care plans with a mission of fostering understanding in the value that health plans contribute to New Jersey's health care system. Our membership includes both health care plans that contract with PBMs as well as some that have PBMs that are affiliated companies. While our member health care plans may operate different businesses within health care, NJAHP is an organization that is focused on the health insurance provider perspective.

The History of Health Insurance Providers and PBMs

The origins of health insurance in the United States are often observed as endeavors by hospital and then physicians during the Great Depression to implement forms of insurance to ensure a means of payment for services. The rise of unions, World War II and some quirks in the federal tax code directed health insurance efforts largely to an employer-based model, which still is the predominant form of health insurance today. Public forms of health insurance, Medicare and Medicaid, were enacted in the mid-1960s to provide coverage for hard-to-finance populations. The 1960s also saw the start of a movement to include prescription drugs in the package of benefits covered by insurance. In the 1980s, extraordinary advances in medical technology and the resulting cost impact helped usher in managed care, which used selective contracts with providers and encouraged price competition to help offset the rising costs to policyholders and consumers. Regulatory interventions (HIPAA, the Affordable Care Act, state laws) were enacted to put strong regulatory guardrails around markets and coverage/benefits in attempts to balance quality, access, cost, and efficiency. Like all enterprises, health insurance was created to meet needs (improving health outcomes, socializing medical costs, providing financial protection, and for employer-based coverage as a recruitment/retention tool) and is constantly evolving.

70x

Similarly, PBMs were created and have been evolving to meet the needs of various plan sponsors and health insurers, within an increasingly strict and complex regulatory framework. As the role, scope and cost of prescription drugs has increased, so has the need to address cost containment, safety and fair access. Today, PBMs play an integral role in the administration of comprehensive health benefits.

Why Do Health Insurance Providers and Employers Contract with PBMs?

No employer or health insurance provider is *required* to contract or use a PBM. However, in almost all cases they do so. PBMs are effectively Americans' bargaining power, negotiating savings for millions of patients.

Generally for the individual and smaller-sized employer markets, policyholders purchase benefit packages with an integrated pharmacy benefit. Health care plans in New Jersey then contract with or use a PBM to administer most of the drug benefits under the plan. Larger-sized employer, unions, government purchasers will often separately procure the services of a PBM to administer a drug benefit. An example close to home of that is the State Health Benefits Plan, where the state contracts separately for coverage for major medical/health benefits and drug benefits. Whether the benefits are integrated or contracted separately, purchasers almost always use a PBM because it provides a range of services useful to the policyholder, including acting as a group purchasing agent. In short, health care plans outsource administration of prescription drug benefits because PBMs can provide these services better than keeping them in-house. Importantly, for integrated benefit plan designs, the health insurance provider remains responsible for all laws and regulations for services and benefits provided by a PBM; a health insurance provider can't outsource ultimate responsibility, even if there are separate regulatory responsibilities for a PBM.

What do PBMs do?

PBMs negotiate drug prices with manufacturers, advise plan sponsors on drug formularies (lists of covered or preferred drugs), provide claims administration, manage pharmacy networks, have programs to ensure safety (*e.g.*, Medication Therapy Management Programs), and adherence programs to optimize patient outcomes, among other services. PBMs aim to lower prescription drug costs for employers, health plans, and patients by negotiating unit cost discounts with manufacturers and retail pharmacies, utilizing mail-order and specialty pharmacies, policing waste, fraud or abuse as well as implementing various quality/cost-saving programs.

Health Insurance Providers and Pharmacies

State regulated health benefits plans are required to meet **strict network adequacy requirements**. NJAHP has not heard from its members that there are challenges in meeting these network adequacy requirements for pharmacies. While provider scarcity for some provider classes does make network adequacy challenging, finding pharmacies traditionally has not been a problem in New Jersey.

New Jersey **has an any "Any Willing Pharmacy" law**, P.L.1993, c.378 (N.J.S.A. 17B27-4601i), which permits any pharmacy or registered pharmacist the right to contract and participate as an in-network provider under the same terms and conditions currently applicable to all other providers. These types of "Any Willing Provider" laws insulate providers from competition and have been found to increase the cost of care.[1] This protectionist measure already exists in New Jersey. It is the only any willing provider law in the state and it is limited to pharmacies.

