

THE ROLE OF
PHARMACY BENEFIT MANAGERS
IN PRESCRIPTION DRUG MARKETS
PART I: SELF-INTEREST OR HEALTHCARE?

HEARING
BEFORE THE
COMMITTEE ON
OVERSIGHT AND ACCOUNTABILITY
HOUSE OF REPRESENTATIVES
ONE HUNDRED EIGHTEENTH CONGRESS

FIRST SESSION

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**THE ROLE OF
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PART I: SELF-INTEREST OR HEALTHCARE?**

Tuesday, May 23, 2023

HOUSE OF REPRESENTATIVES,
COMMITTEE ON OVERSIGHT AND ACCOUNTABILITY,
Washington, D.C.

The Committee met, pursuant to notice, at 10:02 a.m., in room 2154, Rayburn House Office Building, Hon. James Comer [Chairman of the Committee] presiding.

Present: Representatives Comer, Gosar, Foxx, Grothman, Palmer, Higgins, Sessions, Biggs, LaTurner, Fallon, Donalds, Armstrong, Timmons, Burchett, Greene, McClain, Boebert, Fry, Luna, Edwards, Langworthy, Burlison, Raskin, Norton, Lynch, Connolly, Krishnamoorthi, Mfume, Ocasio-Cortez, Porter, Bush, Gomez, Brown, Stansbury, Garcia, Frost, Balint, Lee, Casar, Crockett, Goldman, and Moskowitz.

Also present: Diana Harshbarger (R-TN), Buddy Carter (R-GA), and Jake Auchincloss (D-MA).

Chairman COMER. The Committee on Oversight and Accountability will come to order. I want to welcome everyone here today.

Without objection, the Chair may declare a recess at any time.

I recognize myself for the purpose of making an opening statement.

Welcome to today's hearing on the role of pharmacy benefit managers in pharmaceutical markets. Today, healthcare premiums have increased faster than inflation. List prices for prescription drugs have gone through the roof even though net prices have declined, and despite this increase in healthcare cost, life expectancy has remained stagnant. That means someone is benefiting, and it is not patients. Look no further than PBMs, or pharmacy benefit managers.

Today, we will have our first opportunity to examine how the middlemen in the pharmaceutical supply chain impact the cost of prescription drugs for patients. Today is the first public hearing this Committee has held to examine the behind-the-scenes tactics that PBMs use to prevent payers, including government payers like Medicare, Medicaid, TRICARE, and the Federal Employee Health

Benefits Program, from understanding how PBMs are making billions at the expense of patients and taxpayers.

When PBMs were first created, they were beneficial to the entire healthcare system. There were more than a dozen large PBMs across the country, all competing with each other to provide clear details about costs, fees, and rebates to pharmacies and patients. They were able to quickly tell pharmacists across the country whether insurance would cover a patient's medication and what the patient's co-pay would be. They were able to negotiate reduced cost of prescription drugs, pitting competing manufacturers against one another. They were able to drive down premiums for patients by encouraging greater adoption of lower cost medication.

But today, they have largely outgrown this role. Now instead of fierce competition, three large PBMs—CVS Caremark, Express Scripts, and OptumRx—collectively control 80 percent of the market. Today, every major PBM is owned by a major health insurer and owns or is owned by a specialty mail order or retail pharmacy, or all three. This means that when PBMs negotiate with a pharmacy or a health insurer, they are either negotiating with themselves or one of their direct competitors.

Today, PBMs engage in self-benefiting practices that boost their bottom line without a benefit to patients. In the Medicare program, PBMs often claw back billions of dollars in reimbursements paid to competing pharmacies. PBMs also steer patients to certain pharmacies and certain medications. By doing this, they can increase patients' co-pays and force manufacturers to increase list prices in order to meet the PBMs' higher rebate demands.

The big three PBMs have created group purchasing organizations, some incorporated abroad, to better hide the rebates and fees they receive. It is hard to see how these tactics actually benefit patients. State attorneys general in Ohio, Oklahoma, Utah, Texas, and others have filed lawsuits and opened investigations into the anti-competitive practices of PBMs. State legislatures across the country have passed legislation preventing some of their anti-competitive practices and requiring transparency in pricing and contracts. The Federal Trade Commission has opened an investigation into PBMs' anti-competitive actions.

Congress must act also. Last Congress, Oversight Republicans conducted a review of PBMs. What we found was deeply concerning and raised many questions about PBMs' role in the healthcare industry. That is why the Committee is making examining PBMs a priority this Congress. We hope to answer these questions. How are PBMs using their position at the center of prescription drug markets to undermine patient health, why and how are PBMs using a system of hidden rebates and fees, and how are PBMs harming community pharmacies?

From what we have seen, many PBMs are acting without consequence to the detriment of patients and their pocketbooks because PBMs have been allowed to hide in the shadows. It is time to bring them into the light.

I now yield to the Ranking Member for his opening statement.

Mr. RASKIN. Thank you very much, Mr. Chairman. Good morning to all, and thank you for coming to testify today.

The dangerously high price of prescription drugs is a serious social problem that we have long sought to address. In the last two congresses, Democrats on this Committee held five hearings on how to make medication more affordable and accessible to Americans. The average American spends more on prescription drugs each year than people living anywhere else in the world. In 2022, more than a quarter of U.S. grownups reported they did not take their prescription medication at some point in the last year because they could not afford it, so we are in an affordability crisis. No American should be forced to choose between living expenses, like groceries, rent or transportation, and affording their lifesaving medication. In the wealthiest country on earth, every person should be able to access the care and medication they need.

The Committee's focus on the problem of the PBMs is an important bipartisan step forward in addressing the overall crisis of healthcare in the country. But this crisis begins with the outrageous pricing of pharmaceutical drugs by the Big Pharma companies. Under former Chairman, Elijah Cummings, and former Chair, Carolyn Maloney, this Committee spent 3 years investigating the ways some pharmaceutical companies use unjustified and unfair pricing practices to enrich themselves at the expense of patients across the country. Former Chairman Cummings observed how "For years, drug companies have been aggressively increasing prices on existing drugs and setting higher launch prices for new drugs while recording windfall profits."

The Oversight Committee's investigation found drug companies engage in anti-competitive practices to keep drug prices high and exploited the fact that Medicare was not allowed to directly negotiate drug prices with them. Acting in response to these abuses, Democrats moved and passed historic legislation, the Inflation Reduction Act, to reduce drug prices. Thanks to the IRA, Medicare will be permitted to negotiate prices of dozens of the costliest drugs directly with Big Pharma manufacturers. This will help prevent drug companies from taking advantage of the ways that the Medicare program differs from similar programs in other countries to enrich themselves at the expense of older Americans and American taxpayers.

The IRA will also cap the price of insulin at \$35 a month for people covered by Medicare. Seniors who take insulin for diabetes will no longer be forced to ration their lifesaving medication as drug companies rake in record profits. And the IRA caps out-of-pocket costs under Medicare Part D to \$2,000 a year, indexed to inflation, bringing much needed relief to seniors, like in my district, who are spending thousands of dollars—\$5,000, \$10,000, \$15,000—just to cover the cost of their medication on a fixed monthly income.

But the fight for affordable medication will not stop with the Inflation Reduction Act or the Medicare program. President Biden has put forth bold proposals to expand these cost savings to all Americans, including by capping the price of insulin at \$35 per month for all diabetics in America, not just those in the Medicare program. We are also investigating the role of the pharmacy benefit managers, PBMs, in the prescription drug affordability crisis as intermediaries between insurers, drug companies, and pharmacies. PBMs wield tremendous influence over how much a patient pays

at the pharmacy counter for medication prescribed by their doctor and whether a patient can even afford to obtain their medication at all.

If the U.S. healthcare system worked as intended, PBMs should be negotiating lower drug prices on behalf of insurance companies, who would then pass the savings on to their patients, but that is not what is happening. As we will hear today, some PBM practices appear to be increasing the cost of medicine, actively preventing patients from accessing the drugs that their doctors have determined are appropriate for them, playing outrageous hide-and-go-seek games with people's medicine, and hurting independent and community pharmacies.

The House Oversight Committee has been working to expose PBMs and how they are undermining patient care. That is why former Chair Maloney launched an investigation last year into whether the practices of the PBMs and health insurers in the country create financial barriers for patients trying to access birth control. Under the Affordable Care Act and related guidance, contraceptive products that a patient's healthcare provider deems medically appropriate should be made available to that patient at no cost. The Committee's analysis found that certain products, including newer ones, were less likely to be made available by PBMs and insurers at no cost to patients. Patients or providers have to know to ask insurers and PBMs for an exception to receive these products for free, and the Committee found that PBMs and insurers denied an average of 40 percent of those requests each year, which is outrageous.

Today's hearing is an opportunity to build on this important work. I look forward to hearing from each of our witnesses about the ways that PBM practices may deny or delay the patients' receipt of their affordable medications, but PBMs are just one piece of the puzzle. Drug companies are ultimately responsible for setting high prices, and, in fact, they pour millions of dollars into TV and social media ads as well as lobbying to deflect attention away from their own role in setting high drug prices by shining the spotlight on the PBMs.

So, I would ask all of our colleagues to join with the Democrats in taking decisive action to lower prescription drug prices and engage in comprehensive oversight of the entire healthcare system, not just this part of it. I hope today's hearing is just one of many dedicated to building upon this Committee's longstanding work to improve access to affordable medicine for all. Thank you, Mr. Chairman. I yield back.

Chairman COMER. I ask unanimous consent for Representative Carter of Georgia, Representative Harshbarger of Tennessee, and Representative Auchincloss of Massachusetts to waive on to this Committee for the purpose of asking questions during this hearing.

Without objection, so ordered.

I am pleased to introduce our four witnesses today. Dr. Miriam Atkins is a medical oncologist, physician owner, and partner with AO Multispecialty Clinic in Augusta, Georgia. She is also the president of the Community Oncology Alliance, a national nonprofit that advocates for physician-owned community oncology practices and their patients. Greg Baker is a clinical pharmacist and CEO of

AffirmedRx, a PBM that works to bring transparency, integrity, and patient-centered focus to pharmacy benefit management. Dr. Kevin Duane is a pharmacist and owner of Panama Pharmacy in Jacksonville, Florida, and has previously testified about PBMs before the Florida state legislature. Mr. Frederick Isasi is Executive Director of Families USA, a nonprofit dedicated to ensuring healthcare is accessible and affordable to all. I want to welcome all of you to the Committee. I look forward to hearing from you about your experiences with PBMs.

Pursuant to Committee Rule 9[g], the witnesses will please stand and raise their right hands.

Do you solemnly swear or affirm that the testimony you are about to give is the truth, the whole truth, and nothing but the truth, so help you God?

[A chorus of ayes.]

Chairman COMER. Let the record show that the witnesses all answered in the affirmative. Please be seated.

We appreciate you all being here today and look forward to your testimony. Let me remind the witnesses that we have read your written statements, and they will appear in full in the hearing record. Please limit your oral statements to 5 minutes. As a reminder, please press the button on the microphone in front of you so that it is on, and the Members can hear you. When you begin to speak, the light in front of you will turn green. After 4 minutes, the light will turn yellow. When the red light comes on, your 5 minutes has expired, and we would ask that you please wrap up.

I recognize Dr. Atkins to begin with her opening statement.

**STATEMENT OF MIRIAM ATKINS, M.D., FACP
AO MULTISPECIALTY CLINIC, AUGUSTA ONCOLOGY, P.C.
PRESIDENT, COMMUNITY ONCOLOGY ALLIANCE**

Dr. ATKINS. Good morning, Chairman Comer, Ranking Member Raskin, and Members of the House Committee on Oversight and Accountability. Thank you for the opportunity to appear before the Committee to talk about my experiences on the front lines of medical care dealing with the PBMs and their policies that hinder patient care and harm my patients.

I am a medical oncologist with AO Multispecialty Clinic in Augusta, Georgia. I have been treating cancer patients in private practice for 30 years, and I have served in the United States Army Medical Corps and currently serve as President of the Community Oncology Alliance. During my time treating cancer, I have seen many great advancements such that cancer is no longer a death sentence. Many Americans with cancer are now cured or at least living normal, productive lives with the disease.

When I first started treating cancer patients, I was able to be their physician and focus on caring for them while relying on the knowledge and skills honed during my extensive training. I did not have to spend countless hours fighting with faceless corporations to justify my patients' treatment plans. However, virtually every day, I have to fight insurance companies and their pharmacy benefit miss-managers to get my patients evidence-based, lifesaving treatment they need. PBMs and their corporate insurers want to control what treatments I give and how and where they are given. In es-

sence, PBMs are practicing medicine without a license or regard for my patients. It is simply all about their profits and not my patients.

While new oral cancer drugs offer patients the convenience of not having to come to the clinic for treatment, they often create more obstacles for patients when it comes to insurance coverage at the hands of PBMs. Upwards of 35 percent of drugs we use to treat cancer are orals and are very expensive. PBMs have found a very lucrative and profitable market in controlling these medications. Our practice has a drug dispensary onsite where these oral cancer drugs are available. This allows us to fully integrate and closely coordinate patient care onsite in our practice. Our medical team can educate patients on the importance of taking these drugs as indicated, how to deal with the side effects.

However, PBMs often are mandating that patients get their medications not from our integrated clinic dispensary at the site of care, but from remote mail order pharmacies that the PBMs own or operate. They essentially rip a critical component of the patient's treatment out of our hands simply so they can profit. And as any oncologist will tell you, forcing patients to use PBM mail order pharmacies for potentially lifesaving cancer drugs is often unreliable, unsafe, and wasteful.

PBMs also often dictate use of their preferred drug, which can greatly hinder my patients' care. After all, who knows best to treat my patients, me or some faceless profit-seeking corporation? Unfortunately, the PBM preferred drug is often not the best route for a patient but the most profitable drug for the PBM.

In my written testimony, I cite several examples of PBM abuses. You can read about my 69-year-old multiple myeloma patient, whose treatment was delayed 8 weeks at the hands of a PBM, or the 61-year-old woman with metastatic breast cancer who first had to fail on an inferior drug, which did not negate me from giving her the treatment she should have received in the first place; or the 63-year-old woman with metastatic gastrointestinal stromal cell cancer required to pay a \$1,500 a month insurance co-pay to her PBM, but my practice pharmacy provided the drug for \$128 per month. Treatment delays, denials, and fueling drug costs, this is the PBM hell my patients and I live in every day.

In addition to the seven volumes of PBM horror stories I submitted with my written testimony, I would like to submit for the record another volume that the Community Oncology Alliance just released this morning. PBMs claim they save money. The reality is they hinder care and cost everyone involved, including patients, more money. Integrated with the largest insurers, the top PBMs have such leverage that they do what they want. They are not only driving independent pharmacies out of business, but also physicians who are weary from the endless daily fights with PBMs.

I applaud this Committee and other congressional committees that are exploring PBM abuses. I implore Congress to pass serious legislation this year that reins in the horrors that PBMs inflict on patients and providers and that stops PBM abuses that drive up drug costs.

I appreciate the opportunity to provide this testimony and welcome any questions.

Chairman COMER. Thank you, Dr. Atkins. Mr. Baker.

**STATEMENT OF GREG BAKER
B.S. PHARM
CEO OF AFFIRMED RX**

Mr. BAKER. Chairman Comer, Ranking Member Raskin, and distinguished Members of the House Committee, I would like to thank you for the invitation to speak to you on the necessity of PBM reform in the United States.

My name is Greg Baker. I am first and foremost a pharmacist. I am also CEO of AffirmedRx, which is a transparent PBM I founded and is headquartered in Louisville, Kentucky. I began my career 30 years ago as a pharmacy technician at an independent pharmacy in Fort Wayne, Indiana, that, not surprisingly, is no longer in business for many of the reasons we will touch upon today. Beyond that, I have 11 years' experience working directly with jumbo self-funded employers to help define and develop pharmacy programs. Our goal at AffirmedRx is to partner with self-funded employers to deliver patient-centric pharmacy benefits with a mission to improve healthcare outcomes by bringing clarity, integrity, and trust to pharmacy benefit managers.

Currently, a handful of large PBMs control up to 80 percent of the market in the USA. This is problematic for every employer in the country. These PBMs are not constrained by any obligation to be transparent on their pricing or methodology, and this is causing extreme escalation of costs to all employers using a traditional PBM. This problem is also costing taxpayers significantly since some of the biggest health plans in the country are run by local, state, and Federal Government entities.

Medicare and Medicaid programs throughout the country are also deeply affected by practices of traditional PBMs. And perhaps most importantly, it is also incredibly frustrating for practicing pharmacists who have a professional duty and a moral obligation to their patients to provide the best care possible. Patients themselves who can no longer afford their medications, which they need to live and have productive lives, also do not have good access to their medications.

In August 2022, the American Bar Association published an article explaining trends and developments in price gouging. They define price gouging as the practice of raising prices of essential goods, services, or commodities to an unreasonable, unfair, or excessive level, typically during a declared state of emergency. Most of these laws are also triggered by an abnormal market or economic disruption. I contend, based on the current PBM practices and the state of the pharmacy industry in America, we are in the middle of an emergency, and we need to focus on price gouging occurring in this industry.

Additionally, there has been much discussion about rebates and the relationship between pharmaceutical manufacturers and PBMs. I am not here to defend or hold manufacturers harmless when they are talking about why we have a drug affordability problem in our country. They are by no means innocent, but the PBMs bear significantly larger responsibility to the problem.

There are hundreds of brand manufacturers and only three main rebate aggregators. These three aggregators are all owned by the big three PBMs. They not only negotiate rebates for traditional PBMs, but they also provide these rebate services to almost every other PBM in this industry. These aggregators are Ascent, which was created in Switzerland by Express Scripts in 2019, now owned by Cigna; Zinc which was created by CVS in 2020; and Emisar which was started in Ireland in 2022. Ascent and Zinc each contract for over 100 million American lives, and Emisar contracts for 65 million. They use their scale to create competition between the manufacturers.

There are numerous reasons why costs go up, but the PBMs are at the heart of many of them by creating abnormal market and economic disruption at a time of national crisis when people can no longer afford their medications. If every American could afford their medication and had convenient access to community pharmacy, I believe we would remove hundreds of billions of waste from what is currently a \$1.4 trillion healthcare system.

The practices being engaged by these PBMs are inherently harmful to pharmacies throughout the country, especially independent pharmacies, for several reasons. The first example is steering patients away from their local pharmacy to large mail order organizations owned by these traditional PBMs themselves. Even when these independent pharmacies are included in PBM networks, they are often reimbursement at less than their acquisition cost. In the end, this harms patients and their care.

