STATEMENT IN OPPOSITION TO A2418 / S1066

New Jersey’s research-based biopharmaceutical industry, the “medicine chest of the world,” develops new, innovative cures and treatments that benefit New Jerseyans and patients worldwide, as we have all witnessed first-hand over the past 20 months as the industry responded rapidly to COVID-19 with innovative diagnostics, anti-virals and vaccines.

The HealthCare Institute of New Jersey (HINJ) opposes A2418/S1066 because this legislation not only will not achieve what we all seek – which is to help patients in need access their medicines – it would thwart those research-based biopharmaceutical companies in fulfilling their mission, which is to discover new treatments, therapies and cures to improve human health.

We want to address numerous flawed premises that together create a fundamentally inaccurate perception that the industry is the root cause of whatever ails our health care system. These assertions are simply not based in fact and do a disservice to one of the pillars of New Jersey’s economy and the more than 400,000 New Jerseyans who are connected to the industry.

**The claim:** Biopharmaceutical companies sell their medicines to patients.

**FALSE.** Biopharmaceutical manufacturers sell to wholesalers, who, in turn, together with other players in the supply chain, add their mark-up and sell to retailers, who add their own mark-up and sell to patients. This explains why 46% of the cost of medicines is in the supply chain.

**The claim:** Biopharmaceutical companies set the price at the pharmacy counter.

**FALSE.** The retailer, after its acquisition of the product from the wholesaler and the addition of its own mark-up, sets the price at the pharmacy counter. For this reason, prices vary from pharmacy-to-pharmacy.

**The claim:** Biopharmaceutical companies set consumers’ out-of-pocket costs.

**FALSE.** Out-of-pocket deductibles and co-pays are set by a consumer’s insurance plan. These out-of-pocket expenses therefore vary by patient depending on their insurance plan’s level of coverage. Biopharmaceutical companies play no role in setting these out-of-pocket costs.
The claim: Seniors are forced to pay exorbitant prices for their medicines.

FALSE. All seniors have access to Medicare Part D, and lower income seniors also have access to the state’s Pharmaceutical Assistance to the Aged and Disabled (PAAD) and Senior Gold programs for added coverage at no cost. Therefore, every senior citizen in New Jersey should have access to prescription drug coverage with affordable co-pays as low as $5.00.

The claim: Drugs are the leading cost of health care.

FALSE. Every year, the Centers for Medicare and Medicaid Services (CMS) publishes an analysis, “The Nation’s Health Dollar: Where It Went.” Attached are the analyses for 2019, 2017 and 2011. For each of those years, prescription drugs accounted for only 10% of the cost of health care, behind hospitals at 31-33% and physician and clinical services at 20%. These prescription drug figures have remained relatively static for the past 50-plus years.

Furthermore, 90% of all U.S. prescriptions written are for generic drugs. When a branded medicine loses its patent protection, its cost as a generic substitution is significantly reduced (see further discussion below).

Additional facts to consider

Pharmacy Benefit Managers (PBMs) have an outsized impact on consumer drug prices.

Research-based drug manufacturers pay rebates of about $187 billion annually to Pharmacy Benefit Managers (PBMs) and insurers, representing about 33% of the total price of medicines. However, unlike doctors’, hospital and lab fees, where the patient’s bill states and reflects the negotiated insurance discount that is applied to the price of the procedure or service, rebates and discounts on prescriptions are rarely passed through to the consumer (unlike, for example, when buying a car, the manufacturer’s rebate is passed on to the consumer, not the dealer (middleman)).

In response to this situation, West Virginia in April 2021 became the first state to enact legislation requiring manufacturer rebates to be passed through to the consumer. As opposed to A2418/S1066, this is the type of measure worth considering as a viable and effective means to reduce consumers’ out-of-pocket drug expenses.

This structure also highlights why the focus on a drug’s "list price" is misleading, as the actual “cost” to the PBM is far less than the list price. When a PBM requires a larger rebate to keep a medicine on its formulary, the list price goes up, but the actual cost increase to the PBM is minimal due to the higher rebate. However, the PBM is not passing the rebate through to the consumer and instead it is calculating consumers’ out-of-pocket expenses based on the list price.
The U.S. patent system encourages risk and investment to promote innovation.