Pharmacies are licensed and regulated by the New Jersey State Board of Pharmacy. It is our understanding, that the following are key data points about the pharmacies in the State.

- 1:1 independent to chain pharmacy ratio.
- 1400 pharmacies total, with no deserts.
- Almost 100% of independents use PSAOs.

New Jersey's Regulatory Climate for PBMs

New Jersey has already undertaken significant legislation, the most recent of which is in the process of implementation. Today, PBMs have licensure requirements, report to DOBI and the Attorney General, and provide a range of reporting to regulators, including a demonstration that the full value of all pharmaceutical rebates are provided to the carrier, which must attest that it has either used those funds to lower premiums or pass through at the point of sale.

One point we would like to make is that regulation of PBMs may provide no benefit to consumers, but rather benefit pharmaceutical companies or pharmacists. If these interventions come with costs, they get passed along to health care plans, which in turn likely incorporate such costs into premiums. Interestingly, the state has acknowledged that regulatory interventions will come at a cost, and has exempted Medicaid and the public employee programs, leaving state regulated insurance products for individual families and employers to pay higher rates. [See Conditional Veto message for A3717]

List of NJ Laws Directed at PBMs

- P.L.2015, c.179: Regulates pharmacy benefits managers and requires certain disclosures concerning multiple source generic drug pricing.
- P.L. 2017, c.383: Regulates pharmacy benefits managers as organized delivery systems.
- P.L.2019, c.257: Prohibits pharmacy benefits managers and carriers from engaging in "claw back" and "gag clause" practices; requires certain disclosures by pharmacists; requires Director of Division of Consumer Affairs to conduct public information campaign.
- P.L. 2019, c.274: Prohibits pharmacy benefits managers from making certain retroactive reductions in claim payments to pharmacies.
- P.L. 2019, c.404: Requires New Jersey State Board of Pharmacy to establish prescription drug pricing disclosure website and certain pharmaceutical manufacturing companies to provide prescription drug price information. (Link added...after reviewing the bill, we should remove this)

[1] Klick, Jonathan and Joshua D. Wright, 2014. "The Effect of Any Willing Provider and Freedom of Choice Laws on Prescription Drug Expenditures."

- P.L. 2021, c. 151: Requires DHS to contract with third party entity to apply risk reduction model to Medicaid prescription drug services (Link added…I did find mention of PBMs in this bill).
- P.L.2021, c.257: Requires pharmacy benefits manager providing services within Medicaid program to disclose certain information to DHS.
- P.L.2021, c.285: Requires public members of Drug Utilization Review Board to disclose financial interests and benefits received from and investment interests held in pharmaceutical distributors, pharmaceutical manufacturers, or pharmacy benefits managers.
- P.L.2023, c.107: Establishes new transparency standards for pharmacy benefits manager business practices.

DOBI Regulations

- N.J.A.C. 11:4-2:62: PHARMACY BENEFITS MANAGERS

DOBI Proposals/Adoptions

- Pharmacy Benefits Managers
- Proposed New Rules: N.J.A.C. 11:4-62 (2017)
- Pharmacy Benefits Managers
- Adopted New Rules: N.J.A.C. 11:4-62 (2018)

DOBI Bulletins/Information

- Bulletin 24-18: Carrier, Pharmacy Benefits Manager, and Pharmacy Services Administrative Organization Compliance with P.L. 2023, c.107.
- N.J.S.A. 17B:27F-3.2 Reporting Template for Carriers – Use of Compensation Received from Pharmaceutical Manufacturers, Developers, and Labelers
- Bulletin 18-11: Compliance with N.J.S.A. 17B:27F-4 and 17B:27-46.1; Compliance with Amendments to N.J.S.A. 17:48H-1
- Bulletin 21-10: Early Prescription Drug Refills and Waiver of 90-Day Supply Limits for Consumers Affected by Tropical Storm Ida
- DOBI's PBM webpage

A Note on MCOs/PBMs Value to the State Medicaid Program

New Jersey's **MCOs have provided great value to the State and Medicaid beneficiaries**. The NJ FamilyCare program relies upon MCOs/PBMs to fill 98% of the total prescriptions. New Jersey has the fourth lowest costs in Medicaid pharmacy nationwide and the third highest generic dispensing rate among Medicaid programs nationwide.[2]

The Department of Human Services has also increased the risk and responsibilities for MCOs and their PBMS to provide high-cost genetic therapies like Lyfgenia and Zolgensma to NJ FamilyCare members.