In closing, I would like to point to William Deming, the foremost thought leader in total quality management. He states, "Every system is perfectly designed to get the results that it gets." The system is not broken. It is working perfectly. The problem is we have the wrong system. We need to take time to build the system that works best for Americans, American taxpayers, and independent pharmacists. I commit to you that AffirmedRx will continue to work with employers, state and Federal health plans, and pharmacies throughout the country to find solutions to the challenges faced by every American, ensuring that they have access to drugs they need while keeping down unnecessary costs.

Thank you, Members of the Committee, and I look forward to speaking with you today and your questions.

Chairman COMER. Thank you. Dr. Duane.

**STATEMENT OF KEVIN J. DUANE
PHARM D
OWNER
PANAMA PHARMACY**

Mr. DUANE. Thank you, Chairman Comer, Ranking Member Raskin, and members of the community. I appreciate this opportunity today to speak to you regarding my experience as a pharmacist and pharmacy owner, and how the current marketplace distortions from pharmacy benefit managers, or PBMs, have negatively impacted my ability to care for my community.

My name is Kevin Duane, and I am a pharmacist and the owner of Panama Pharmacy in Jacksonville, Florida. Panama Pharmacy is one of the oldest community pharmacies in Jacksonville, having

served patients in our area for over 100 years. Our patient base is largely from a poor and underserved community with over 70 percent of patients on a government-funded health plan. I am a first-generation pharmacist, I am actually the first in my family to attend college. I have always considered small business ownership to be that kind of American Dream that you hear about in life, but my experience in this field could better be described as a nightmare, and the monster in my dream is a PBM.

The outsized role PBMs take in the pharmacy space has caused many problems for our patients and our practice. Since the three largest PBMs control 80 percent of the marketplace, patients are forced to use a certain pharmacy because their PBM mandates it, or they may be forced to get their drugs through the mail, even though they want a pharmacist face-to-face in their community. Patients and their doctors have virtually no say in what drugs are used since the PBM essentially forces which drugs can be used, and not because a drug is better or worse, but because the PBM just can make more money off of it.

Our service members and families covered by TRICARE can no longer get most brand name medications at regular pharmacies. Instead, they are being forced by their PBM into using the mail order or the on-base pharmacy. In Jacksonville, this leads to days-long waits and delays in treatments of sometimes weeks or more. The Naval Air Station in Jacksonville base is attempting to service more than three times the current patient load that they are staffed and equipped to serve. People are being harmed, and it is because of PBM greed.

The PBMs also wreak havoc on our store's financial health. We cannot negotiate any aspect of our contracts with them in any meaningful type of fashion. It is just take it or leave it. Some of the most basic, yet most life-sustaining medications, like drugs to prevent heart attacks or blood clots or to prevent rejection of a transplanted organ, for example, are commonly underpaid compared to the true cost in the market. I could shop 50 different wholesalers of medications and not find one that I could buy from that would break me even on what the PBM is providing for payment, and that does not even cover the actual cost to dispense the medicine.

You know, the Centers for Medicare & Medicaid Services says that in Florida, it costs about \$12 to dispense any given medication. But it is not unusual in my pharmacy to get maybe a nickel from the PBMs as our cost-to-dispense fee. Some PBMs do not even pay a single cent for it. There is no other industry where the service that you provide can mean the difference between life and death for the person that you are providing it for. While the payment for that same service is a total of less than \$1 and sometimes pennies compared to our brake-even, it is just madness. And meanwhile, PBMs pay themselves more for prescriptions at their own retail and mail order pharmacies with some of the newer drugs, sometimes paying out hundreds or thousands of dollars to the PBM per prescription that they fulfill.

There was a recent report out from the Medicare Payment Advisory Commission, the MedPAC, as well as studies from other states that we have seen that have all found that when PBMs are

vertically integrated, they appear to be reimbursing the pharmacies that they are affiliated with more than they reimburse pharmacies that they compete or are non-affiliated with.

And I mentioned TRICARE earlier. Last year, we had to make the difficult decision to opt out of participation in the network. Jacksonville is a really proud military town with two large Navy bases, so this decision was a really tough one for us. I have family who have served in the Navy, and many of our friends and our neighbors have as well. Dropping out of the network to no longer care for those people was especially tough, but the contract was just unsustainable. We would have lost tens of thousands of dollars per year to continue in the TRICARE network.

Small businesses should not be asked to subsidize any plan, let alone a taxpayer-funded program, yet we are time and time again, and all the while, three of the largest PBMs are in the top 12 of Fortune's 500 richest companies. When companies are forced to compete, the consumer wins, but the problem is, in our industry, free and fair markets do not exist. There is no competition because the game is rigged. The PBMs' own health insurers, drugstores, they are buying doctors' offices now. A small business like mine cannot hope to compete when the deck is stacked against us like it is, so I think that any pharmacy that wants to participate in the network should be able to participate in that network.

And patients are not made of money, so these games where a drug is priced very high and then a kickback is paid to the PBM in the form of a rebate needs to be done away with. Community pharmacies, and especially small business pharmacy like mine, represents the forefront of healthcare, and I think that urgent legislative action is needed.

Thank you for the important work in this critical matter, and I am happy to answer any questions that you all may have.

Chairman COMER. Thank you. Mr. Isasi.

**STATEMENT OF FREDERICK ISASI, J.D., M.P.H.
EXECUTIVE DIRECTOR, FAMILIES USA**

Mr. ISASI. Thank you. Perfect. Thank you. Thank you for the opportunity to testify today. I am Frederick Isasi, the executive director of Families USA, a nonpartisan nonprofit that for over 40 years has been the leading national voices for healthcare consumers. And thank you very much for holding this hearing on lowering drug costs and pharmacy benefit managers.

As you have heard, millions of Americans live with the fear of not being able to afford their prescriptions, and one-third of Americans are not taking their prescriptions because they are too expensive. Year after year, prescription drug companies launch drugs here in the U.S. and charge three or four times more than in other countries. And then in their greed, they raise these outrageous prices much faster than our paychecks and inflation, and the American people need relief.

The drug industry makes a lot of false arguments, and, at its core, the problem of out-of-control drug prices is very simple. Congress created a system that provides a government-granted monopoly of drug makers and many within the industry are abusing these Federal laws. Let me explain what I mean. Over time, so

much of the industry's focus has shifted from creating innovative drugs that can save lives to doubling down on high-powered lawyers to help find loopholes, sue competitors, and generally abuse the spirit in which Federal prescription drug laws were created. That adds up to a crisis for families and hundreds of billions of dollars in waste.

Let me tell you about one person, perhaps, who can study your resolve take on Big Pharma's abuses. Her name is Maureen. She is 80 years old and living in a small house in the mountains of North Georgia. Maureen depends on Medicare for health insurance and Social Security for her income. Like so many retirees, she lives check to check. She is taking care of herself and is healthy, but unfortunately, Maureen developed blood clots in her leg and lungs that threaten her life. Maureen was prescribed anti-blood clotting medication which she will have to take for the rest of her life and is required to pay \$400 every 3 months just in cost sharing for this treatment, and Maureen simply cannot make ends meet.

Drug companies have caught Maureen in a terrible bind. She either pays for the drugs or she could lose her life. So, in the end, Maureen has given up all of her non-essentials. She has given up almost all driving to save on gas and maintenance costs. She cannot afford to go to the dentist. But that still is not enough, and so Maureen has made the incredibly heart-wrenching decision to cut back on food. Maureen is limiting herself to eating one meal a day. And when hunger sets in, she says she drinks water because it fills her up. These are the impossible tradeoffs people are making as a result of our broken system. An 80-year-old woman has made the decision to give up food to pay for her prescriptions, and it is unconscionable. Maureen is a survivor, and she is resigned, but in her own words, "Funding Big Pharma was not in my Social Security budget plan, yet here I am."

We at Families USA are very supportive of the Inflation Reduction Act, which finally allows the Federal Government to negotiate a fair price for some of the highest-spend drugs in Medicare. The law takes the savings generated by getting a fair price and invests in finally capping annual out-of-pocket costs for seniors, supports free vaccinations, and a host of important reforms.

Today's hearing is focused on PBM abuses, and this is an important issue, but let us not be confused. Drug corporations pocket most of the profits from drugs, and the central problem is these drug corporations are price gouging off the backs of our Nation's families. While PBM reforms are worth doing, drug corporations are using this issue to detract from their own abuses and weaken PBMs, which, after all, are responsible for negotiating with drug companies for lower prices.

The most important reforms to PBMs should be to increase transparency between the PBMs and the private sector employers paying for their services so that we can better track the actual price being paid for pharmaceuticals, including the rebates, and to ensure that consumers will benefit directly and at point of sale for discounts. But even more important would be to extend the reach of the Inflation Reduction Act and the ability of the government to negotiate a fair price for all consumers, not just Medicare, and stop

price gouging by Big Pharma. Congress created the problem of out-of-control drug prices, and time for action is now.

Thank you for holding the hearing and thank you for giving Families USA a chance to be here. I look forward to taking your questions.

Chairman COMER. We will now begin our questioning. I will begin.

Mr. Duane, I will start with you. You mentioned in your testimony that Jacksonville, Florida is a military town with two large Navy bases, so lots of Jacksonville residents have TRICARE insurance. And you explained in your testimony that you stopped covering TRICARE because of the reimbursement rates. Did the PBM push the TRICARE recipients to a pharmacy that they owned?

Mr. DUANE. Yes, sir. I mean, I think one of the largest things that Express Scripts did when they began or continued this issue with the TRICARE network is a lot of the patients that used to go, not just to my pharmacy, but to the thousands of other pharmacies that were left out of the network, they use their own mail order pharmacy, and they own their own pharmacy, so they can easily push people to that pharmacy. So yes, sir, they did.

Chairman COMER. What was their difference in the prices through their mail order pharmacy and the prices that you charge the patient?

Mr. DUANE. Yes. It is my understanding that, like, before we lost the contract, whenever an insured beneficiary would come to our pharmacy that they would have to pay a co-pay. They did pay co-pays on their drugs, but it is my understanding that in the mail order pharmacy, they were not required to pay a cost share.

Chairman COMER. That is right. So, what are the effects of no longer accepting TRICARE, not just for your pharmacy, but with the Jacksonville residents?

Mr. DUANE. Well, I mean, it has been tough. Not everyone wants to use the mail order pharmacy. Not everyone has the wherewithal or the health literacy to use an online or mail order pharmacy. So, then they are forced to either pay large amounts of money out of pocket and not use the benefits that they fought hard in order to earn, but two, if they have to go to the base, I mentioned in my comments that the base is overwhelmed right now with patients. So, I mean, I think they are serving somewhere between like three and four times the amount of people.

Chairman COMER. Absolutely. Mr. Baker, I want to turn to you. You are the CEO of AffirmedRx, a PBM that works to promote transparency. AffirmedRx is the PBM for Mark Cuban's company, Cost Plus Drugs. I want to show the comparison between how much a drug would cost a patient if they bought it at Cost Plus Drugs versus if they got it at CVS.

[Chart]

Chairman COMER. This poster shows imatinib, a generic chemotherapy drug used to treat leukemia, can cost the patient at CVS more than \$17,000 for a 30-day supply. An identical prescription, a 30-day supply of imatinib would only cost \$72 at Cost Plus Drugs. That is a massive difference. Mr. Baker, do you attribute the difference in cost to PBMs?

Mr. BAKER. I do. Yes, sir.

Chairman COMER. Obviously, imatinib does not cost \$17,000 if Cost Plus Drugs can sell it for \$72, so where does the extra money go?

Mr. BAKER. That is a great question, Chairman Comer. At the end of the day, Mark Cuban started his pharmacy about 18 months ago. And what we do really love and appreciate about the brand and generic drugs that Mark Cuban in his pharmacy is selling is they list their invoices online so you can see exactly what they are paying for all of the drugs they procure. They mark them up 15 percent, and then they sell them with a small labor cost and shipping cost, so it really gives us a good comparator.

Chairman COMER. What a noble concept in healthcare, right?

Mr. BAKER. Exactly.

Chairman COMER. That could be in everything in healthcare, but we are talking about PBMs, so.

Mr. BAKER. Yes, and we appreciate working with Mark and his pharmacy. Their tagline is they are selling trust, and I think that is so important in the conversation here today because that is lacking in a lot of areas. But the reality is, Mark Cuban's pharmacy buys thousands of times less drugs than the big traditional PBMs do, and acquisition cost is usually based off volume. So, the contention probably is the large traditional PBMs are getting imatinib at a lower cost than Mark Cuban does. And so, when we can compare what he has actually been selling those drugs for with a very healthy 15-percent mark-up in general to some of the other prices we see and state and other public organizations, it paints a very bad picture.

Chairman COMER. Dr. Atkins, as an oncologist, do you think a patient is more likely to be able to take the drug to treat their cancer if it is \$72 or \$17,000?

Dr. ATKINS. Seventy-two dollars for sure.

Chairman COMER. So, would you agree that insane prices on vital medications like this are killing people because they cannot afford it?

Dr. ATKINS. Yes, because some patients that cannot afford it, they will not take the medication.

Chairman COMER. You have a lot of stories and examples of this. Can you think of another example of a cancer patient that obviously, when they determine they have cancer, like my mom found she had stage 4 cancer. It is of the utmost importance to start treating that. What are average delays for getting people medication when they have to go through the PBMs? How much time is that?

Dr. ATKINS. Well, I will elaborate on the patient I mentioned in my testimony. I wrote his prescription on October 14, and when I saw him 2 weeks later, I said, "How are you doing? How is the medicine?" He said, "I do not know. I do not have it." So, I investigated with my own pharmacy, and they told me, well, his insurance told us to send it someplace else. And then that pharmacy took it to CVS Caremark, and the patient went back and forth, back and forth. He finally got his medication on December 1. And when I spoke to that patient a few weeks ago to see how he was doing, he is actually doing well on the medication. Unfortunately,

he told me he has to go through these hoops every single month to get his medication refilled.

Chairman COMER. Unacceptable when time is of the essence.

Dr. ATKINS. Yes, it is.

Chairman COMER. Thank you. I want to thank our witnesses, again, for being here today, and I now yield to Ranking Member Raskin for his questions.

Mr. RASKIN. Thank you kindly, Mr. Chairman. Mr. Isasi, there are a lot of complexities in the healthcare system, as we have just heard from the witnesses, so I want to try to get some clarity on the basic points. Who ultimately sets the price for prescription drugs?

Mr. ISASI. No question, the drug manufacturer.

Mr. RASKIN. OK. Mr. Chairman, I want to ask unanimous consent to submit to the hearing a record, Committee Democrats' Comprehensive 2021 Drug Pricing Investigative Staff Report, which makes this case.

Chairman COMER. Without objection, so ordered.

Mr. RASKIN. The investigation found that drug companies aggressively raise prices to meet revenue targets, that drug companies targeted the U.S. market for higher prices than are set in other countries, and that drug companies were engaged in anti-competitive practices to keep prices high. And at the same time, it appears that PBMs, the pharmacy benefit managers, are also to blame for a number of problems. Three of them dominate 80 percent of the market, giving them enormous leverage over drug prices, patient choice, and independent pharmacies. The three major PBMs have also each been vertically integrated into the large health insurance corporations, which also own their own pharmacies, and this presents a serious structural conflict of interest and incentivizes practices that may make it more difficult to get timely access to affordable medication.

Dr. Atkins, how do PBMs take the practice of medicine out of the hands of doctors, as you say, and prevent patients from receiving the treatments that were specifically prescribed for them?

Dr. ATKINS. I can give several examples. One would be the antiemetic therapy for patients getting chemotherapy. When someone has cancer, they are, No. 1, afraid of dying, two, afraid of being in pain, and three, they are afraid of being sick. So many times, it is a drug we use because we have certain guidelines for how we treat cancer patients, and we want to use one drug for nausea, and the pharmacy benefit manager will say, no, you cannot use that. Once the patient gets really sick and they failed it, then we can use the medication we want to use. And it has an effect on the patient, because once someone gets very sick like that, sometimes you really have to convince them to try the medication again so they can keep getting the treatment for their cancer.

Another example would be, as I mentioned in my statement, I had a patient. I wanted her to get one drug for her metastatic breast cancer, it is something called a CDK4 inhibitor. So, what I wanted to give the patient, her PBM said, no, she has to fail another one first. Well, if you look at the national guidelines for cancer treatment, if a patient fails one CDK4/6 inhibitor, you do not

give them another one behind that because it is the same type of drug. This happens every day.

Mr. RASKIN. Well, as a cancer patient recently declared in remission—I rang my bell 3 weeks ago—thank you much, Dr. Atkins.

[Applause.]

Mr. RASKIN. I have got to say, what you are telling me is just horrifying. The idea that you, as the oncologist, would prescribe a specific drug for your patient and then be forced to use a different drug, that does not work when obviously you are an expert in the field and you have someone presumably who is a non-doctor overriding your judgment and forcing the use of this other drug. Can you explain why that is happening? How is that in any way to the financial benefit of the PBM or the insurance company to do that?

Dr. ATKINS. Well, a lot of times, insurance companies will make a decision based on what drug is less expensive for them and not what is the best for the patient. So, I would assume that the drug they wanted me to give this patient was less expensive for them and not the other drug.

Mr. RASKIN. OK. Mr. Baker, following up on this, how do PBMs actually make their money? What are their incentives that cause them to appear, based on Dr. Atkin's inventory of really horrible examples of people getting the runaround? What are the incentives that the PBMs have to keep people from getting their medicine?

Mr. BAKER. Yes, thank you for the question. I am not sure how much time we have here today if we want to go into all of the different ways PBMs make money, but I can start with just a few. At the end of the day, what the PBMs are consistently trying to do, in our opinion, is figure out how they get around the different mechanisms by which people can see transparently what they are doing, the rules that they are making, and then how they are charging, I would say, the American taxpayer, the American government, and self-funded employers everywhere for medications. As the poster behind, you know, Chairman Comer shows, one way is they drive to their own pharmacies. They decide what they pay themselves, and bad things can occur when a PBM can decide what they ultimately pays itself. They keep a percentage of manufacturer revenue.

Two of the big three GPOs, as we have talked about today, are not based here in the United States—one is in Switzerland and one is in Ireland—for what is mostly an American issue of paying rebates back to put formulary-placed drugs out. And so it is that rebate and the formulary placement that I think also drives some of the decisions that PBMs make that then oncologists everywhere have to abide by.