Research-based biopharmaceutical companies invest more than $100 billion annually in research that carries a high risk of failure. Even with their few successes, only 20% of new drugs will recoup the average R&D cost of $2.6 billion. In exchange for taking the risk and to promote innovation, research-based manufacturers are granted a period of patent exclusivity to recoup their investment before the patent on their discovery becomes available to generic manufacturers who do not invest in research but merely follow the patent, enabling generic medicines to be sold at a greatly reduced price while the drug’s original developer pursues new research on the next generation of medicines. This embodies the ecosystem of drug development and distribution.

The U.S. patent system is designed to encourage investment and risk to promote innovation, with the incentive being a limited period of exclusivity to earn a return on investment – a concept deemed so central that patent protection was embodied in the U.S. Constitution. Without the promise of a return on investment, investors – be they private equity, institutional investors or large companies – will look elsewhere to invest, causing patients in need, particularly those suffering from a rare disease (1 out of every 10 Americans), to wait even longer for someone to undertake the research to discover, develop and commercialize a cure, treatment or therapy for their disease state.

In conclusion, we therefore respectfully urge that, as opposed to unfounded rhetoric, any discussion of ways to reduce health care costs for patients must be grounded on the facts, and that we work together to develop real, fact-based solutions to help patients in need access their medicines in ways that also keep New Jersey the “medicine chest of the world.”

For these reasons, HINJ opposes A2418/S1066.

December 20, 2021
THE NATION'S HEALTH DOLLAR ($3.8 TRILLION), CALENDAR YEAR 2019, WHERE IT WENT

- Hospital Care, 31%
- Physician and Clinical Services, 20%
- Prescription Drugs, 10%
- Dental Services, 4%
- Other Professional Services, 3%
- Nursing Care Facilities and Continuing Care Retirement Communities, 5%
- Government Administration and Net cost of Health Insurance, 8%
- Durable Medical Equipment, 2%
- Other Non-Durable Medical Products, 2%
- Other Health Residential and Personal Care, 5%
- Home Health Care, 3%
- Public Health Activities, 3%
- Other, 14%

1 Includes Noncommercial Research and Structures and Equipment.
2 Includes expenditures for residential care facilities, ambulance providers, medical care delivered in non-traditional settings (such as community centers, senior citizens centers, schools, and military field stations), and expenditures for Home and Community Waiver programs under Medicaid. Note: Sum of pieces may not equal 100% due to rounding.

THE NATION'S HEALTH DOLLAR ($3.5 TRILLION), CALENDAR YEAR 2017, WHERE IT WENT

- Hospital Care, 33%
- Physician and Clinical Services, 20%
- Prescription Drugs, 10%
- Other, 14%
- Nursing Care Facilities and Continuing Care Retirement Communities, 5%
- Government Administration and Net cost of Health Insurance, 8%
- Durable Medical Equipment, 2%
- Other Non-Durable Medical Products, 2%
- Other Health Residential and Personal Care, 5%
- Home Health Care, 3%
- Public Health Activities, 3%

1 Includes Noncommercial Research and Structures and Equipment.
2 Includes expenditures for residential care facilities, ambulance providers, medical care delivered in non-traditional settings (such as community centers, senior citizens centers, schools, and military field stations), and expenditures for Home and Community Waiver programs under Medicaid.

Note: Sum of pieces may not equal 100% due to rounding.

The Nation’s Health Dollar ($2.7 Trillion),
Calendar Year 2011: Where It Went

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Care</td>
<td>31%</td>
</tr>
<tr>
<td>Physicians and Clinics</td>
<td>20%</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>10%</td>
</tr>
<tr>
<td>Dental Services and Other Professionals</td>
<td>7%</td>
</tr>
<tr>
<td>Government Administration and Net Cost of Health Insurance</td>
<td>7%</td>
</tr>
<tr>
<td>Nursing Care Facilities and Continuing Care Retirement Communities</td>
<td>6%</td>
</tr>
<tr>
<td>Other Medical Products</td>
<td>3%</td>
</tr>
<tr>
<td>Other Medical Products and Other Health, Residential, and Personal Care</td>
<td>5%</td>
</tr>
<tr>
<td>Government Public Health Activities</td>
<td>3%</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>3%</td>
</tr>
<tr>
<td>Other</td>
<td>14%</td>
</tr>
</tbody>
</table>

1 Includes Research (2%) and Structures and Equipment (4%).
2 Includes Durable (1%) and Non-durable (2%) goods.
3 Includes expenditures for residential care facilities, ambulance providers, medical care delivered in non-traditional settings (such as community centers, senior citizens centers, schools, and military field stations), and expenditures for Home and Community Waiver programs under Medicaid.
Note: Sum of pieces may not equal 100% due to rounding.