---

[2] *Menges Group, "Assessment of New Jersey's Prescription Drug Management Performance and Policy Options." (February 2021).*

Additional PBM Legislation?

At this time, **NJAHP is not seeking or recommending legislation to further regulate PBMs**. Our members are sophisticated contracting partners. We do not believe that any further interventions are necessary to ensure fair contracting. These are private market contracts that should control these relationships without state-mandated provisions. Further, PL 2023, c. 107, the last amendment to the 2015 PBM law, already created a requirement that a PBM acts as the carrier's agent in good faith and fair dealing in the performance of all of its contractual duties.

If the Legislature develops additional legislation or regulations of PBMs, we would like consideration of the following:

- Is the policy designed to help consumers/patients, or is it designed to assist specific industry players? A clear articulation of the beneficiaries will help policymakers consider the merits of the intervention. It is our position that much of the regulatory interventions over the past ten years has been about increasing the contracting and negotiating power of pharmacies. To what markets does the intervention apply (e.g., commercial, Medicaid, SHBP/SEHBP, self-funded ERISA plans, other?). If there is a cost impact to the legislation, what is the policy rationale to carve out the application to the state as a payer (Medicaid, SHBP). Put another way, why is the financial impact something employers and unions can withstand, but the State can't?
- ERISA pre-emption has a complicated jurisprudence but the state should work to get a clear idea of whether an intervention is preempted by ERISA before embarking on interventions that may lead to costly legal challenges and compliance confusion. The Rutledge decision should not be read to mean that any and all regulation of PBMs is permissible under ERISA.
- Contracting flexibility for our members is a critical tool that allows health care plans and employers to select the plan that is best for their employees, best fits their budget, and best aligns with their tolerance for assuming financial risk. Contracting flexibility also encourages health insurance provider innovation that drives lower prescription drug spending and benefits employer clients.

While not part of today's discussion about PBM legislation, we would urge the Committee and the Legislature to look into wholesalers and PSAOs, which have largely avoided scrutiny in New Jersey's regulatory scheme.

We appreciate the opportunity to comment at today's hearing.

PETER ANDREYEV
State President
MICHAEL FREEMAN
Executive Vice-President

ORGANIZED 1896
MEMBERSHIP OVER 30,000

732-636-8860
FAX 732-636-0172

New Jersey State Policemen's Benevolent Association, Inc.

158 Main Street Woodbridge, New Jersey 07095

Peter Andreyev, President, New Jersey State Policemen's Benevolent Association
Submitted to the New Jersey Senate Commerce Committee
June 23, 2025

Chairman Lagana, Vice Chair Cryan, and members of the Committee:

Thank you for the opportunity to submit testimony on behalf of the New Jersey State Policemen's Benevolent Association (NJSPBA). Our members—active and retired law enforcement professionals—rely on the State Health Benefits Program (SHBP) to access the care they've earned through a lifetime of public service. We are grateful that this Committee is examining the conduct and impact of pharmacy benefit managers (PBMs) in New Jersey. It is a conversation that is long overdue.

Across the country and here in our state, PBMs are operating in a manner that drives up costs while actively reducing accountability. A recent report by the U.S. House Committee on Oversight and Accountability (July 2024)[1] concluded that PBMs—particularly the "Big Three" of CVS Caremark, Express Scripts, and Optum Rx—inflate drug prices, interfere with clinical care, and operate in ways that would not be tolerated in any other market. These vertically integrated conglomerates now control over 80% of the prescription drug market, and they often exploit that position to maximize revenue at the expense of payers, taxpayers, and patients.

In our own plan—the SHBP—we have seen firsthand the results of these practices. According to the State's mid-year 2025 actuarial report, prescription drug trend increases range from 18% to 23% for actives and early retirees, with specialty drug spend rising more than 23%. These aren't hypothetical trends. They translate into real premium increases, real financial pressure, and real harm to public employees and local governments trying to stay in the plan.