So, my contention is it is not always driving to a lower cost. It is more frequently driving to a higher cost because when you, as a for-profit company, make a percentage of revenue, would you want to make seven percent off a \$50,000 drug or seven percent off of \$50 drug? And that is the conflict that exists when these large organizations are trying to come up with formulary decisions and tell physicians how they are supposed to prescribe.

Mr. RASKIN. Well, thank you very much, Mr. Chairman. I am going to yield back, and I just hope we can figure out some bipartisan reforms that change the incentive structure here.

Chairman COMER. One hundred percent in agreement with you on that, and I hope that we can do that. That is the objective and look forward to doing that. The Chair recognizes Dr. Gosar from Arizona for 5 minutes.

Mr. GOSAR. Thank you, Chairman. James Madison once said monopolies are sacrifices of the many to the few. Thomas Jefferson wanted to include an anti-monopoly provision to the Bill of Rights. The author of the Declaration even thought that all patents should expire after a certain amount of years in order to protect against monopoly. George Mason refused to sign the Constitution due to the lack of prohibition of monopolies. Even though an explicit anti-monopoly provision never made it into the final text of the Constitution, all the founders shared a fear that monopoly power would result in the rich few setting unjust prices all at the expense of the common man.

Whether it is Big Tech, Big Banks, or airline industry, Americans lose when monopolies form and thrive. Censored conservative Americans had almost nowhere to turn to voice their views thanks to Big Tech. Community banks are disappearing as the Treasury Secretary publicly promises to bail out big banks, but let the smaller ones fail. There is clearly something wrong, not right, with the healthcare industry. There are very few, but gigantic entities among health insurers, drug companies, pharmaceutical industries, and, of course, pharmacy benefit managers.

I actually had the opportunity to spearhead the passing of a bill in early 2021 that ended a special privilege afforded to health insurance companies that allowed them to ignore important antitrust protections. I commend Chairman Comer for his willingness to shine the light again on this questionable business practices of these PBMs.

Dr. ATKINS, do you believe these three companies accounting for 80 percent of an entire market with revenues of over \$453 billion dollars is healthy?

Dr. ATKINS. No, I do not.

Mr. GOSAR. Do you consider it a monopoly?

Dr. ATKINS. I would consider it a monopoly.

Mr. GOSAR. Mr. Baker, do you feel the same way?

Mr. BAKER. I would consider it an oligopoly which is very similar to a monopoly, but yes, sir.

Mr. GOSAR. And Dr. Duane?

Mr. DUANE. Absolutely, yes.

Mr. GOSAR. Do you think it is important for the American Government to protect against monopoly power in an industry where 82 percent of the Americans participate? Dr. Atkins?

Dr. ATKINS. Yes, I do.

Mr. GOSAR. Mr. Baker?

Mr. BAKER. Yes, sir, I would agree.

Mr. GOSAR. Dr. Duane.

Mr. DUANE. I do agree.

Mr. GOSAR. Now, Dr. Gaurav Gupta, founder of the Ascendant BioCapital, testified in the House Energy and Commerce Health Subcommittee hearing in 2021 that 47 percent of the price of the drug that a patient pays goes for the middlemen, mostly PBMs.

Does that stat inspire confidence that America's consumers are engaging in a healthy drug market? Dr. Atkins?

Dr. ATKINS. No, it does not.

Mr. GOSAR. Mr. Baker?

Mr. BAKER. I would say if there is transparency and we knew exactly where that 47 percent was going, and it was being used to make drugs more affordable, yes. But, in this point in time, where there is no transparency, no.

Mr. GOSAR. Dr. Duane.

Mr. DUANE. I cannot think of another market where the person in the middle gets nearly half of the entire dollar, so no.

Mr. GOSAR. Does not make sense. Now President Trump's Center for Medicare and Medicaid Services released a proposed rule in February 2019 and a final rule in November 2020, that the PBM lobby was able to stop in courts. Are any of you familiar with that rule and able to point to any of its positives or shortcomings? Dr. Atkins?

Dr. ATKINS. I cannot comment specifically, but I know that PBMs take money from patients and make it harder to treat patients. And I think when you have monopolies, patients have fewer choices, and it is not just PBMs, it is hospital corporations, et cetera.

Mr. GOSAR. Yes. Mr. Baker?

Mr. BAKER. If you are referring to the rebate rule, as I think it was called, yes, we know that rule. It was, of course, I think, as we sit here today, it has been delayed until 2032, so I think there is a lot of conversation that can still be had on that. I think in general, PBMs can do a good job of making drugs more affordable in the United States. I think if we understand where and how they are making the decisions they are making, they can help keep pharmaceutical manufacturers in check so they do not price gouge on the American public. But again, at the end of the day, those things are not occurring as we sit here today, and those are problems I think we need to solve.

Mr. GOSAR. So, Dr. Duane, can you think of any administrative changes that will be beneficial to this ruling to actually make it more applicable?

Mr. DUANE. I mean, my opinion, it should be applicable immediately. I mean, the sooner you get rid of rebates, the sooner you can see drugs completely transparently in their cost, and the sooner that pharma can compete on the merits of a drug itself and not just based on who is willing to pay more to a kickback.

Mr. GOSAR. Mr. Baker, you brought up the point that two of these beasts are not in the United States, but they do business in the United States so we can actually dictate to them, can we not?

Mr. BAKER. I would hope that is the case. Yes, sir.

Mr. GOSAR. Dr. Atkins, do you see anything that from your vantage point as a prescriber, a doctor, things that we could do administratively to make this thing work better.

Dr. ATKINS. More transparency and more choices for patients.

Mr. GOSAR. Thank you very much. I yield back.

Chairman COMER. The gentleman yields back. The Chair recognizes Ms. Norton from Washington, DC.

Ms. NORTON. Thank you, Mr. Chairman. Mr. Isasi, you offered an example of a woman called Maureen who had to give up food in order to pay for prescriptions. Actually, half of all Americans insured by Medicare lived on an income below \$30,000 in 2019. That translates to 30 million seniors and people with disabilities who are living on \$30,000 or less per year, and about 15 million of those Americans live on less than \$17,000 per year. Out-of-pocket health costs can be particularly difficult for seniors who often live on fixed income. I am proud that Democrats passed the Inflation Reduction Act last year, which will cap out-of-pocket costs for seniors covered by Medicare Part D at \$2,000 per year, along with other steps to make healthcare more affordable.

Mr. Isasi, how will provisions in the Inflation Reduction Act, like the expansion of low-income subsidies and a cap on out-of-pocket costs, help seniors with less income?

Mr. ISASI. You bet. I mean, it is so important to say, and to your question, the way that those improvements, capping out-of-pocket costs, providing immunizations for free, right, these really important provisions, capping the cost of insulin, they were paid for by finally letting the government to get in and negotiate a fair price. So, it is a perfect example when we stop Big Pharma greed, we can actually do really important things for our seniors and our disabled families.

Ms. NORTON. Well, in our 3-year long investigation into drug pricing, Oversight Committee Democrats found that pharmaceutical companies' practices often inflate drug prices. The Inflation Reduction Act responded to these findings by requiring for most drugs in Medicare Part D that drug companies pay the government any price increase above inflation. So, Mr. Isasi, how will this rebate requirement help lower drug prices for people covered by Medicare Part D?

Mr. ISASI. It is so important. So, the two main elements for Big Pharma in terms of their play on price gouging is launching a price absurdly high, and then year after year after year raising them faster than our paychecks and inflation. And so, the Inflation Reduction Act actually stops that and says once your drug is coming to market, you cannot increase it faster than inflation, and if you do, you have to pay us that money back. It is very important and it has already kicked in, and it is holding drug costs down.

Ms. NORTON. Well, Committee Democrats and the Biden-Harris Administration are making sure that seniors see some relief from high drug prices. I will continue to work to hold the industry accountable, so healthcare is more affordable and more accessible to all seniors and Americans, and I yield back.

Chairman COMER. The Chair recognizes Dr. Foxx from North Carolina.

Ms. FOXX. Thank you very much, Mr. Chairman, and I thank our witnesses for being here.

Dr. Atkins, I would like to say from the start that I support capitalism and for-profit companies, along with the amazing innovation they provide our Nation. However, I have serious concerns over the PBM industry promotion of fail first policies, also known as step therapy, that can prevent or delay patients from accessing the medicines they need. A recent study found that a significant

share of commercially insured patients taking medicines face step therapy restrictions.

Dr. Atkins, in your role as an oncologist, you have patients that are required to fail first on a medication and what can you do when a patient has to fail first?

Dr. ATKINS. Yes. We deal with fail first almost every day. Usually it is more common with the antiemetic medications but also with iron products that we use. And also, I mentioned in my written testimony about another patient who had to use a different drug than what I wanted to use. We try to talk to the insurance company, talk to the PBM. Sometimes that works, sometimes it does not. Unfortunately, in my practice, we have to deal with this every day. We have 10 oncologists and 8 people in charge of dealing with PBMs and insurance. Every day is more than a full-time job, so we try to jump through whatever hoops we need to get the patient treated. So, my whole goal is to get my patient treated.

Ms. FOXX. Well, a little follow-up on that then. Can you explain a little bit more the dangers of requiring a patient with a life-threatening illness to fail first on a drug they were not originally prescribed? And do you believe the insurance industry should be telling patients what medicines they can take, or should that be a decision left to you and the patient?

Dr. ATKINS. What drug the patient should take should be left up to the physician because we are trained to take care of patients and know what the best drug is for the patient. Some of the dangers are treatment delays. As I mentioned earlier, if a patient gets really sick with a medication because I am forced to give them a different antiemetic than what I want to use, it is really hard to convince the patient to try another cycle of the medication. Some patients would just say, I am not going to do the treatment anymore, which could shorten their life. We deal with this every day.

Ms. FOXX. Again, Dr. Atkins, in 2021, the FDA approved 93 first generic drugs which provide more affordable options for patients. In fact, generic drug prices can be up to 95 percent less expensive when compared to brand drug prices. Are you aware of instances where PBMs block patient access to lower-cost generic drugs in favor of higher price brand drugs, and if so, why would this be the case?

Dr. ATKINS. When I treat a patient, I am looking at the drug itself. I do not think about if it is generic or not, so I cannot really give a specific information about whether they blocked it in favor of a more expensive drug. I just know that every day the PBMs get in the way of treating my cancer patients, and my whole goal is to take care of the patient.

Ms. FOXX. Thank you. Mr. Baker, we know that PBMs create formularies or lists of prescription drugs that will be covered by certain insurance plans. Does AffirmedRx create formularies, and how does your company decide which prescription drugs will be covered?

Mr. BAKER. Thank you, Dr. Foxx, and first, I absolutely agree with your comments about capitalism. We think that everybody should be able to make a fair amount of money, but everybody knows what you pay for a gallon of milk. Nobody knows what they pay for their prescription drugs, and I think that is a big part of

the problem. So, when we really look at our formularies, we have partnered with the Cleveland Clinic. Twelve years ago, they brought all of their own pharmacy benefits into their own world, and they have their own pharmacists and technicians who manage this. So, we really wanted to say let us partner with a world-class organization who understands the clinical nature of pharmacies, and they also help guide us to make sure that we are making the right decisions on behalf of our clients and their members.

Ms. FOXX. And what happens if a patient is prescribed a drug that is not on the formulary?

Mr. BAKER. They always have a path to coverage, Dr. Foxx. So, we would always work with the providers that want the patient to have that medication and make sure that if there is a good sound clinical reason for them to be on it, that we can get that approved for them.

Ms. FOXX. Thank you. I want to just make a short statement, Mr. Chairman, about what Mr. Baker just said. We need transparency. That is the whole issue in all of our medical field. We need transparency on pricing. We passed our surprise billing bill out of the Education and Workforce Committee. We still do not have the transparency that we need from hospitals. We have to have transparency in the cost of medical care. We have the best medical care in the world. It is also the most expensive. Thank you, Mr. Chairman. I yield back.

Chairman COMER. The gentlelady yields back. The Chair recognizes Mr. Lynch from Massachusetts for 5 minutes.

Mr. LYNCH. Thank you, Mr. Chairman. I want to thank you and the Ranking Member for holding this really important hearing. Years ago, when I was Chairman of the Subcommittee on the Federal Workforce, we actually conducted an extensive investigation into the role of PBMs, pharmacy benefit managers with respect to the Federal Employee Health Benefit Plan, FEHBP, so we were just focusing on what Federal employees were paying for their pharmaceuticals. The FEHBP, the Federal Employees Health Benefit Plan, is the largest employer-sponsored group health insurance program in the world. It has got 8 million Federal employee members, retirees, former employees, and also their families. What our previous investigation found was that the Federal employees who were part of this health benefit plan were paying up to 45 percent more for their prescription drugs than other Federal programs, including those administered by the VA and Department of Defense. And we found that the one singular reason for the inflated costs of prescription drugs in that program was that the program relied upon pharmacy benefit managers to negotiate prescription drug benefits and maintain affordable prices.

In fact, one of the aspects of our investigation involved a report issued by Change to Win, which was a Federal coalition of big labor unions that were trying to use their bargaining power to lower the prices of the drugs they were paying for. And the report demonstrated the need for greater transparency in pharmacy benefit management contracting. In particular, and this is what really got me, we found that CVS Caremark, which is a drugstore and PBM combination, we found that they were treating people walking

in off the street better than members of this health benefit plan that the PBMs were covering.

So, here you have members who have insurance. They are part of an 8 million member health benefit plan. They have insurance. They walk into the drugstore, and they pay more than someone walking in with no insurance just off the street. The PBMs were offering less coverage than someone with no insurance, and remember, we are talking about the bargaining power of 8 million employees completely wiped out because of the greed of these PBMs.

In fact, as the Federal Government, we could not find out what the profit margin was for these different drugs. That was several years ago. Has that changed at all? Can we find out what the PBMs are paying for their drugs and how much they are marking them up? Dr. Atkins, Mr. Baker, Dr. Duane, or Mr. Isasi.

Dr. ATKINS. I think one main problem is the lack of transparency.

Mr. LYNCH. Right.

Dr. ATKINS. You do not know what they are paying for the drug. Also, when I write a prescription for a patient, they are asking me how much is this drug? I tell them I do not know because their copay is different based on their insurance and where they get the drug prescription filled.

Mr. LYNCH. Yes.

Mr. ISASI. So, we do not know in this example, and this is so important to point out. It is a large employer arrangement, right, where the PBM is negotiating. In Medicare we do know. Medicare receives all of that information, and the PBMS have to true up and explain exactly what the net price was, and this is a good example of two very important points. One, we have to change the law to make sure that the employer who is using the PBM knows what is the net price that is actually being generated here. And the second piece is, this idea that when rebates become the driver, right, you can have someone walk in and spend more in their cost-sharing, like, for example, with the Federal employees health benefits card, than if they just went to that same CVS and said pretend I am uninsured, you know.

Mr. LYNCH. Yes.

Mr. ISASI. And that is a crazy outcome. So, at the point of sale, no one should ever have to pay more in cost-sharing. The cost-sharing should be based off of the net price and not the list price, and that is a fundamental problem.

Mr. LYNCH. Mr. Chairman, my time is running out, but I just want to say this is an area where I think we have bipartisan cooperation. I know that Congress is not known for its speed, but we need to do something about this pretty quick. I actually had a bill. It was the FEHBP Prescription Drug Oversight and Cost Savings Act. I know you want to do something more broadly, but maybe we might use that as a reference point to try to get some work done. But again, I congratulate you on focusing on this problem. I think we can make a difference if we get together on this. Thank you. I yield back.

Chairman COMER. You know, I appreciate that, and I look forward to cooperation between Republicans and Democrats on this

Committee and our staffs to try to solve this problem. The Chair now recognizes Mr. Higgins for 5 minutes from Louisiana.

Mr. HIGGINS. Thank you, Mr. Chairman. Mr. Chairman, the topic of this hearing is rather difficult to grasp due to the complexities that converge here. As Americans from sea to shining sea watching this thing, and we do not understand how this stuff works, man, but we understand this as sort of a comparison, and Americans, you know what we want? We want somebody put in jail over this. That is what we want.

This is the kind of thing that we run into, like, family to family, and it is such a wall of impossible complexities that we face through the prism of medical fear. My wife has MS, and twice a year, she has rather complex treatments, and all year long just to go through evaluations and testing to determine if her treatment is working well. And thank God it is working well, but let me tell you, it has been quite a journey because the medications change and the doctors are determined to prescribe the best medication. And then it becomes like this quest of hope that you can potentially get insurance coverage for the pharmaceutical that is required for the treatment.

I do not gamble. It has never been something that has attracted me. I have been to Vegas many times on business, but I do not gamble. You know, I do not bet on football or anything else. But twice a year it is very much like my wife and I are forced to engage in some kind of a lottery for her medicine that she needs. And this is the kind of thing that I do not have an answer for, but I can tell you we are going to find it. We are going to seek a legislative solution to this. And you PBMs out there, hey, get your retirement in order because the end of your era of pushing Americans around like this is closing. There is no excuse for this.

I have a question that has been given to me by a very experienced doctor, that is a dear friend, in preparation for this hearing. I am not sure who would address this question. I am thinking Mr. Baker, but I do not pretend to be an expert in this. So, the four of you listen to this question and the best one answer, please. Why cannot pharmacy manufacturers contract directly with pharmacies? Do you understand that question? And you are nodding your head, Mr. Isasi.

Mr. ISASI. Yes.

Mr. HIGGINS. That gives you the green light, brother. Please answer the question.

Mr. ISASI. Well, I think what is important to say here is—remember that underneath what you are describing, and I think everyone is in agreement, this cannot happen; it is not fair to the American public—the vast majority of money that is flowing through the system is landing in the pockets of Big Pharma, and we have got to say that. And the reason that we have got PBMs is because they are negotiating a better rate, so the reason that we have these conglomerates is because the government cannot negotiate a fair price. That is what the problem is. So, all of this is about one simple fact: Big Pharma is charging way too much money for their drugs, and we are trying to get a better price. And now what has happened is that PBMs, which are just a middle-man—

Mr. HIGGINS. But let me just ask because, again, it is not my area of expertise.

Mr. ISASI. Yes.

Mr. HIGGINS. A regular American says, well, if Big Pharma sets the price, how can it be this low on the left and this high on the right?