PBM conduct contributes directly to this problem through a number of tactics:

Rebates: PBMs negotiate large rebates with manufacturers, then restrict formularies to high-cost brand name drugs that offer them the biggest payouts—even when lower-cost generics or biosimilars exist. According to the House Oversight Committee, PBMs routinely block

biosimilars from their formularies or place them on non-preferred tiers to maintain rebate flow. As a result, plan sponsors are boxed into formularies built around profit rather than clinical value.

"Spread Pricing": While the SHBP contract is technically a "full pass-through" arrangement—meaning that the PBM is supposed to remit all rebates and discounts back to the plan—national investigations have shown that even in pass-through models, PBMs shift profit-making upstream. Instead of making margin on each claim, they insert excessive administrative fees, inflate contracted reimbursement rates, or rely on rebate-driven formulary design to extract revenue. A recent Congressional investigation (U.S. House Oversight Committee, 2024) found that PBMs use affiliated group purchasing organizations (GPOs) and overseas entities to aggregate rebate flows and charge layered fees before funds reach the plan sponsor. These practices obscure the true cost of drugs, even when the contract claims transparency. In other words, spread pricing may be removed from the pharmacy transaction, but the spread simply reappears elsewhere—in ways that are often undetectable to plan fiduciaries, including the SHBP PDC members.

Patient Steerage: many PBMs, including the SHBP's, own their own mail-order and specialty pharmacies and use differential copays, restrictive networks, and specialty drug carve-outs to funnel patients to their in-house pharmacies. The result is reduced patient choice and higher cost—often with delayed access to critical medication. Moreover, this type of practice hurts our independent pharmacists throughout the state, whom many people rely on for more than prescription refills.

Fees and Clawbacks: As described in United States Senate Judiciary testimony just last month (May 2025), PBMs impose retroactive fees and nebulous performance penalties on pharmacies—often months after a prescription is filled. One pharmacist testified that he was reimbursed $10.33 for a $728.35 medication that he was ethically obligated to dispense. These practices are causing pharmacy closures nationwide and locally here in New Jersey – significantly destabilizing local access to care.

Closer to home, labor has consistently sounded the alarm on these PBM practices and offered responsible, data-backed alternatives. In recent years, labor has proposed options to trim costs, including a modernization of the SHBP formulary—only to have the proposal dismissed.

Instead, the administration imposed a 16.3% premium hike in 2025, and is poised to do something similar in 2026. The only alternatives that have been offered by the Administration involve more cost-shifting to the members, which is simply unacceptable given the current disregard for prudent plan management.

Perhaps the most glaring example of this disregard is the current PBM contract itself. We are now in year six of a contract with Optum Rx—a contract originally structured as a 3-year term with two 1-year extensions (3+1+1). That term has come and gone. Yet no RFP has been issued, no competitive bidding process has taken place, and no alternative options have been presented to members or stakeholders. The contract will undoubtedly enter its seventh year. That is far beyond what is considered a best practice in any fiduciary setting. Public plans should not be

locked into long-term contracts with vendors whose practices have drawn bipartisan scrutiny at the national level.

Let me be clear: our members need and value the benefits provided through the SHBP. These are not overly generous benefits—they are fair compensation for public service. The problem is not the benefit design. The problem is the entities entrusted to manage those benefits who are now enriching themselves through opaque, rebate-driven, anti-competitive behavior.

We need urgent reform to restore accountability to the pharmacy benefit side of our health plan.

We urge this Committee to ensure that New Jersey does not continue down a path that has already been exposed as deeply flawed and harmful to plan participants. The SHBP should be a model of public sector benefit administration—not a captured market for corporate profit extraction. We thank you for your attention and for taking steps to rein in these harmful practices.

Sincerely,

Peter Andreyev
President, New Jersey State Policemen's Benevolent Association

[1] https://oversight.house.gov/wp-content/uploads/2024/07/PBM-Report-FINAL-with-Redactions.pdf

NACDS NATIONAL ASSOCIATION OF CHAIN DRUG STORES

NACDS and Testimony to the New Jersey Senate Commerce Committee

Monday, June 23, 2025

The State of Pharmacy Benefit Managers in New Jersey

Chair Lagana, Vice Chair Cryan, and Members of the Senate Commerce Committee, the National Association of Chain Drug Stores (NACDS) would like to offer our sincere thanks for the opportunity to provide written testimony regarding the state of Pharmacy Benefit Managers (PBMs) in New Jersey. Comprehensive and enforceable PBM reform is absolutely paramount to continued access to medications for patients across New Jersey.