Mr. ISASI. Well, in part, this is a generic. They make most of their money for name brand drugs, and they get 12 times more in profit, Big Pharma does, than the PBM. PBM gets two percent. Big Pharma gets 12 percent. I am sorry. It gets 24 percent. So, at the end of the day, we cannot hide the fact that underneath all of this it is because Big Pharma is price gouging us, and we are trying to come up with some mechanism like a PBM to negotiate a fair price. But at the end of the day, it is because the government is not negotiating price. In the rest of the world, they do. In the rest of the world, they are paying two or three times less at launch. That is what this is really all about.

Mr. HIGGINS. Thank you for your answer. Mr. Chairman, my time has expired, but I am going to advise all the panelists that my office is going to submit questions in writing to each of you. These will be questions that we will use to help us develop a legislative response to this nightmare Americans face. Thank you, Mr. Chairman.

Chairman COMER. I want to thank the gentleman from Louisiana, and I think the witnesses can see and everyone who is watching this hearing can see, there is a sincere desire among this Committee to work together to try to solve this problem. And I think that is a very positive development, and I am really excited about the future.

With that, I recognize Mr. Krishnamoorthi from Illinois for 5 minutes.

Mr. KRISHNAMOORTHI. Thank you, Mr. Chair, and thank you to the witnesses. Thank you to the audience for paying attention to this very important issue.

Dr. Duane, since 2010, independent community pharmacies have been disappearing from the landscape. In fact, more than one in seven have disappeared. That is about 15 percent of independent pharmacies. And one reason for the dramatic decline is because of something called DIR fees, direct and indirect remuneration fees, that PBMs charge pharmacies. You are familiar with these fees, right, Dr. Duane?

Mr. DUANE. Indeed, I am, yes.

Mr. KRISHNAMOORTHI. For those who are not familiar with these fees, these are unpredictable fees PBMs retroactively charge pharmacies months after they dispense prescriptions and after PBMs have reimbursed the pharmacies for doing so. Sometimes these DIR fees amount to retroactive clawbacks of the entire amount of the reimbursements that they provided to the pharmacies, and shockingly, sometimes they are more than the reimbursements they provided the pharmacies. So, instead of making money on these prescriptions, these pharmacies end up losing money on these prescriptions because of the DIR fees, right, Dr. Duane?

Mr. DUANE. Yes, that is right. That is absolutely right. There can be two ways to incentivize someone. You could use a carrot or you

could use a stick, and the DIR fees that these PBMs have used are quite a big stick.

[Slide]

Mr. KRISHNAMOORTHI. Well, let me jump in. According to the government, these DIR fees increased by 107,400 percent from 2010 to 2020. This is not a typo. This is not a typo. This is a travesty. And you know what PBMs really stand for, Dr. Duane? It stands for Pretty Big Markups. That is what PBMs stand for, and we have got to stop this. Let me turn to another slide that I have talking about another aspect of what PBMs do.

[Slide]

Mr. KRISHNAMOORTHI. PBMs make a lot of money, and one way they make money is through rebates, which you talked about earlier, I believe. Mr. Baker, originally these PBMs were supposed to help third-party payers like insurance companies, employers, help negotiate the lowest price of prescription drugs, right?

Mr. BAKER. Correct.

Mr. KRISHNAMOORTHI. But what they did was they maintained these lists of medications called drug formularies, which listed the drugs and the drug makers that made the best deals with the PBMs on behalf of their clients. Here is where the problems began. The PBM started extracting "rebate payments," as you described earlier, from drug makers to be listed on the formularies, even though the PBMs did not pass along the rebate payments to the payers and the consumers. So, what ended up happening is that these rebate payments looked like kickbacks, not like rebates or discounts. Isn't that right?

Mr. BAKER. I would agree with that statement.

Mr. KRISHNAMOORTHI. And look at what has happened. It has fattened the bottom line of PBMs. PBMs have seen their profits rise from 2010 to 2020 by 97 percent, so almost doubling in 10 years. That is three times what the stock market has yielded. So, you know, let me just ask you, Mr. Baker, is it any surprise that PBMs have caused such great concern among consumers?

A recent poll by Morning Consult showed in March 2023, so this year, that 85 percent of Americans are "concerned," including almost 70 percent very concerned that PBMs are "overcharging" for prescription medicines and pocketing the differences profit. And in that survey, 88 percent of Democrats and 88 percent of Republicans shared that concern. Can you think of a single issue where almost 90 percent of Democrats and Republicans agree on anything, Mr. Baker?

Mr. BAKER. No, but that is encouraging to see.

Mr. KRISHNAMOORTHI. I think, Mr. Chairman, we have a mandate on the part of the American people. When 90 percent of Americans are concerned about an issue like PBMs, we must investigate. I am glad the FTC and the Biden Administration are doing so right now. I look forward to the results and on taking corrective measures. We cannot be complacent on this issue. Thank you, and I yield back.

Chairman COMER. Thank you. The Chair recognizes Mr. Biggs from Arizona for 5 minutes.

Mr. BIGGS. Thank you, Mr. Chairman, and thank you for holding this important hearing, and I appreciate our witnesses being with

us today. Thank you so much. Mr. Chairman, I think Buddy Carter of Georgia has done a little work in this area, and I request unanimous consent to submit into the record his report entitled, "Pulling Back the Curtain on PBMs."

Mr. CHAIRMAN. Without objection, so ordered.

Mr. BIGGS. Thank you. I have serious concerns about the impact of concentration and apparent self-dealing activities in the pharmacy benefit manager market, which seems to be driving up costs for consumers. The largest three PBMs control about 80 percent of the market: CVS Caremark has 34 percent; Express Scripts, 25 percent; and OptumRx with 21 percent.

Mr. Baker, thank you for being here today. Can you talk with us about the role of PBMs, how that role has changed over time, how it went from where it started out and how we got to where we are today, please?

Mr. BAKER. Yes, thank you for the opportunity. And as I said in my opening statement, I think PBMs are critical to the American healthcare system, but as with many things in healthcare, there are a lot of blind spots where people cannot see what is happening. Additionally, I think we have created a PBM industry where, in the general mantras and chaos, there is profit. So, as we have talked about extensively today, this is a very complex, chaotic world, and I think a lot of that is by design, and we do not feel it needs to be that way.

We feel that PBMs do a very good job in general trying to keep down prices when they want to. But unfortunately, as you brought up, in the intervening years since they started their mission of coordinating care for people and making sure that there is payment mechanisms for independent pharmacists to quickly get paid, these for-profit companies have created numerous pockets of money that they can hide and make sure that they are investing back in shareholder value, which is driving up cost for the American public, and that is probably not fair.

Mr. BIGGS. So, the largest PBMs are vertically integrated. Do you think that is a practice that has increased or decreased prices?

Mr. BAKER. Increased prices.

Mr. BIGGS. How about transparency for consumers? Has it increased transparency or decreased it?

Mr. BAKER. Decreased.

Mr. BIGGS. Do you believe that this structure increases or decreases opportunities for self-dealing or conflicts of interest?

Mr. BAKER. I think it increases those opportunities.

Mr. BIGGS. Has this structure lead to delays for patients seeking medication?

Mr. BAKER. It hurts patients.

Mr. BIGGS. Dr. Duane, have PBMs made it more difficult for veterans and service members in your community to access prescription drugs in a timely manner?

Mr. DUANE. Absolutely.

Mr. BIGGS. How so, please?

Mr. DUANE. I mean, when they offer a contract to a pharmacy like us, it is completely unsustainable and would drive us out of business. It reduces the number of options that our servicemen and

women have in order to obtain their drugs. So, by definition, you know, a decrease in access would increase difficulty.

Mr. BIGGS. Beginning in 2019, many of the largest PBMs began forming group purchasing organizations based in Switzerland and Ireland. These decisions were framed as steps to increase their bargaining power to negotiate lower drug prices. Mr. Baker, have consumers seen any reductions in prescription drug costs since these decisions were made?

Mr. BAKER. By all metrics I am aware of, no.

Mr. BIGGS. Have they produced increased transparency either?

Mr. BAKER. Not at all.

Mr. BIGGS. How does your PBM differ from large PBMs, and what has your experience been competing with larger players?

Mr. BAKER. It is a very interesting role trying to compete with the largest PBMs. I think in general there is a misnomer that the industry likes to push that the bigger guys get the best deal and pass those deals on. And I think as we have seen through some of the illustrations here today, that is generally incorrect.

We have made it a point that we will never make money on a drug, so any money we get from a pharmaceutical manufacturer we believe should be pushed to the client to benefit them and their members. We will not create spread on independent pharmacists, so we want to pay them a fair wage for the job that they do and pass that exact cost along to the client as well with full transparency.

Mr. BIGGS. So, Mr. Chairman, some of the things I have heard is we are in a milieu of chaos, and that that facilitates hiding pockets of money, reducing transparency, reducing options for patients. I am grateful that you are holding this hearing today. I think this is something that we need to continue to work on, look at. And with that, Mr. Chairman, I yield back.

Chairman COMER. Thank you very much. The Chair recognizes Mr. Mfume from Maryland for 5 minutes.

Mr. MFUME. Mr. Chairman, thank you very much. I particularly just want to add to all the others who have spoken here about our thanks to you and the Ranking Member for holding this hearing. It is so, so vital. And I am sure that people who are watching this after a while are scratching their heads and wondering how do these so-called PBMs, who are really pharmacy benefit mis-managers, sleeping at night? This is a damn shame. That is the only way that I can describe it. This is a damn shame that Americans have to be ripped off in this manner and for it to continue over and over and over again.

Dr. Atkins, I was particularly moved by your testimony about your patients in Georgia. It is heart wrenching, and your bottom line was that drugs do not work if people cannot afford them, and there are so many people that cannot afford them. Household spending on healthcare has increased in the past three decades, increasingly with detrimental impacts, as we all know, on our Nation's seniors, on people with disabilities, on other patients who are treated by Medicare. And we are at a crossroads right now, I think, in this Nation, which is why there is this demonstration of bipartisan support, but also bipartisan anger, at what is, for lack of a

better term, a real rip-off. People are dying while companies are profiting.

In my own state, the Maryland Prescription Drug Price Affordability Board documented more than 1,200 prescription drugs with prices that outpaced the rate of inflation throughout just last year alone. That translates into real people facing real crises. Case in point: Kyle, whose last name will remain anonymous for this hearing, his wife is from Baltimore City. She has lupus as well as a degenerative disc disease and is currently on multiple medications. The cost of her prescriptions amount to \$1,200 every 3 months, and her doctor's visit adds another \$1,000 to that. A college retiree, he had to return to work because he had no other choice to try to find a way to qualify for benefits to support his wife's medical expenses, but most of all, to keep his wife alive. John from Baltimore County was diagnosed with multiple myeloma and recently finished bone marrow treatment. John now takes 21 doses of Revlimid, and each pill costs \$990. He needs the drug to keep his cancer under control and has been left with no other choice but to beg for the generosity of drug manufacturers and these pharmaceuticals.

So those, unfortunately, are just a few stories of the many, many millions of stories that represent the realities for people. Some of them are our families, some of them are our friends, they are our neighbors, and they are looking to us in this practice, to end this kind of foolishness.

Mr. Chairman, I would like to ask unanimous consent to submit to the record the report last year of the Prescription Drug Affordability Community Forums that happened throughout the state of Maryland taking testimony from persons of all walks of life.

Chairman COMER. Without objection, so ordered.

Mr. MFUME. I just want to say a couple of other things. I do not like getting angry like this, but when you hear something that is hurting people in this way, it cries out for solutions. I do not like the fail first policy and practice, which is absolutely ridiculous. I do not like the fact that the preferred drug offered up is oftentimes the most expensive drug. We all are ticked off of at this notion of ongoing price gouging, the lack of transparency, and the fact that no one seems to regulate the PBMs.

But the PBMs, they are having a field day out there, getting rich over and over and over again. They are practicing medicine without a license, ladies and gentlemen. They are making determinations that oftentimes end the lives of people who cannot fight back for themselves. And so, I hope and pray that out of this Committee and out of this very important hearing comes bipartisan legislation to create a solution to end this once and for all. It is a sin, it is an abomination, and it is an affront to everything that we hold moral and right in this country. Thank you again, Mr. Chair, to you, and the Ranking Member, and I would yield back.

Chairman COMER. Thank you, and we look forward to working with you, Mr. Mfume. The Chair now recognizes Mr. LaTurner from Kansas for 5 minutes.

Mr. LATURNER. Thank you, Mr. Chairman, and welcome to all of those on the panel today. Mr. Baker, there have been many allegations of PBMs participating in spread pricing where they pay pharmacies less for generic drugs than they are charging insurance pro-

viders, and then they pocket the difference. In my home state of Kansas, accusations of this practice were recently settled for \$26.7 million. Can you explain more about how the spread pricing model works and why it is controversial?

Mr. BAKER. Yes. Thank you, sir. So, again, at the end of the day, spread pricing is as simple as the pharmacy middlemen has all the rules, they have all the data, and they do not share a lot of that, so people do not really know what is going on. So unfortunately, independent pharmacists are getting paid a low amount for the prescriptions that they are dispensing to help communities live better, healthier lives. And then self-funded employers have a separate contract with these pharmacy benefit managers. And then the PBM can sit in the middle and say, hey, so here is \$10 for the prescription that you dispensed and the hard work that the independent pharmacist did. Self-funded employer, I am going to charge you \$20 then for that same prescription because you really do not know what I paid the pharmacy over here. And it creates a lot of opacity and a lot of opportunities for profiteering.

Mr. LATURNER. Thank you. Dr. Duane, I am interested in knowing more about your contracts with PBMs. Pharmacies contract with PBMs in order for the pharmacy to participate in the PBMs' network, correct?

Mr. DUANE. Yes.

Mr. LATURNER. What does it mean to be in a PBM's network?

Mr. DUANE. Well, for our practice, it means everything. Sometimes when people think they hear "networks," they may think of, like, the idea of a preferred network or a non-preferred network like we might have in Medicare. I mean, to be in a PBM's network means that I can bill a PBM and receive payment for services. If I am not in their network, it means that I cannot take a single cent from them and that the patient would be forced to pay the full out-of-pocket cost.

Mr. LATURNER. How do pharmacies join these networks?

Mr. DUANE. I mean, there are several different ways that we can join. In some of them, I simply ask, you know. In others, we have administrative organizations that can help us join on our behalf.

Mr. LATURNER. Is it difficult for an independent pharmacy to participate in a PBM's network?

Mr. DUANE. It is very difficult. It is twofold, the question is. No. 1, it is difficult sometimes to even get a contract offered to you, but second, it can be difficult to get a contract that makes you whole or even to participate. So, even though you get a contract, it may not be one that makes sense for you to be able to participate in.

Mr. LATURNER. Independent pharmacies across the country have been shut out due to PBM anti-competitiveness practices, correct?

Mr. DUANE. Absolutely we have, yes.

Mr. LATURNER. PBMs sometimes pay competing pharmacies, that is, pharmacies they do not control, lower amounts than they pay the pharmacies that they do control. A lack of transparency, however, sometimes allows them to claim they paid competing pharmacies higher reimbursements than they actually did. There have been a number of lawsuits to recoup such overpayments. For example, Ohio Medicaid was overcharged \$223.7 million, and Ken-

tucky Medicaid was overcharged \$123.5 million. What should Congress be doing to prevent this practice in the future?

Mr. DUANE. Thank you for that question. That is a great question. I think it is very simple. I think it is twofold. No. 1, I think you have to get rid of the rebates. I have heard a lot about how Big Pharma is the one who is making the prices. Big Pharma is the one that keeps pushing it up, and please make no mistake, I am not carrying any water for Big Pharma. But I think that the problem is that these rebates really obscure what the true price is. And you hear this concept of gross to net bubble, and you can say that, well, the gross list price of a drug goes up, but after the rebates, the price actually decreased over time. So, I mean, you have to be able to get rid of those in order to make sure that we are playing with a full deck of cards.

The second thing that you need to do is, I think, that we need to look at what the Medicaid program in some states does, and that is they reimburse based on a fair, evidence-based, reference-based price for the drug, and then they reimburse on a fair, referenced-based, evidence-based price for our services. And I think that there is some legislation looking at that in the Medicaid space federally right now, and the CBO scored it is saving a billion dollars over 10 years.

So, I mean, that is a no-brainer to me. And I think it makes sense because, you know, Metformin, it is a common drug for diabetes. It is very, very, very inexpensive. It is one of the most life-saving drugs that you can prescribe for a diabetic, and it is very, very inexpensive. We make almost no money on it at all. But there are other drugs that are, you know, vanity drugs or lifestyle drugs or something like that, that we make quite a bit more money on, and it does not make sense because the labor is the same.

So, by anchoring the price to a reference-based price in ingredient cost and a reference-based price in service fee, you ensure that everyone is getting the best deal, but that competition can still exist.

Mr. LATURNER. I appreciate your time. Mr. Chairman, I yield back.

Chairman COMER. The Chair now recognizes Ms. Ocasio-Cortez from New York for 5 minutes.

Ms. OCASIO-CORTEZ. Thank you for this hearing, Mr. Chair. I think it is incredibly important that we tackle these issues substantively. And I have been very surprised to hear some of the commentary across the other side of the aisle. I heard earlier Republicans saying someone should go to jail for how expensive some drugs are in this country, and I thought I saw a pig flying across the ceiling of this Committee room. But where there is common ground, I think we should pursue it, and we should pursue it aggressively.

Now, I want to take a step back here and really make sure that we are illustrating this issue in a way that the public can understand because if we do that, then I think we can all get on the same page about developing energy toward a solution. So, if I am just an everyday person and I am getting a prescription from my doctor and I get that prescription, I take it to my pharmacist, and then all of a sudden, I get a bill and I realize that my insurance

co-pay, whether it is for any condition, diabetes, cancer, whatever it may be, it could be a thousand dollars. And before you know it, you are paying your rent check on a medication that you need to save your life.

And we need to take a step back and figure out how did we get here, especially on drugs like insulin, where there is a public patent and there really is no reason for it to be that expensive. So, we see that there is a drug. Between the drug and you receiving that at a pharmacy, there are several steps. You have your drug manufacturer, which folks call Big Pharma. Then you have your insurer. Those are the areas that I think people understand. Someone makes the drug. Someone insures that drug that I can buy it, but then there is someone in the middle, and that is known as a PBM or a pharmacy benefit manager. Isn't that correct, Mr. Isasi?

Mr. ISASI. Yes.

Ms. OCASIO-CORTEZ. And so, what we see is that the drug manufacturer very often does not sell their medication directly to the pharmacy or does not sell their medication directly to the insurer, but there is this middle person known as a PBM. The manufacturer will set a price very high, and then the PBM will say, let us make a deal, and they say if you give me a rebate, then I can make the formulary for the insurance, and I can make sure that your drug gets covered by this insurance. You can sell a lot of your drug, and then, you know, all is well in the world. And that is the general concept, the pitch from the PBM. Isn't that right? Do I have that correct?

Mr. ISASI. Yes. There are a few more middlemen, but that is exactly it in a nutshell.

Ms. OCASIO-CORTEZ. And each step along the way, someone is taking a cut.

Mr. ISASI. Yes.

Ms. OCASIO-CORTEZ. You have got the manufacturers charging, you have got the PBMs charging, you have insurers. And then before you know it, you are paying a rent check on insulin, which should cost virtually nothing.

Now, my question here is that we have to figure out a solution. We have a vicious cycle with the PBMs because they say if you give me a rebate, I will pass it on to the insurers. So, the drug manufacturer says, great, I will make my price even higher. So, I will say that my list price for a drug is \$5,000, so then I can charge you \$1,000 or even more, and I will make you seem like you are getting a deal so that you will put me on a higher level on the formulary. And all about this process is focused on who is making how much money instead of what people are getting the treatment that they need.

Now, I am very curious, genuinely, to hear from the other side of the aisle and some of our witnesses here today—everyone OK over there—from the other side of the aisle and some of our witnesses here today about solutions. I will be candid about mine. I believe that the profit-seeking motive in the pharmaceutical industry is out of control, and I think that it is what is hurting people. I personally believe that if you have a public entity that does not have a profit motive, like Medicare, negotiate these prices with the manufacturers, including the transparency that we see, along with

other entities like TRICARE, Medicaid, et cetera, then we can get an actual fair price for these medications that includes their manufacturing and R&D costs, but will not finance stock buybacks and other types of predatory behavior. And then I believe that Medicare should expand its eligibility so that people can buy into at-cost public insurance.

Now, I understand that not everyone in this room agrees with that assessment. I am very curious to hear about any other proposals because I think at the core of what we are talking about is an extreme out-of-control profit motive that has virtually no guardrails and that Congress does not impose guardrails on for a whole bunch of other dark money reasons.

And so, I am interested to hear from Dr. Atkins, Mr. Isasi, Dr. Duane, and Mr. Baker. In addition, you know, we have heard about things like eliminating rebates. We have heard about things about increasing transparency. I think those are very important steps. I am curious about what other solutions, whether broadly systemic or more tailored, that you all would propose to this Committee that we consider in order to help actually solve this problem and go beyond talking about it.

Mr. ISASI. I just wanted to say really quickly, you put your finger right on it, right on it. At the end of the day, the only reason PBMs exist is because we do not have the ability to fairly negotiate with Big Pharma, so we came up with PBMs. And I wanted to be really clear: this idea of repealing the rebate, this was under the Trump Administration. The CBO scored that at \$170 billion in costs because PBMs are actually saving us money, right? But the fundamental problem, first of all, as we have heard about, one, is in Medicare, PBMs have to operate under what is called the medical loss ratio where we limit the amount of money they can make in profits. That does not exist in other areas, right?

So first of all, let us put them on some guardrails and say, look, at the end of the day, this is not going to be about you putting money in your coffers. It is about getting a good price for the American family, right? Two, to the same end, we got to create a lot more transparency, particularly for, like, the Federal Employees Health Benefit Program we heard about or other large employers, right, that they can actually see what is the fundamental, the net price I am paying, so that they can actually track and hold them accountable.

But let us not forget, at the end of the day when you look at all the money flowing through the system, the manufacturers are getting 12 times more profit than everyone else. So, this is all about one major problem: drug makers are extorting obscene prices from the American public and it needs to end.

Chairman COMER. The Chair recognizes Mr. Palmer from Alabama for 5 minutes.

Mr. PALMER. Thank you, Mr. Chairman. I am going to ask Mr. Baker some questions about when your firm develops your formularies, does the high-priced drugs, which you get higher rebates from, does that factor into the decision about what drugs you will cover?

Mr. BAKER. No, sir. We always look at the clinical criteria first and then drive to lowest net cost second.

Mr. PALMER. All right. I have got several things I want to cover following up on the gentlelady from New York. She raised some good points. So, the PBMs act as middlemen between the drug manufacturers and payers, like health insurance, for discounts on the drugs in the form of rebates, and she made that point. What I want to know is where is that money going?

Mr. BAKER. That is definitely the big question, and I do not think we have transparency to completely understand.

Mr. PALMER. But is it possible that the PBMs are pocketing the difference because it is not getting back to the patient?

Mr. BAKER. That would be my contention as well.

Mr. PALMER. They have indicated that the PBMs have increased required fees while reducing the rebates in order to avoid passing these discounts on the patients. Do you think that is the case?

Mr. BAKER. I believe so. Yes, sir.

Mr. PALMER. Are you familiar with rebate aggregators?

Mr. BAKER. Yes, sir.

Mr. PALMER. Could you explain what they are?

Mr. BAKER. Yes. And if you look at the end of the day, there has been, I know, a lot of talk about the fact that manufacturers today make 12 times as much as everybody else, and I do want to point out manufacturers are actually making lifesaving drugs for everybody. These GPOs were established, two of the three, overseas. If you go online and you look on LinkedIn, I have never been able to find more than 30 people associated with these big three GPOs, and they are bringing in close to \$200 billion a year in revenue for three entities.

So, where the money goes, I think, is anybody's best guess, but they do have numerous fees that they charge. They keep those fees inside of their own organization for profit purposes and to drive shareholder value. And then what actually trickles out the other end, I do not think anybody really understands what went in the top versus what went in the bottom and how much is kept in the middle.

Mr. PALMER. You made a point just now that I think needs to be followed up on. That is, that these aggregators are sometimes located in foreign countries, is that correct, like Switzerland, Ireland?

Mr. BAKER. That is correct.

Mr. PALMER. What drives that business to those countries?

Mr. BAKER. That is a very good question. I think we can only speculate.

Mr. PALMER. Could it be that we are so overregulated on our end? I mean, I think there is a problem on both ends of this, that our regulatory regime has created an environment that forces things overseas. I know in 1996, President Clinton signed a bill repealing Section 936 of the IRS Code that devastated the pharmaceutical industry, manufacturing industry in Puerto Rico, literally put Puerto Rico in depression, but we also had an issue with taxes.

I know of one Chicago-based pharmaceutical company bought an Irish pharmaceutical company, said that a higher enough percentage of the company would be located in Ireland. They could avoid the U.S. tax rates. It was 12.5 percent in Ireland. Is that part of the problem?

Mr. BAKER. That would be my guess, but I do not have facts to state otherwise.

Mr. PALMER. Part of my concern is, is when they have these aggregators overseas, it is a form of tax evasion, isn't it?

Mr. BAKER. I will rely on your expertise on the IRS Code.

Mr. PALMER. I am asking you. This is not an IRS Code. This is a business question issue. Are they making business decisions to avoid paying higher taxes by locating \$200 billion in profits overseas?

Mr. BAKER. I was not there when they made those decisions, but, again, I think it definitely looks like that is what was occurring.

Mr. PALMER. Are you familiar with PBM practice of spread pricing, and can you explain why there is a controversy around that?

Mr. BAKER. Yes, sir. I think depending on what happens with the money that is actually spread, so some people contend that when that spread occurs, the moneys go back and help drive down plan costs. And if that is the case and we have transparency around it, it might not be a bad thing. My general contention is the opposite, that I think, more often than not, spread pricing is just used in a world where nobody sees what is occurring to drive profits back to these large organizations, and that is a bad thing.

Mr. PALMER. So, you could be directing patients to use certain medications to receive the larger rebates, and I guess we do not have the transparency. We really cannot track it. Is that what you are saying?

Mr. BAKER. That is a very accurate statement.

Mr. PALMER. Mr. Chairman, I think this is an extremely important hearing. I think we have gotten some information from witnesses that I think will be constructive in working together in a bipartisan way to come up with some solutions to help patients. And one of the things I think we need to look at is where a lot of these profits are landing. And with that, Mr. Chairman, I yield back.

Chairman COMER. Thank you very much. The Chair now recognizes Ms. Bush from Missouri for 5 minutes.

Ms. BUSH. Thank you, Mr. Chairman. St. Louis and I are here today specifically in support of Medicare for All and healthcare as a human right. Leaving life or death medical decisions in the hands of drug manufacturers and multibillion dollar PBMs instead of patients and their healthcare providers is literally killing people.

Let us put this conversation into context. In the wake of a deadly pandemic that has left millions traumatized, disabled, and suffering long-term health challenges, Republicans are using the debt limit to needlessly restrict access to Medicare and Medicaid. This will leave millions more uninsured or underinsured and have to rely on predatory corporations like PBMs to receive medical care. As we have heard today, pharmacy benefit managers are intermediaries that negotiate with drug manufacturers, health insurers, and pharmacies to determine the cost and the coverage of medicine.

As a nurse, I have seen America's broken healthcare system force patients to make the impossible choice between paying for life-saving medication or buying groceries. I have seen them cry because their medications were changed, and the doctor ordered one

thing, and they were not able to get that particular medication because of this broken healthcare system.

When congressional Democrats and the Biden Administration worked to pass the Inflation Reduction Act, we capped the price of insulin for Medicare beneficiaries and empowered Medicare to directly negotiate lower prices for drugs. But St. Louis and I know that we still have such a long way to go. That is why Senator Bernie Sanders and I recently introduced the Insulin for All Act, historic legislation to rein in Big Pharma and cap the price of insulin at \$20 per vial for every person who depends on insulin to live. The privatization of our healthcare system itself is at stake, which is why I stand with my colleagues, and I demand Medicare for All be enacted now.

Dr. Duane, according to a 2019 study by the American Medical Association, one in eight pharmacies closed between 2009 and 2015, and these closures disproportionately affected independent pharmacies in low-income neighborhoods. In St. Louis, 15 percent of residents live more than a mile away from a pharmacy, and the lack of trust in culturally insensitive medical providers, which I have seen firsthand, can pose just as great a barrier to accessing care as a lack of transportation. What can be done, Dr. Duane, to level the playing field so independent pharmacies, like GreaterHealth in my district, can keep serving our communities and those hard to reach populations?

Mr. DUANE. Yes, ma'am. Thank you for the question. I think that the biggest thing that we could do is to make sure that providers are being not asked to subsidize any system that is in place. Like, my pharmacy is in a predominantly low-income area as well, and sometimes we have to make heavy decisions about whether we participate in certain Medicare plans or whether we participate in certain Medicaid plans because we know that it will not be sustainable for us to do so, and that that is not a choice that as a healthcare provider I should not have to make. I should just be able to do what I went to school, what God put me on this earth to do, which is to care for people.

So I think that anything that we look at has to be looked at through the lens of making sure that the practitioners that are here to serve all patients, those underserved patients included, make sure that they are able to do so in a sustainable manner based on not the profitability of three, you know, Fortune 12 companies, but of what we as practitioners need the resources, the tools in order to do what is right by those patients.

Ms. BUSH. Yes. Thank you for those insights. This industry is dominated by three big PBMs that control about 80 percent of the entire market. These PBMs also integrated with insurance companies and pharmacies to funnel business toward their own pharmacies at the expense of our independent community pharmacies, which our communities lean on. Dr. Duane, does this create a conflict of interest, in your opinion?

Mr. DUANE. It absolutely does. I think that no matter what walk of life you come from or what kind of insurance you carry, you ought to be able to choose the person that you receive care from. And when the PBMs restrict their networks, or when they, you know, steer you through the advertising that they send to your

home, or the logo that they print on your insurance card, it makes you second guess yourself or wonder, you know, if you can go to a certain practitioner, or if you are forced to go to a different pharmacy, or something like that.

So, I think that it does disadvantage people because, you know, this is a very difficult concept for someone like me who lives it and breathes it every day. But for someone who, you know, is of low health literacy or is just not able to involve themselves in their care to the extent that they may want to, it becomes almost insurmountable to understand really the complexities of that system. And I think that the PBMs end up taking advantage of that, and they rely on people to not investigate and instead to just kind of, you know, go with their intention, which is to push them to the pharmacy that they stand to benefit from the most.

Ms. BUSH. And with that, I yield back. Thank you, Dr. Duane.

Chairman COMER. Thank you. The Chair recognizes Mr. Fallon from Texas for 5 minutes.

Mr. FALLON. Thank you, Mr. Chairman. So much of this is head scratching, the formularies and gross-to-net bubbles and aggregators. I mean, it kind of makes my brain hurt a little bit, to be quite honest. I think it is purposely complex, though. I think there is a method to the madness, and I have seen my colleague from Georgia, Congressman Buddy Carter, a great pharmacist in his own right.

I was reading through this, and kind of in the middle, he made mention that 2,300 independent pharmacies, the United States lost 2,300 independent pharmacies between just December 2017 to 2020, in just 3 years. That scares me as a small business owner, a former small business owner. And just curious, Dr. Duane, do you think this is in part because it is so difficult for independent pharmacies to join PBMs that we have lost so many in just 3 years?

Mr. DUANE. You know, it can sometimes be a lose-lose because if the PBM offers a contract to us that is unsustainable and we take it, it runs us out of business quicker. If we decline a contract that is unsustainable, their affiliate pharmacies stand to gain those same members that I do not serve for that reason. So yes, I think it is.

Mr. FALLON. Is it fair to say, I mean, we have seen as spending on drugs has decreased as a percentage of overall healthcare expenditure since 2009, but I think it perhaps could be the vulturous vertical integration that is not helpful in any regard. In the fall of 2022, Express Scripts announced that they would be reducing prescription reimbursements for almost 10 million TRICARE members. Additionally, 15,000 primarily rural and independent pharmacies were dropped from the TRICARE network. That is particularly concerning to me because I represent 10 rural counties. Options for TRICARE patients and their families were reduced, especially in rural communities. The TRICARE pharmacy network was temporarily reopened in November 2020 after significant congressional pressure. To my knowledge, no new pharmacies rejoined the networks.

So, Mr. Baker, you may not be able to speak to this from direct experience on the issue, but I would like for you to talk about how

this impacts access and competition. It was reported that Express Scripts removed rural staples like Walmart, Kroger, Sam's Club in favor of CVS, of course, a pharmacy owned by one of the other big three. As a smaller PBM competing with the big three, do you find it harder to compete in the market?

Mr. BAKER. We absolutely do. Yes, sir. Yes.

Mr. FALLON. Have you seen evidence that the big three playing favorites with are preferring pharmacies that they own over other pharmacy options?

Mr. BAKER. I think when we deal with jumbo, self-funded employers who have mandatory mail and specialty programs, that is very obvious. Yes, sir.

Mr. FALLON. And if we are removing competition from TRICARE networks, how does that improve service and lower costs?

Mr. BAKER. We agree that it does not do either of those things.

Mr. FALLON. And what is particularly concerning to me is when you have three PBMs owing 80 percent of the market share and then 82 percent of Americans participating in this, that is very, very concerning. And Dr. Duane, did you know Admiral Kevin Delaney, by the way?

Mr. DUANE. I do not know.

Mr. FALLON. No. OK. Just curious. He was a staple in Jacksonville. You spoke in your opening statement about how TRICARE-covered patients are affected by PBM pharmacy network changes. How is this impacting our veterans' community?

Mr. DUANE. It is terrible. I mean, I am not going to sugarcoat it. There was a story on the local NBC channel the week before last that said that people were waiting days, sometimes weeks for their medicine. I do not think that is any fault of the Navy base. I think they are working with them as much as they can. But I think that, you know, what you mentioned, the dropping of tens of thousands of pharmacies almost overnight, and then you spoke to the reopening of the network.

I can tell you that I examined that contract fairly and closely, and I looked, and on any typical brand name medicine, we would have lost somewhere between \$20 and \$30 every time we tried to fill a medicine. And that is before we talk about the \$10 or \$12 that it takes to fill a medicine and break even. So, I mean, you are talking about \$40 to \$50, sometimes at that point. So, I think that they have a markedly reduced option now to get their medicine. The options that do exist in Jacksonville are overburdened and overstressed as a result, and I think that ultimately that leads to poor patient care, and I do not think that that can be argued.

Mr. FALLON. OK. Well, Mr. Chairman, what I have seen here is a lot more agreement that I have seen in the two-and-a-half years I have been in Congress just today, so I think we do have a mandate and we should be talking about solutions. I think these rebates, kickbacks, whatever you want to call them, are something that probably we need to address, and eliminate, and prohibit moving forward, but this is something that we have an opportunity. Let us do the right thing by the American people. Let us work together, and let us fix this. Thank you very much, and I yield back.

Chairman COMER. Absolutely. Thank you. The Chair recognizes Ms. Brown from Ohio for 5 minutes.

Ms. BROWN. Thank you, Mr. Chairman. I am pleased that this hearing presents an opportunity to consider broad bipartisan agreement regarding the dangers of a healthcare system that prioritizes profits over people. We cannot lose sight of the big picture. Caring for the sick and providing lifesaving medications should not be a cash cow opportunity. It is staggering that last year alone, pharma spent \$8.1 billion on advertising, while millions of Americans still cannot afford their medications. This kind of behavior by Big Pharma and pharmacy benefit managers, or PBMs, squeezes those in greatest need who have the fewest resources.

So, Dr. Duane, I appreciated hearing your testimony about your work as an independent pharmacist. Could you tell us why it is important patients have access to a local pharmacy they trust?

Mr. DUANE. Yes, thank you. So, people need to be able to go to a pharmacy that they know will be able to take care of their complex medication regimens, and I think that the average person sees their pharmacist a lot more than they see their doctor. So, I think that it is very important that they have a variety of choice, because someone needs to, just like any other healthcare practitioner, have a level of trust and confidence in that person that they are receiving care from.

Ms. BROWN. Thank you so much for that, and I want to circle back. As stated by my colleague, Rep. Bush, according to one of the studies in 2019, 1 in 8 pharmacies closed between 2009 and 2015. This is deeply unfortunate, especially for those who rely on their neighborhood pharmacies for more than just their prescription pickup. Now, we heard from Dr. Duane when he responded to Ms. Bush's question. But I want to ask you, Mr. Isasi, if you could elaborate a little bit more on how the closure of an independent or a community pharmacy limits healthcare access for a patient living in a low-income urban setting.

Mr. ISASI. You bet. So, important to say that pharmacists can play a critical role in the ability of people to get high quality healthcare. There are wonderful examples across this country. North Carolina Community Care comes to mind where they help patients who are coming in for a very complex inpatient procedures, and pharmacists played a key role in continuity of care and making sure they were OK.