States across the country, including New Jersey, have recognized the acute need to enact PBM reform and to press forward with implementation, enforcement, and oversight despite PBMs' efforts to oppose or roll back such reforms. While more than 155 new PBM reform laws were enacted nationwide from 2021 to 2024, additional reforms and rigorous enforcement of existing laws remain urgently needed. As the Commerce Committee is aware, PBMs claim to reduce prescription drug costs, but their unregulated business practices are key components of skyrocketing healthcare spending. PBM activities include unfair and opaque dealings with pharmacies with respect to reimbursement, network design, audit practices, constructing artificial barriers that limit patient choice and competition, self-referring patients to their own mail-order and/or retail operations, switching patients to more expensive medications to benefit the PBM and questionable use and disclosure of sensitive patient information. PBMs claim their ability to negotiate with drug manufacturers and pharmacies reduces overall prescription drug costs. However, despite their claims, overall prescription drug spending and patient out-of-pocket costs continue to increase steadily. Simply put, without meaningful PBM reform, more dollars are flowing to PBMs instead of reducing prescription drug costs for patients across New Jersey and safeguarding access to their trusted and convenient pharmacies.

Implementing and enforcing fair and adequate pharmacy reimbursement will help to ensure sustained patient access to pharmacy care services at neighborhood pharmacies across New Jersey. Fair and adequate pharmacy reimbursement should always be comprised of two parts: 1) the ingredient cost for the prescription drug; and 2) a professional dispensing fee across payer markets to help ensure reasonable reimbursement and sustainable pharmacy service for Marylanders. Without necessary rate floors that ensure reasonable and sufficient reimbursement for community pharmacies, inadequate or below-cost reimbursement to pharmacies and pharmacists has already, and is likely to continue, to result. This outcome could force pharmacies to either operate at a loss, be unable to stock certain medications, or worse, potentially close their doors permanently—negatively impacting patients by ultimately worsening patient outcomes, reducing medication adherence, and increasing prescription abandonment and hospitalizations.

In fact, the detrimental impact of pharmacies and pharmacists being reimbursed at inadequate rates has been widely reported and has become, simply put, insurmountable for many pharmacies. Throughout New Jersey, neighborhood pharmacies are experiencing economic hardship associated with shouldering the financial burden of continued unsustainable, below-cost reimbursement that threatens their long-term viability, and ultimately, patient access to lifesaving care. In 2025 alone, New Jersey will see the closure of 34 Rite Aid stores/pharmacies after the company's Chapter 11 bankruptcy filing.

New Jersey pharmacies provide increased options for safe, affordable, and convenient patient care. Yet, this access can be undermined when health plans and their PBMs "claw back" fees retroactively from pharmacies weeks or months after a claim has been adjudicated or processed. These "claw backs" can diminish access to care and can result in a pharmacy reimbursement that falls below a pharmacy's costs (e.g., cost to buy the drug based on ingredients and to dispense the drug). "[P]ost-sale adjustments can require a pharmacy to, often blindly, make payments of hundreds of thousands of dollars back to the PBM months after the relevant prescriptions are dispensed."[1] The financial pressures that retroactive pharmacy fees place on pharmacies have contributed to some pharmacies choosing to close their doors, while others have chosen to pare back hours and health care services.

The United States House of Representatives, Committee on Oversight and Accountability's 2024 report found "retroactive fees are often arbitrary and can be levied weeks to months after a prescription is processed. Even though a pharmacy may be in-network, extraneous PBM fees add up, often costing a pharmacy more to fill a prescription than it is reimbursed. Due to the market share of the three largest PBMs, pharmacies are often faced with choosing between accepting fees or not serving patients."[2] Similarly, the United States Federal Trade Commission, Office of Policy Planning's 2024 report confirmed that "another key factor adding to pharmacies' difficulties in understanding and predicting reimbursement is the financial adjustments PBMs make many weeks and months after the point of sale. These adjustments exacerbate information asymmetries that disadvantage unaffiliated pharmacies...Through these adjustments, PBMs often extract significant fees and claw back payments from pharmacies."[3]