When you move people to mail order pharmacies, you move people out of community-based settings. You lose all of that context. And for folks who are in underserved communities, they already have much less access to doctors, nurses, et cetera. Pharmacists can be on the very front line and very effective, so it is a really concerning trend if we are creating financial incentives that are closing the access that patients have to their pharmacists.

Ms. BROWN. Thank you so much. According to the same study, in 2019, closures were twice as likely to occur for independent pharmacies located in lower-income neighborhoods. These pharmacy closures, as you stated, make it more difficult for the people that are already more likely to experience health disparities to access care and medication. I also continue to call for greater transparency from PBMs on how and why specific drugs make it into their formularies. The secretive selection process of winners and

losers where PBM make backroom deals with manufacturers is just unacceptable.

I am proud of the achievements that congressional Democrats delivered in the Inflation Reduction Act, elevating quality care for vulnerable populations and dramatically lowering the cost of prescription drugs for Medicare patients. Democrats are committed to putting patients over profits, and we will continue to fight to make healthcare more accessible and more affordable. I want to thank the Chairman and the witnesses today for their testimony. This is a very important issue, as you can see by the level of participation and the collaboration of both Democrats and Republicans. And with that, I yield back.

Chairman COMER. Thank you. The Chair recognizes Mr. Edwards from North Carolina for 5 minutes.

Mr. EDWARDS. Thank you, Mr. Chair. Thanks to all of our witnesses for being with us today. I am curious, as we look at some of these examples, on the charts earlier today, and there is no denying there is reason to be alarmed with those margins. Can any of you point to any impetus that may have led to these types of margins, or is this something that has grown over time? If it has grown over time, for what period of time has it grown to this point? Anyone?

Mr. BAKER. Yes, I will go ahead and get that started. I think it starts in the reality that healthcare is generally run by for-profit companies that need to make more money next year, the year after, and the year after. You know, I would note we do not think that, you know, for-profit companies are a bad thing, but we have, you know, designated ourselves as a public benefit corporation. You know, I love the comments. Our motto is same, patients over profits. I think if we focus on patients first, you can still do the right thing and bring a lot of good to this world. But I think it also hits what we call in the industry a lot the balloon squeeze, right? So, as somebody starts looking in one area, PBM profitability, there is always another profitable area that kind of pops up in a more opaque fashion. So, depending on how they need to maintain their profitability to achieve better shareholder value year over year, I think that is why those situations occur.

Mr. ISASI. And the only thing I would add to that is, you know, the fish stinks from the head down, right? The problem, the reason these prices have gone up so fast is because the manufacturers are charging outrageous prices. The PBMs are just a set of those middlemen who are siphoning off those outrageous prices. And what we have seen is, in Medicare, for example, we do have medical cost ratio requirements where we can limit the amount of profit that they can make, but in other sectors, it is not transparent. We do not know, and there seems to be a lot of gaming around rebates. And so, we need much greater transparency and guardrails, right, but they are negotiating a better rate than we would get if we just went straight to the manufacturer.

Mr. EDWARDS. Thank you for that. My next question is, as I have heard because this is not a new issue, I have served in the North Carolina Senate for a number of years, this was something that was always at the forefront. I have heard from drug manufacturers that they need to charge more than cost for drugs in order for re-

search and development to add additional cures for diseases to create drugs that would have less side effects and that sort of thing. Do any of you have an opinion?

Mr. ISASI. Yes, I absolutely do. And just to make it very clear, first of all, the deal that was struck under patent law for drug manufacturers was go out there and find a cure for cancer and make a bunch of money for a limited period of time, you know, 9 years, 11 years depending, and then go find something else. Every single moment that we let drug manufacturers use patent thickets and games so that they are making money from existing drugs, we are disincentivizing innovation. And to be very clear, this is a direct quote from the Stanford business professor in Forbes magazine.

“In the 21st century, most drug companies have replaced moonshots with chip shots, strategies aimed at minimizing risks rather than chasing elusive game changing drug. Today’s biopharma giants focus on monetizing easy wins. We know they are spending much more on marketing than they are on research and development.”

Mr. EDWARDS. Thank you for that. My last question, Dr. Duane is in the North Carolina legislature, again, this was at the forefront. And what we did in North Carolina is that we gave more authority to our insurance commissioners and feel like we gave him the tools to better make transparent transactions with PBMs and to regulate them. Have you seen any other states take any actions? And can you comment on what you see working in the states, what you see not working, and any advice that you have got for this Congress as a result of what we have learned from what is taking place in the states?

Mr. DUANE. So, I think that states have taken steps for that. The state I live in, Florida, has just recently passed a large bill to address a lot of the things that we have talked about today, like spread pricing. In the state of Florida, the legislature, working with the Governor, made sure that rebates were passed down directly to the point of sale to the patient to make sure that it lowers their out-of-pocket costs through their premiums that they pay and their co-pays at the pharmacy counter. So, I think that that is important. Other states have looked at reference-based pricing structures and reference-based dispensing fee structures.

So, I think that, yes, there are states that have taken the lead. I mean, certainly we do not hear about states’ actions that have been taken that have risen drug prices faster than what we see nationally. So, I think that that speaks for itself, what the states are doing and how they are regulating their office of insurance regulation and those kinds of things have lowered costs because we have heard nothing to the opposite.

Mr. EDWARDS. Thank you. Mr. Chair, I yield. Thank you.

Chairman COMER. Thank you. Chair recognizes Mr. Garcia from California for 5 minutes.

Mr. GARCIA. Thank you very much, Mr. Chairman. Thank you to our witnesses for being here. We appreciate your time. And I think we can all agree that, certainly, our country is the wealthiest Nation on earth. We should be ensuring that everyone has access to high-quality, affordable healthcare all across our country, regard-

less of whether someone is in between jobs, unable to work, or wherever their condition is, whatever their age is.

Now, we know that the Inflation Reduction Act has made really great progress in this area, and we are really grateful to the work of the Administration. And the cost of prescription drugs is a critical issue for our country, and we know that the prescription drug industry overall has failed to prevent prices and price surges as a history in this country. And we know that pharmacy benefit managers play a role in that, and so I appreciate all the comments that have been made.

Now, for millions of people, we know that these people make impossible choices. I have heard it back home, and we all hear it from constituents and the choices of medication, the choice of paying rent, the choice of being late on bills, is a real thing for so many Americans, for seniors, especially for low-income folks as well, and I appreciate this hearing. But I just want to remind us, and make it crystal clear that the biggest obstacle to fair pricing is Big Pharma, period. I will say it again, the biggest obstacle to fair pricing is Big Pharma. They wield the most power in this market, and so this hearing is really important. I would love to have a hearing with the heads of all Big Pharma to be able to ask them the questions as to why they are price gouging the average American. I think that is also a very important, and an important conversation that we need to have.

Now, we know that in a 5-year period between 2016 and 2020, pharmaceutical companies raised their prices on drugs 36 percent, almost four times the rate of inflation during that same period, and this is something that is continuing to happen. We do not see it stopping, and we have done some incredible work. I want to thank the President, again, the Inflation Reduction Act, and the work it is doing around Medicare, and the capping of prices is really, really important. This has been a priority. It is finally getting done, and we want to thank President Biden for that.

This Committee found that from 2014 to 2018, taxpayers lost \$25 billion in savings on seven drugs alone because Medicare cannot negotiate those prices. Now we are going to have some reform, we are going to have some change, which we want to encourage. I want to also just say for the record, I have been a long advocate for Medicare expansion, and Medicare should be covering everyone, in my personal opinion. Medicare is popular. We should be building on that work, and I just wanted to make sure we noted that.

Going back to pharmacy benefit managers, it seems clear to me that, essentially, a lot of pharmacy benefit managers are essentially extracting fees, serving as middlemen, and not passing on, in my opinion, a lot of value or significant value to consumers or the public. And we should always be looking at unnecessary costs and strategies to uphold monopoly pricing. Now, monopoly power is a huge concern in the pharmaceutical space, as well as pharmacy benefit managers where three companies control 80 percent of the market. Well, that has been discussed already in this hearing. Mr. Baker, can you also again, briefly once again, describe why consolidation hurts consumers?

Mr. BAKER. Yes. I think at the end of the day, when you look at the fact that three of these organizations are controlling hundreds

of billions of dollars of revenue, it gives them the ability to basically make whatever rules they want to drive to higher costs. And then those higher costs, as we have discussed today, always fall back to a percentage of profit for them. So, it allows them to drive to that higher profit.

Mr. GARCIA. And this monopoly that is currently in place in our country is hurting average Americans, and especially low-income folks and seniors. Would you agree?

Mr. BAKER. I think that is accurate. Yes, sir.

Mr. GARCIA. Do you think it is fair to say that this consolidation is directly allowing these benefit managers, and the pharmaceutical space in general to price gouge?

Mr. BAKER. I would agree with that. Yes, sir.

Mr. GARCIA. I think we obviously need to look at more enforcement, and so I think something I hope the Committee looks at as well in the future is how we are going to enforce and ensure that this price gouging is not happening. What we have essentially going on right now is a system, a monopoly system, that is causing direct harm to consumers and to folks within our healthcare system that need access to pharmaceuticals. And so, I just think we ought to uplift that and continue to call out this serious monopoly that is going on in our country.

I want to again, just thank you for the work, for the witnesses. Again, I think that we should have another hearing with the heads of all the pharmaceutical companies who are causing the absolute biggest damage to consumers to those that need medicine, who need healthcare. And with that, Mr. Chairman, I yield back.

Chairman COMER. The Chair now recognizes Mr. Donalds from Florida for 5 minutes.

Mr. DONALDS. Thank you, Mr. Chairman, and first of all, Mr. Chairman, I do want to recognize fellow Floridian, Mr. Duane. Dr. Duane, my apologies. I want to make sure I get it right.

Mr. DUANE. Thank you.

Mr. DONALDS. Thank you so much for taking the time to come up here. The rest of the witnesses, thank you so much for your time as well. Dr. Duane, I am going to start with you. In your testimony, you described PBMs as the monster in a nightmare. Do you care to elaborate on that? And also, do you think the rest of the witness panel would agree with your characterization?

Mr. DUANE. So, my wife and I bought the pharmacy with an SBA loan. We saved up what money we needed in order to put the money down. The rest of it we used an SBA loan for. That was in 2016. Since 2016, PBM, vertical integration, the steering that they do to push their patients to their own affiliated pharmacies, has increased dramatically. If I knew then what I know now, I probably would not have done the same thing. So, in that, I say that what I saw to be a wonderful opportunity, what I hope can still be a great opportunity for my community, is in peril because, specifically, the things that we have talked about today. So, in that, what we believe to be the real American Dream, owning your own business, owning your own destiny, that kind of thing, it has been a whole lot tougher than what we thought it would be.

Mr. DONALDS. Anybody else want to comment? Dr. Atkins? Mr. Baker?

Dr. ATKINS. Yes, I would agree. As I mentioned in my testimony, when I first became a physician, I could just focus on taking care of patients. Now, every day I have to fight a faceless corporation who does not do what I do, does not understand what I do, and really does not care. They try to tell me how to take care of my patients, what drugs I can and cannot use. They take prescriptions from my patients, delay their care, delay them.

And another example of the mail order about patients where some chemotherapy agents require a certain temperature for the drug, so these medications sometimes left on their front porch in the heat of the summer. So, when they get the drug, it may be too hot, and then we do not know if it is still effective. Sometimes the drugs are lost, and patients are charged. These are obstacles for patients.

Sometimes PBMs also mandate the use of an innovative product instead of using a less expensive biosimilar, and all these things interfere with patient care. They also destroy the patient's hope and destroy their quality of life.

Mr. DONALDS. Mr. Baker? I see you have bated breath over there, Mr. Baker. Go ahead.

Mr. BAKER. Yes, so, thank you. I think even a different spin on this. I think we have talked a lot about the independent pharmacist and the patient impact. But even from the employer perspective, we deal with a lot of the largest employers in the country, and they do not get access to their data. So, they do not really know what they are paying for their medications. They do not see at the claim level how much rebate dollars are making back to buy down the cost of their healthcare.

So, this lack of data is a real problem. If we go to any manufacturers and ask what they are paying for aluminum, what they are paying for tires, what they are paying for any of the other vendor services that they use, they can tell you almost exactly at that CFO level. But for some reason, when it comes to PBMs, everybody is OK saying, well, gosh, I do not get the data. I do not know. And that lack of data causes a lot of real problems, in our opinion.

Mr. DONALDS. Mr. Baker, real quick and probably in the last minute and a half, can you expand on the transparency piece of it, and, really, how do you think transparency through PBMs? And by the way, I see over there, Claudia. Claudia Davant. I worked with her when I was back in the state legislature where we took on some reforms of PBMs back in Florida. But could you comment to what those adjustments federally would kind of look like and what that level of transparency would mean for consumers and for medical professionals, obviously, in the field of medicine?

Mr. BAKER. Yes, thank you. I think it goes back to again, if you look at any other industry, consumers can make a decision on how much they want to pay for something and what profit is OK. You know, that is the basic form of capitalism. And I think we have tried to live in a world where that applies to the pharmacy industry, and unfortunately, it does not because that same level of visibility into costs and profit do not exist in our space, and because of that, then it has continued to drive up profit that hurt American corporations. They need to then continue to increase premiums for their overall health plan, and then, unfortunately, all the people

where 55 percent of self-funded employers use co-insurance and high deductible health plans, when those PBMs are preferring brand over lower cost generic options, when the patient shows up at the pharmacy counter, they have to pay a percentage of a much higher cost.

So pretty significantly across the board, those higher cost decisions are made. They are made in a way that is always, to me, at the detriment of the American corporation and family, and it absolutely needs to be something we continue to address.

Mr. DONALDS. Well, thanks so much everybody for being here. Mr. Chairman, great hearing. We should continue this work, and I yield back.

Chairman COMER. The gentleman yields back. The Chair recognizes Mr. Frost from Florida for 5 minutes.

Mr. FROST. Thank you, Mr. Chairman. Hello. Thank you all so much for being here. According to the AARP, nearly 3 in 10 Floridians have stopped taking prescription medications because of the cost. Big Pharma's massive profits are being paid for literally by the lives of our people. It is very important that we in Congress understand the practices that lead to higher drug prices, and one of these practice entails PBMs offering pharmaceutical companies prime placement on a health insurer's list of covered medications in exchange for steeper discounts or rebates on drugs. Mr. Baker, can you briefly walk us through how exactly the specific rebate process works?

Mr. BAKER. Yes. Thank you, sir, and I think the best way to do that is through an example. We have talked for years in the industry about the biosimilars coming for Humira. Humira is the largest pharmaceutical drug in the history of the world, \$200 billion medication. We now have lower cost generic alternatives available. Very first biosimilar that came out, came out at two list prices, one what we call high-WACC, high rebate. So, it was a five percent discount off what is almost a \$9,000 a month drug. The second one was a low-WACC, low rebate, 55 percent off. So, as my previous comments just made, when we think about somebody who has got co-insurance or deductible and they have to show up at the pharmacy counter and pay a percentage, high is bad.

The other issue is there is no visibility on how much of those rebate dollars are actually being paid into the system to, you know, make cost of healthcare better. So, we are living in a world where most PBMs continue to pick the high WACC, high rebate because they like the lack of transparency that goes into those rebate dollars. They can siphon some of that money off, and we really do not know which one of these is cheaper, but it should be going to the lower cost option in our opinion.

Mr. FROST. And some would say that the current system incentivizes drug companies to have higher prices so they can give higher discounts rebates to PBMs. Do you agree with that?

Mr. BAKER. I would agree with that. Yes, sir.

Mr. FROST. Florida consistently ranks as the most popular place to retire in America; however, with a larger population of seniors comes a larger population of folks vulnerable to healthcare challenges, and that, essentially, is especially sensitive to the price of prescription drugs.

Dr. Atkins, you testified about a case in which your patient's insurance company charged her a co-pay of \$1,500 per month for a drug she needed to treat her cancer. That is simply unaffordable for many Americans. In fact, most Americans, over 60 percent cannot afford the unexpected \$400 bill tomorrow. What happens to patients whose doctors are not able to take the time out of their busy day to see if their prescriptions can be obtained for a more affordable price?

Dr. ATKINS. Most of those patients just will not take the medication, and then that will affect their life expectancy.

Mr. FROST. Dr. Duane, my first question for you is—and hello to another fellow Floridian—my question for you is, can you briefly share the important role of independent pharmacies like yours, what role they play in the community, especially for those who face barriers to accessing healthcare?

Mr. DUANE. Yes, thank you for that question. So, my pharmacies are located in lower income parts of Duval County. We are kind of the hub. It is more than just, you know, here are your medicines, we put the pills from a big bottle into a littler bottle for you. I have people that bring letters from their bank or from the electric company and ask me to read them because they are functionally illiterate. I have people who ask, you know, my HMO is telling me I have to see a new doctor, I need a new primary care doctor, do you have any recommendations? Who else do you see that comes through here?

So, it is much more important to the community than just the actual prescription filling process. I will say that a representative earlier asked about an article from the Journal of the American Medical Association about what happens when a community pharmacy, especially independent community pharmacy closes. People get sicker when that happens. In that zip code, when a community pharmacy closes, their blood pressure goes up, they have more heart disease, there are more heart attacks. These are things that we can definitively link to the absence or presence of a community or independent pharmacy in a particular zip code, so it is vital for the community.

Mr. FROST. And PBMs have a lot to answer for when it comes to the sky-high prices of drugs, but big pharmaceutical companies, like Representative Garcia pointed out, have been price gouging for years. This is something that personally impacted me. You know, in 2017, Mylan, the pharmaceutical company responsible for EpiPen, settled a \$465 million class action lawsuit over a scheme to avoid paying rebates, so they can maximize profits. In 2016, an EpiPen two-pack costs folks \$313. According to the suit now, the cost is between \$650 and \$700. Four years ago, I almost died because I did not have an EpiPen. I carry one everywhere I go. If you are not able to afford it and you have an anaphylactic attack, you die.

Dr. Duane, almost no time left, but real quick, Dr. Duane, what can be done to level the playing field so independent pharmacies like yours can keep serving our communities and hard-to-reach populations?

Mr. DUANE. Yes. I mean, it is just very difficult for us to compete when the person that we are trying to compete with holds all the

cards, when the person who makes the contract is also the person who owns the competitor, which is also the person who increasingly owns the doctor's office, which is also increasingly the person who owns the insurance company. I mean, you cannot hope to compete with that. So, I think anything that is addressed as far as looking at how they stack up, how they got to be that stacked up, and how we can make sure that there is still a level playing field within that system of integration.