New Jersey pharmacies need predictability and transparency in their pharmacy reimbursement to continue to be viable and reliable access points of care for much needed patient services. The Committee must ensure implementation and rigorous enforcement legislation that prohibits a health benefit plan issuer or pharmacy benefit manager from directly or indirectly reducing the amount of a claim payment to a pharmacist or pharmacy after adjudication of the claim through the use of an aggregated effective rate, quality assurance program, other direct or indirect remuneration fee, or otherwise. PBMs should be not only obligated, but legally compelled, to offer predictable and transparent pharmacy reimbursement to better protect pharmacies as viable and reliable access points of care for patient services across New Jersey.

PBMs, on behalf of health plans, routinely conduct audits to monitor pharmacies' performance and reverse or

---

[1] Pharmacy Benefit Managers: The Powerful Middlemen Inflating Drug Costs and Squeezing Main Street Pharmacies. https://www.ftc.gov/system/files/ftc_gov/pdf/pharmacy-benefit-managers-staff-report.pdf

[2] The Role of Pharmacy Benefit Managers in Prescription Drug Markets. https://oversight.house.gov/wp-content/uploads/2024/07/PBM-Report-FINAL-with-Redactions.pdf

3 Pharmacy Benefit Managers: The Powerful Middlemen Inflating Drug Costs and Squeezing Main Street Pharmacies. https://www.ftc.gov/system/files/ftc_gov/pdf/pharmacy-benefit-managers-staff-report.pdf

claw back pharmacy payments when there are issues with a particular pharmacy claim. However, audit processes can be inefficient and vary across PBMs, creating unstandardized processes and unforeseen administrative challenges that can delay and disrupt patient care delivery in pharmacies—particularly in vulnerable communities. Audits interrupt the pharmacy workflow, can extend wait times, and detract attention from quality delivery of pharmacy patient care services. In an effort to minimize disruption to patient care for patients across New Jersey and apply fair audit practices, the Committee should seek and subsequently enforce legislation that established guardrails around pharmacy audits that include, at a minimum, providing pharmacies with needed adequate notice, harmonized standards, and time to compile pharmacy claims and supporting documentation requested by PBM auditors.

Patients across New Jersey rely on their neighborhood pharmacy for dispensing of needed medications and essential healthcare services like health screenings, disease state management, vaccinations, testing, and treatment services (e.g., patient counseling, medication adherence). However, this access to care can be undermined when commercial health plan coverage *requires* patients to use mail-order pharmacies – especially when patients are seeking out multiple-month supplies of their medications. Some plans impose penalties such as higher copays or other financial disincentives for choosing a retail pharmacy instead of a mail-order pharmacy which is often owned by the PBM. This limitation impedes patient choice and access to these important, in-person pharmacy services and may impact health outcomes among patients. Recognizing the importance of maintaining comprehensive patient access to these types of services, many states have enacted laws to prohibit insurers from requiring or steering patients to fill their prescriptions using a mail-order pharmacy. Such laws support patients' rights to access pharmacy services from the pharmacy provider of their choice.

NACDS is greatly concerned that previous and future legislative and regulatory successes in New Jersey may be undermined if/when PBMs fail to comply with such laws and/or the state is unable to fully enforce PBM laws - potentially significantly impacting pharmacy reimbursement and patient access. It is imperative that the Committee focus on enforcing PBM and pro-pharmacy laws and regulation that advance a measurable and meaningful positive impact on pharmacy operations and seek to close any and all loopholes that PBMs are using or may use in the future to circumvent these laws and regulations to the detriment of the state, the patients, and the pharmacies and pharmacists who serve their needs.

NACDS provides its sincerest thanks to the Commerce Committee's continued commitment to engaging in comprehensive PBM efforts and would like to take this opportunity to reaffirm its support for ***S3538/A5531 – the Equitable Drug Pricing and Patient Access Act, as well as S3842/ A4953 – Patient and Provider Protection Act, two pieces of pro-patient and pro-pharmacy legislation that take invaluable steps toward ensuring continued access to prescription drugs and pharmacy services in New Jersey.*** NACDS and its members stand prepared to work in partnership with the Committee to achieve these goals. Simply put, comprehensive and enforceable PBM reform is imperative to continued access to medications for patients across New Jersey.