Mr. FROST. Of course. Thank you so much for your time. I yield back.

Chairman COMER. The Chair now recognizes Mr. Sessions from Texas for 5 minutes.

Mr. SESSIONS. Mr. Chairman, thank you very much. I have been sitting here for an hour and a half or so and not sure that we really get it right.

[Slide]

Mr. SESSIONS. This slide shows—I hope you can see it—Cost Plus Drugs, which Congressman Higgins showed, cost annually \$499, CVS pricing \$110,000. We have heard about how great this Administration was at lowering drug prices. We have heard how great it is to have everybody go on Medicare. The bottom line is, is that there is money here, what did the Administration at the time they cut the deal, what did they think about this, and did they not look at this price? It is one thing to blame the drug manufacturers. It is another thing to look at what the consumer pays, and I am not sure we have gotten to that. Perhaps we have, Dr. Baker, but please help me to understand what did the Administration do when they saw this, or did they ignore it? Dr. Baker? Mr. Baker?

Mr. BAKER. Yes. No, thank you, sir. What I would say is, this is a very interesting example. It is a generic drug. There are no rebates and nobody can have any rebate conversations around it. This is simply pure cost, and this is—

Mr. SESSIONS. By the way, let the record reflect that each of you on this panel, or at least several of you, are agreeing with what you are saying. Please continue, sir.

Mr. BAKER. Yes, thank you, and in this situation, it is a drug that gets mailed. We talked a lot about the impact on independent pharmacies. Many of these, especially in oral oncolytic drugs, maybe if you want to mail them, that is OK because they do not need special patient monitoring requirements. But many specialty drugs are injectable. They have very bad side effects. And in my opinion, the mailman, when they force people to go to their own specialty pharmacy and mail it to your home, is not the best person for injection technique. Probably an independent pharmacist would be much better at that, so.

Mr. SESSIONS. I could agree with that.

Mr. BAKER. Yes.

Mr. SESSIONS. But go to this difference. What did the Administration see when they were trying to thoughtfully help the American public and the consumer? What did they do about this because they are the ones that, by and large, has universal access to this problem? We talk about Congress all the time. Our young Chairman and others do want to fix this. What did the Administration do about this?

Mr. BAKER. To my knowledge, I have seen most of the regulation focused on brand manufacturers, and with this being a generic medication, I am not aware of anything that has occurred to fix that problem.

Mr. SESSIONS. But this is big.

Mr. BAKER. It is a big problem.

Mr. SESSIONS. Is this an isolated problem? No, it is not, so there is more work to be done, I think is what I would say. More work to be done. What should be done, in my opinion, is why we are having this hearing today. We are trying to filter out things, but the bottom line is, is that this cost somebody \$499, and this cost somebody 110,000. Who paid this?

Mr. BAKER. I would bet most of that payment came out of the plan sponsoring that situation, and then ultimately everybody who is part of the plan had to pick up the costs.

Mr. SESSIONS. So, they spread it out?

Mr. BAKER. Yes, sir.

Mr. SESSIONS. What advantage would a person have who did this? Is it individual person, a person perhaps who was paying up an HSA? What kind of person would this be versus this being a plan? What is this? I know what it is, but what kind of person benefited from that?

Mr. BAKER. I would say the person who bore more of the costs and could actually see what those total costs were. In the \$110,000 situation, I guarantee that cost was buried in millions of claims, and nobody is really looking at it because they do not know what—

Mr. SESSIONS. And I am talking about maybe an end user or a person who used this. What kind of person is this? Is this a person who was maybe uninsured? And we have heard that there is some disparity there. What kind of person comes to Cost Plus Drugs or DrugRX or Blink or any these other seemingly smaller, perhaps companies, but non-PBMs?

Mr. BAKER. Yes, I think the root of the problem stems, and you can look at the fact that 10 percent of all prescription drugs filled in America go to cash discount cards, and 85 percent of those people who use those have insurance. So, it is a classic case where insurance is not driving to the lowest cost, and now American consumers have to try to figure out this arcane system on their own to find a medication they can afford.

Mr. SESSIONS. Mr. Chairman, I know, I am at my time. Do you think an answer is possible by this Committee? Do you think that we can study it and pinpoint those problems, whereas the Administration evidently did not go that direction?

Mr. BAKER. I am very encouraged by the overall positive comments we are hearing from everybody that we are talking to today that there could be a solution that we can figure out. Yes, sir.

Mr. SESSIONS. Well, I am hopeful that there are people in the American public, perhaps other people who have great knowledge have on this, and I hope that they will write our young Chairman. I am the Subcommittee Chairman for Government Operations. Not saying all this falls in my bailiwick, but I hope people will give us feedback. I want to thank each of you today, and I think we are

getting closer by having the hearing today. Mr. Chairman, I yield back.

Chairman COMER. Absolutely. Thank you. The Chair recognizes Ms. Balint from Vermont for 5 minutes.

Ms. BALINT. Thank you, Mr. Chair. In many rural communities like Windham County, Vermont, where I live, pharmacies play a vital role in meeting community healthcare needs, just like, Dr. Duane, you said earlier, that resonated so much with me, all of what you said about the role that independent pharmacies play. It is really beyond dispensing medication. It is providing basic medical information services, providing counseling.

And, you know, at one point, I was between healthcare plans and the paperwork was not done. And my independent pharmacist, his name was Frank, came in, and my asthma medication was hundreds of dollars a month. He came in, he said, "you know, Becca, it has not come in, it is not running." He literally gave me the medication. He said, "I know where you live. Come back when you have it straightened out." That is the kind of care that you get from independent pharmacies, so thank you for doing what you are doing for your community.

Now PBMs, as we all know, is what we are talking about today. They contract with pharmacies to create these pharmacy networks and whether or not patients use pharmacies in these networks can affect the amount that patients pay at the counter. And these arrangements can drive patients away from independent pharmacies in their communities. And in fact, I had a pharmacist tell me at one of my independent pharmacies, I cannot really fill this for you or I am going to take an incredible hit on my bottom line. And you have been a customer with us for years, and it is paining me to tell you, you are going to have to fill it somewhere else.

So, when I was the leader of the Senate in Vermont, we tackled the problem by enacting legislation that prohibits PBMs from reimbursing pharmacies in Vermont less than they would reimburse PBM affiliates for the same services, which I think is critically important. And, Dr. Duane, I know Representative Frost asked you some about this, but I am wondering now that we have a little bit more time, can you explain why it is so difficult for independent community pharmacies like yours to be part of these pharmacy networks? Just lay it all out for us.

Mr. DUANE. So, it is twofold. The first thing is that they can afford to offer themselves contracts that are poor, and then they can offer me the same contract. They will happily, when they are vertically integrated, lose money out of one pocket to ensure that the money stays in the other pocket, so it is a lose-lose.

Ms. BALINT. And you do not have another pocket?

Mr. DUANE. No, ma'am, I do not.

Ms. BALINT. Yes.

Mr. DUANE. So, if I participate in that contract and it is a poor contract, I run out of business all the quicker, and they are happy. And if I do not participate in the contract and I close my doors to those patients, then those patients find themselves into an affiliated pharmacy, and they are able to keep that money.

Ms. BALINT. Yes, and this is the reason why we have lost over half of our independent pharmacies in Vermont, for this exact rea-

son. And we know, and you talked about this, that each of the three largest PBMs also owns a specialty pharmacy that they use to dispense medications that treat rare or complex health problems, but these drugs do not legally have to be dispersed through a specialty pharmacy. And any licensed pharmacy can dispense a specialty drug as long as that drug can be purchased from a manufacturer or authorized wholesale distributor. So, Mr. Baker, how do PBMs use the specialty pharmacies that they own to incentivize patients to fill their prescriptions at the specialty pharmacy instead of Dr. Duane's independent pharmacy?

Mr. BAKER. Yes. I would say they do not necessarily incentivize anything, they mandate.

Ms. BALINT. Thank you.

Mr. BAKER. It is you cannot go to his pharmacy, you have to come to mine.

Ms. BALINT. Thank you for just like cutting right through that.

Mr. BAKER. Yes, ma'am.

Ms. BALINT. Not an incentive, just a mandate. So, it is not hyperbole to say that independent pharmacies in so many of our rural communities are the heart of the community. That is where people get the medical attention and advice that they need. Especially as rural America is losing so many of its healthcare providers, the pharmacy is critically important to communities like my own.

And so, it is really important that we understand the ways that PBM practices, you know, may be steering patients away from these pharmacies and making it impossible for these pharmacies to stay open. So, it is a critical part of the ongoing work that I see that we have to do and that Democrats, I feel like, have been doing for years to try to make medication more affordable and accessible to all. And I am so glad that we are having this hearing. I really appreciate this.

Mr. Chair, this is part of a problem that is making it incredibly difficult for rural Americans to stay healthy. It is as simple as that. Thank you. I yield back.

Chairman COMER. Very good. The Chair now recognizes Mrs. McClain from Michigan for 5 minutes.

Mrs. MCCLAIN. Thank you, Mr. Chair, and thank you all for being here on this very important topic. I think what is encouraging is if you look around, we all agree, finally, there is a problem and it needs to be fixed, right? It does not matter what side of the aisle you are on, what color your skin is, what race, we have a problem, which is wonderful. Now we can get down to the business to fixing it.

What I want to make sure that we first understand is to make sure I understand it correctly. And if I am correct, pharmacy benefit managers were originally meant to facilitate negotiations really to drive the cost of prescription drugs down for their patients, correct? I mean, originally. I do not think it was done with malice.

Mr. ISASI. Yes.

Mrs. MCCLAIN. That was the original. However, PBMs, it seems like, has evolved into middlemen with an outsized role in the pharmaceutical marketplace, operating really behind the scenes to manipulate drug costs, control access to certain medications, and, ulti-

mately, decide the payment pharmacies receive for all of their own benefits, so it seems that it switched. Am I directionally tracking?

Mr. ISASI. Yes. I would not say it switched. The main driver is still Big Pharma, but to your point, there are all these other ways they are trying to make money, that PBMs are trying to make money, that is distorting the original—

Mrs. MCCLAIN. Right. I mean, the largest PBMs control 80 percent of the market, right? Each own their own pharmacies, disincentivizing negotiations and enabling them to further benefit, really, from higher prices. So, I have a good understanding of what it was and what it has evolved to now. Mr. Baker, real quick, what do you believe the No. 1 goal or priority should be?

Mr. BAKER. Yes, thank you. I think we have used the word “transparency” quite a bit here today as witnesses. The other thing I think is important to point out, we have tried to say as a public benefit corporation how are we going to be a completely unconflicted PBM. Like, so how am I going to make sure I am always making decisions in the right vein for our clients and their members?

Mrs. MCCLAIN. Yes.

Mr. BAKER. And I think a big part of that is we have made this decision never to own our own pharmacy. I think the day I start deciding what I pay myself, conflict can occur, and that is not a really good thing.

Mrs. MCCLAIN. OK.

Mr. BAKER. My mail order pharmacy, if I were to have one, again, does not provide the same level of services we clearly get from independent and other community pharmacies. And we think the overall healthcare picture needs to be viewed not just an insular profit I can make off a drug that I dispense for my own.

Mrs. MCCLAIN. So, who would benefit from increased transparencies in the PBM world?

Mr. BAKER. I think the American corporation would benefit greatly by knowing what they are actually paying for medications and being able to competitively figure out if they want to continue doing what they are doing. I think the American taxpayer would benefit greatly from that as well.

Mrs. MCCLAIN. Why do you think the PBMs are against transparency? I cannot figure that out.

Mr. BAKER. We hide behind the term “proprietary” a lot in this industry. Everything is proprietary. Everything is hidden. It is going to hurt my ability to negotiate and really get this better price. I think we have heard that so long, I personally am callous to it. Everybody likes to—

Mrs. MCCLAIN. Do you believe that?

Mr. BAKER. I do not, no.

Mrs. MCCLAIN. OK.

Mr. BAKER. I think we can look at the facts and costs go up every year, so we can continue doing what we are doing, and guess what? Costs are going to go up.

Mrs. MCCLAIN. Right.

Mr. BAKER. Now is the time we need to try to—

Mr. ISASI. And just a point of clarification, which is it is true that when a PBM negotiates a better price for funds from the drug

maker, that unveiling that price is probably not the best thing. That is what they are using as a red herring. We need to know. For example, an employer who is paying for their services needs to know, and there is a way to keep that private and still make sure there are safeguards all the time.

Mrs. MCCLAIN. And I appreciate that. In the interest of time because I only have a minute left, what I am trying to make a correlation to is, we all agree there is a problem, which I think is dogs and cats living together, OK? In order to fix a problem, I think we have to fully understand what the problem is, and the more data and the more we can see, right, the more transparency there is, will help us figure out which lever to pull to fix the problem. Would you all agree with that?

Mr. BAKER. Yes.

Mrs. MCCLAIN. It is amazing to me, and it always seems like when we do not want to be transparent. I mean, I come from the financial planning world. We have to be transparent. We have a prospectus that we have to give all of our clients to see where our dollars come from. That was mandated by Congress. Quite simply, do you think if we made the PBMs or this process more transparent, do you think that would help us identify the problems to get to the best solution?

Mr. BAKER. Yes, and I love your analogy around financial services. Everybody knows the prospectus and what is happening on those. When it comes to healthcare, self-funded employers do not put that out, right? They do not know how to say here is the profit being made, here are the fees, here is everything accounted. So, you plan it, participant knows that information, I think that is a great analogy.

Mrs. MCCLAIN. And it leads to a lot of mistrust as well. So, thank you, Mr. Chairman, and thank you, witnesses. I yield back.

Chairman COMER. The Chair now recognizes Ms. Lee from Pennsylvania for 5 minutes.

Ms. LEE. Thank you, Mr. Chairman. I am excited to be able to talk about something in this Committee that is actually meaningful to American people: lowering prescription drug costs and increasing access to affordable care. I am happy we all agree that drug prices are out of control, yet we seem to be the only country suffering from this problem. This Committee's 3-year investigation into drug companies discovered many ways that pharmaceutical companies prioritize profits over people, including flagrant anti-competitive behavior, to maintain their monopoly pricing. Mr. Isasi, how specifically has anti-competitive behavior led to higher drug prices?

Mr. ISASI. It has driven out competition. It has created consolidated power amongst individual drug makers, and they raise their prices unchecked.

Ms. LEE. Thank you. This Committee also found that drug companies were specifically targeting the U.S. for high drug prices because Medicare cannot negotiate the price of drugs directly with those companies. So, Mr. Isasi, can you explain how the U.S. is different from so many other countries in this way and how that has led to higher drug prices?

Mr. ISASI. Yes, that is exactly right. We are talking about an industry that is over a trillion-dollar industry a year. Half of their

profits are coming just from the U.S. and Canada out of that trillion-dollar industry, so they are fleecing Americans. And until we passed the Inflation Reduction Act, we had no ability to get in there and negotiate a fair price. And it is really important to point out Part D, which is the benefit that allows seniors to get prescription drugs, so important, was designed so there was no real negotiation. It was designed so there were small regional prescription drug plans who had no negotiating power, so it was, by design, a terrible deal for the American public.

Ms. LEE. People across the country have been struggling for years to afford healthcare. Though important, drug prices are just one piece of that puzzle. How do drug prices inflate overall healthcare costs that families pay, and what does this mean on a practical level for someone who relies on high-cost medication?

Mr. ISASI. Well, what we know is, in many cases, a quarter of all the premium increases you are experiencing are because drug prices are going up so fast. And what is really important to say is, lots of people out there are not taking prescription drugs, right? So, they do not even realize that every year their premiums are going up because prescription drug companies are fleecing them. And it goes into the risk pool of your employer, the risk pool of your insurance program, et cetera.

Ms. LEE. So, in keeping with that point, more than half of overall spending goes to so-called specialty drugs, even though they make up about two percent of the medicines dispensed. This designation is defined differently across market by PBMs. Mr. Baker, can you explain how PBM's arbitrary decision-making on whether to label a drug specialty is affecting patients?

Mr. BAKER. Yes, absolutely, and that is an incredible point. In the pharmacy industry, we can pretty well come to an agreement on what is considered a brand and generic drug. It all stops there, so this world especially has really started growing since about 2014–2015. It is exponentially growing, to your point, being 50 percent or more of all spend today. And PBMs can call any drug they want a specialty. Every PBM will have a different specialty list. Every PBM could have a different specialty list for different type of fulfillment channels. So, the specialty list that we use for independent pharmacies can be different than the one I use for my own PBM pharmacy if I wanted to use it. So, this lack of transparency and ability to have oversight on what is considered specialty limited distribution or other does drive to a lot of profiteering.

Ms. LEE. Thank you. In the end, this is actually a somewhat simple conversation. Drug companies set drug prices. If the drug companies set lower prices for medications, American families would pay lower prices. That said, it is important to understand the context in which those drug companies operate and who they operate with. Americans should not have to choose between feeding their families and their diabetes medication. We should not have to go into bankruptcy to treat our loved one's cancer, and we should not have to raise thousands of dollars on a GoFundMe site when we are injured in an accident. This is a uniquely American problem.

Our healthcare system is broken and rotten to its core on every level. PBMs are just a part of a greater problem, and we cannot allow them to be a scapegoat to avoid addressing true issues.

Americans deserve universal healthcare. We deserve Medicare for All. And with that, I will yield back. Thank you.

Chairman COMER. Thank you. The Chair recognizes Mrs. Boebert from Colorado for 5 minutes.

Mrs. BOEBERT. Thank you, Mr. Chairman. Dr. Duane, I think it has been mentioned many times here today, and I apologize that I was not here for a lot of it. We have other committees going on as well. But we have seen an increase in prices for medication and treatments over the past few years. You would agree?

Mr. DUANE. Yes, I would absolutely agree with that.

Mrs. BOEBERT. Yes, and I think that you all have elaborated as far as the why, and you are welcome to elaborate more if you would like. But do you see that patients leave their prescriptions at pharmacies because they can no longer pay for it?

Mr. DUANE. They absolutely do in my pharmacy. Yes, that happens more than should make most people comfortable.

Mrs. BOEBERT. I actually have a fun little story. My staff is probably going to talk to me about this later, but I left a prescription at a pharmacy once. I went to get birth control, and I was there at the counter and went to pay for it, and the price was very, very high. I said wow, is this a 3-to-6-month prescription? No, ma'am, this is 1 month, and I said it is cheaper to have a kid. And I left it there, and now I have my third son, Caden Boebert, and so actually it turned out to be a really great thing, but I personally experienced that when times were tough. But thank you so much for your indulgence there, and I will talk to the team about that comment later.

Excuse me. Please state your name for me, please.

Mr. ISASI. Isasi.

Mrs. BOEBERT. Isasi, thank you. Mr. Isasi, now you state that drug launch prices have increased 20 percent per year from 2008 to 2021. Other than inflation, what other factors caused this price hike?

Mr. ISASI. Drugmakers' greed.

Mrs. BOEBERT. And you state that there are, on average, 125 patient applications per drug that extends their monopolies and blocks competition up to four decades. What kind of distinct ability do these patients have from others to make them patentable?

Mr. ISASI. Right. They are exceeding their patent. The patent was to last 9 years, maybe 11 years or 12 years, and they are going for 40 years because they are just suing their way into greed.

Mrs. BOEBERT. And how could we end patent abuse without restricting someone's patentability?

Mr. ISASI. I mean, this is so important. By really focusing in on this kind of greed, what we are actually doing is ending drug companies' ability to make money by just extending the existing invention. We want them to stop making money at the 9 year and go find something else, and every year we let them keep making money from that same drug. We are killing innovation, so it is critically important.

Mrs. BOEBERT. Thank you. And, Dr. Atkins, as an oncologist, can you give us an example in which PBMs have obstructed your patients from getting the medications that you prescribed to them?

Dr. ATKINS. We could stay here all day, but I will just give one.

Mrs. BOEBERT. Yes, ma'am.

Dr. ATKINS. Particularly what I mentioned earlier in my statements that I wrote a prescription October 14. I saw the patient 2 weeks later, and he still did not have the medication. Asked him what had happened because we thought we could fill it at my dispensary, my practice, I found out from a pharmacist that our dispensary sent a prescription someplace else, and then the patient's PBM, CVS Caremark, took the prescription, told the patient we have not heard from your doctor. We are like, "that is not true, we have been going back and forth." Anyway, the patient got his medication on December 1, so this happens very frequently.

Mrs. BOEBERT. Right, which presents consequences to your patient?

Dr. ATKINS. Definitely. Yes.

Mrs. BOEBERT. Yes. Thank you very much, Doctor. And, Mr. Baker, on May 16, your company changed the name and has a new tagline of Patients Over Profits. What prompted this change?

Mr. BAKER. Yes, I think it really falls to a lot of the conversation here today. We think you can run a very viable organization that drives to a highest clinical quality, lowest net cost, and not focus on profit being your sole endpoint. So, we really want to make sure that everything that we do and everybody we work with knows that patients come first. And you know what? This is a hundreds-of-billions-of-dollar-a-year industry. There is plenty of money left over to create a market-driven solution that still creates good profit for people.

Mrs. BOEBERT. Yes. And in your opinion, do you oftentimes see PBMs using rebates or promote expensive brand drugs, even if they do not work as well on patients?

Mr. BAKER. We do. You can, publicly available, pull a lot of PBM formularies and continually see brand name drugs that have lost patent exclusivity that are now generics, but those are still the drugs that are preferred on those formularies.

Mrs. BOEBERT. Thank you very much, Mr. Baker, and, Dr. Atkins, do you mind explaining the protocol of step therapy or fail first?

Dr. ATKINS. Sure. Fail first, one example I gave of it, anti-medications for nausea and vomiting for chemotherapy. There are certain drugs we want to use with certain chemotherapy because some drugs cause more nausea than others. So, I may want to use drug X, and the PBM will say no, you have to use drug number A. And if the patient fails that by getting really, really sick, then I can go back to the drug I want to use. That is one example of step therapy or fail first.

Mrs. BOEBERT. So, you have seen patients be affected?

Dr. ATKINS. Yes.

Mrs. BOEBERT. Do you think that patients are being failed by PBMs and their insurers?

Dr. ATKINS. I think they are. I mean, as a physician, my job is to take care of patients the best way I know how. And when I give a recommendation or write a prescription and then someone else who does not do what I do, does not have my training, stands in the way of me taking care of my patients, that is definitely failing the patient.

Mrs. BOEBERT. Thank you. Well, I am very excited to have had this hearing today. Thank you, Mr. Chairman, and thank you to my colleagues on the other side of the aisle. It sounds like that we have a lot of things that we can work together on. Thank you so much to our witnesses here for providing your testimonies and your expertise here in this committee room today. I hope that we can provide solutions to help you help your patients and to get this problem that we all see as very detrimental, under control. Thank you so much. I yield.

Chairman COMER. Thank you. The Chair recognizes Ms. Crockett from Texas.

Ms. CROCKETT. Thank you, Mr. Chair, and thank you to each of you for being here and being willing to repeat yourselves a lot. So, what I am going to try to do is, No. 1, applaud all my colleagues, which, you know, this Committee tends to be a little partisan, and so, I did not know that we could actually agree on much of anything. And so, you know, today has revealed the miracles that are still happening in the world.

But I think that we all agree that Americans deserve an affordable healthcare system that works, and the one that we have right now is broken, but it does not have to be broken because we know that other countries are doing this so much better. But we are supposed to be the gold standard in the world, and so what I want to talk about is a little bit of my experiences, and I most likely will maybe have a question for Dr. Atkins.

When I swore into Congress, I honestly did not know what to expect as it relates to the No. 1 constituent issue. If I had to guess, I would assume people would generally call to get guidance regarding tax returns. After all, I was swearing in in the thick of tax season, and financially, people were struggling. But instead, the No. 1 topic of our phone calls was regarding Medicaid and Medicare. I was floored, but it was so overwhelming that I recruited an amazing constituent advocate by the name of Mary from the hospital sector to assist us and minimize the learning curve of all the complexities regarding Medicaid and Medicare.

I thought, great, we are off to an amazing start. The Democrats in the 117th, along with President Biden, were the architects of the Inflation Reduction Act, which, as mentioned over and over in this hearing, dramatically reduced some of the pharmaceutical burdens on our most vulnerable populations. But there is still more work to do, which is why we are here.

The question is, how did we get here, though? I mean, as mentioned before, we are the United States. And so, over time, we have learned that certain medications are more vulnerable to drug shortages when there is a lack of economic incentives to produce them. And so, I want to talk to you about a constituent call that I received because it feels like this is a multi-layered issue.

So just this week, Melissa called our office, and Melissa also, I think she wanted to make sure that I got the message. She decided that she was going to tweet at me as well, and so she tweeted at me on all my accounts to make sure that I knew, but it is just that serious, and that is what I want people to understand. This price gouging while we heard a conversation about not being able to get birth control is not necessarily life or death. When Melissa called,

Melissa called because there is a shortage as it relates to cancer medications.

Dr. Atkins, I know that you just mentioned some things as it relates to cancer, but are you aware that there is currently a massive shortage that we are experiencing in this country as it relates to cancer medications?

Dr. ATKINS. Yes. Right now, there are several drugs that are shortage of. One is a medication called carboplatin. And it is a very old drug. So, it is only generic, and there are not a lot of incentive to keep making it. So right now, I mean I talked to my pharmacist about this yesterday before I came here and said where do we stand with carboplatin. And he told me, well, we are allowed to order based on what we ordered last month, so we are good through June, but after June, we do not know. And so, every other oncology practice in this country is experiencing the same thing. Another medication that is on shortage is a medication called 5FU. 5FU is the base drug for every GI cancer, colon, stomach, appendiceal, esophageal. So, these are our real problems that we face every day, and that is not on top of the price of drugs.

Ms. CROCKETT. Exactly. And so, it is frustrating because, literally, Melissa, called our office, and Kylie who answered my phone, sent a message talking about the fact that she was almost in tears when she got off the phone because Melissa is scared that she literally may lose her life because she cannot gain access in this country.

What is frustrating for me—I am from the state of Texas, as mentioned, and even in the state of Texas, there was a bill that was just passed. And this bill is creating an organization within the state of Texas so that we import drugs from Canada because of the cost that our drugs are placing on our most vulnerable.

The final point that I really want to make, though, is that we are also right now in the midst of a fight as it relates to the debt ceiling, and right now, this is the partisan issue. I am going to tell you that it is quite frustrating that we are talking about potentially not funding folk that are already struggling because this hearing is about the fact that most people cannot afford these drugs as it is. And now we are talking about they may not even have the coverages of Medicaid and Medicare because we are talking about cutting them off. We deserve better, the American people deserve better, and I appreciate your fight. We are in this together. Thank you so much, and I yield back.

Chairman COMER. The Chair now recognizes Mr. Fry from South Carolina.

Mr. FRY. Thank you, Mr. Chairman, for having this hearing today. This is actually pretty remarkable, just the back and forth, the camaraderie a little bit that we see on both sides of the aisle.

Last year, PBMs raked in billions of dollars in profits. This effectively means that every American, based on the profits, pay about \$70 to PBMs just to have access to prescription drugs. Drug manufacturers received 37 percent of that money spent on prescription drugs, which is a decrease from 50 percent in 2013. PBMs are retaining 69 percent of the money hardworking Americans are spending.

And I get these figures, Mr. Chairman, and I think Dr. Carter is going to be in here, but if he does not make it, I would like to request unanimous consent to put his paper, "Pulling back the curtain on PBMs: A Path Toward Affordable Prescription Drugs," into the record.

Chairman COMER. Without objection, so ordered.

Mr. FRY. Thank you. One of the things that we touched on a little bit, and another Ranking Member did, and Ms. Boebert did, are fail first policies or step therapy. Dr. Atkins, in your role as an oncologist, how frequently are your patients required to fail first a medication?

Dr. ATKINS. I could not give an exact percentage, but one time is too many, as far as I am concerned. To give another example, I had a patient who had stage 4 breast cancer, and there was one medication I wanted to give her called a CDK4/6 inhibitor. And the one I wanted to use, her PBM said, no you have to use this one, and if she fails that one, you can use the one you want to use. Well, the thing that was frustrating was, one, they are getting in the way of me taking care of my patient. That is No. 1. No. 2, per the national guidelines, if a patient fails one CDK4/6 Inhibitor, you do not give them another one. So, they are getting in the way of me taking care of my patient, also trying to treat a patient without a license, and trying to treat that patient in the wrong manner.

Mr. FRY. Right. They are not medical doctors.

Dr. ATKINS. No, they are not.

Mr. FRY. They are not licensed in your state. They do not have the training that you have. Is that correct?

Dr. ATKINS. That is correct.

Mr. FRY. But they are making these decisions, and we can speculate why. We have a lot of reasons why, but they are making these decisions without being in the room, the clinical room, with you and that patient.

Dr. ATKINS. Exactly.

Mr. FRY. Why do you think they do that? What do they cite as a reason when they deny a patient?

Dr. ATKINS. Well, the real reason is money. They do whatever is more profitable for them. They will say it is for safety or to maybe rein in unnecessary spending, but that is not the truth. The truth is, the more they inhibit me, the more money they make.

Mr. FRY. Right. And so, what does your patient do when they are required to fail first?

Dr. ATKINS. The patient is very upset. They lose hope. Their life expectancy is shortened. And with oncology, you have the cancer diagnosis, and you have the emotional toxicity of the whole diagnosis. So, if someone cannot get their treatment on time, the treatment that their doctor recommends, it pretty much destroys the patient emotionally.

Mr. FRY. You are a very competent doctor. When your patients call, I am sure you call them back. But you see these barriers, these delays even within the office setting when a patient is required to fail first, they have to call your office back, correct?

Dr. ATKINS. Yes.

Mr. FRY. And get another prescription. Is that right?

Dr. ATKINS. Yes.

Mr. FRY. And you have other patients that you are seeing. You are incredibly busy. And so, in one of the most vulnerable moments of their life, they do not have the ability to get the treatment that they need because these PBMs are requiring you to fail first?

Dr. ATKINS. Exactly.

Mr. FRY. Without that medical training?

Dr. ATKINS. Exactly.

Mr. FRY. And this is not just cancer, Doctor, right? These are a whole host of other medical conditions, right? I mean, if you look at opioid use disorder, you are required to fail first on that. Congressman Higgins talked about MS. You are required to fail first on that. These are not just cancer drugs. These are a whole litany of conditions that somebody may have that they are required to fail first.

Dr. ATKINS. That is correct.

Mr. FRY. So, you have the delays. Is it fair to say that you have an increased cost to the patient because they are constantly having to go back to the doctor?

Dr. ATKINS. That is correct, yes.

Mr. FRY. So, who is this saving money for?

Dr. ATKINS. PBM, I suppose, but not the patient.

Mr. FRY. Well, I mean, based on the data, I would say that it does not even save them money.

Dr. ATKINS. I think if the patient does not take the medication or the patient is no longer alive, they may save money by not providing care.

Mr. FRY. Can you talk about the dangers this poses with life-threatening illnesses, like cancer in your instance, what dangers these delays pose to a patient?

Dr. ATKINS. Several. One, patients may not get the medication. I have one example where there was a patient who was prescribed a medication called Cabometyx. So, they wanted to get the medication at the drugstore, where the pharmacy, where the physician was. Usually in our office, we have a patient account manager, who will help patients get assistance for drugs.

Mr. FRY. Are you aware of any instances where a fail first policy led to a severe disability for a patient, maybe yours or somebody else's?

Dr. ATKINS. I will say yes. Someone has a lot of nausea and vomiting, they are very sick unnecessarily if they fail the first. They are not allowed to use the medication I want to use if they fail significantly first. Yes, I will say nausea, vomiting probably are the most common one.

Mr. FRY. Thank you, Mr. Chairman. I know I am out of time, but with that, I yield back.

Chairman COMER. The Chair now recognizes Ms. Stansbury from New Mexico for 5 minutes.

Ms. STANSBURY. Thank you, Mr. Chairman, and I want to say thank you also to our witnesses. Thank you for serving, caring for, and fighting for our families and communities.

I personally believe that healthcare is a human right, a fundamental right. The ability to access healthcare, obviously, is not just about the dignity and wellbeing of our communities but about the survival of our family members. Yet millions of Americans and

thousands of New Mexicans struggle to access even the most basic care. In New Mexico, in my home state, over 60 percent of our community members are dependent on Medicaid and Medicare to receive care of any kind. We have one of the highest rates of Medicaid and Medicare need in the entire country.

You know, today, we have talked a lot about policy. We have talked about very technical issues around billing and insurance. But at the end of the day, what we are talking about is people's lives. These are our parents, our grandparents, our children, people who are unable to actually access lifesaving care, medications, because No. 1, they cannot afford it. No. 2, in New Mexico, we have such a severe provider shortage, they are not actually able to access providers. And I think as we heard today, these for-profit companies are helping to drive more and more care providers out of business. So, when we talk about these issues, we are talking about the life and death of our communities.

And for me, this is a very personal issue. I grew up in a very low-income family. Before the Affordable Care Act, I did not have healthcare insurance. I have watched as countless members of my community could not access care, could not access lifesaving medication. And it is why I have spent much of my elected career, since I was first elected in 2018, fighting to change this broken system, advocating in the state legislature to reform prescription drugs, and prior authorizations, and other necessary improvements in insurance, and here fighting for the passage of the Inflation Reduction Act.

We have talked a lot this morning about the Inflation Reduction Act and the ways in which it will enable Medicare, in particular, to address prescription drug costs. But I was struck, Mr. Isasi, in your testimony, and I really appreciated that you provided a pretty detailed description of many of the ways we can build on the IRA to address these issues. So, I wonder if you could briefly just share some of those solutions so that we can walk away with some real solutions today.

Mr. ISASI. Yes, absolutely. Thank you for the question. So first and foremost, we have to extend the negotiated price to the 180 million Americans who have employer-sponsored coverage, who right now do not get the benefit of that. Two, we have to expand the number of drugs. Right now, in 2026 we will have 10 drugs negotiated, right? We should have at least 50 that are subject to negotiation. So those are the two really, really important reforms, make sure the inflationary caps apply across all patient populations, et cetera.

Ms. STANSBURY. Yes. In your testimony, you said, and I quote, that "the Inflation Reduction Act is the most significant legislation ever passed by Congress to end the abusive price gouging by pharmaceutical companies," and I think a lot of people do not really know what the Inflation Reduction Act is. And not only did it address pharmaceutical prices, but it extended access to Medicaid in New Mexico for thousands of individuals. Those are lives that will be saved. Those are people who can go to see doctors, like Dr. Atkins, in order to get lifesaving care, and to get their medications. So, what we do in this chamber is not just a bunch of talking points.

And I want to add on the note that my colleague from Texas made, that while I do appreciate the bipartisan tone and tenor of this particular hearing, we are in the midst of a battle right now in the halls of this chamber over our debt ceiling. And part of the cost of that battle right now is our colleagues across the line are threatening to take away access to Medicaid for millions of Americans. So, while we can sit here in this hearing room and talk about how discouraged we are, that these for-profit companies are price gouging our elders and our family members, our friends across the aisle are actually trying to take away your healthcare right now. So, let us be real about what is actually happening in the chambers of this Congress right now.

So, I appreciate the conversation. I do appreciate that we have talked about some real solutions today. I appreciate, Dr. Atkins, your lived experience and you are sharing about your patients. Thank you for bringing those stories into this room. But if we really believe that healthcare is a human right, then it is not just about one hearing, one bipartisan hearing. It is about making sure that the laws that we pass, that the arguments that we have in these chambers actually reflect that we believe and are going to take action to make healthcare a reality for every American. And with that, I yield back.

Chairman COMER. The Chair recognizes Mr. Timmons from South Carolina.

Mr. TIMMONS. Thank you, Mr. Chairman. I think over the last few decades, we have been having this conversation about is healthcare human right. I think that has been put to bed. I do not necessarily agree with the outcome of it, but I think for all intents and purposes, that has been ceded. So, if that is the case, I would like to talk about the fact that rights come with responsibilities.

The American population is failing, is failing. Thirteen percent of the population of planet earth is obese, 40 percent of the United States. As you get overweight and obese, it goes up to 70 percent in the United States. Diabetes alone, 37 million Americans, of which about 95 percent have type 2 diabetes. That costs annually \$237 billion in direct costs and \$90 billion in lost productivity. And we are talking about costs, and we are nickel and diming where we can. That is what we do, but at the end of the day, we have to overhaul the system. We treat sickness. We do not facilitate health and wellness. And if you have been taking a pill for more than a couple of weeks or months, you probably could have made life changes that would result in you no longer needing that pill.

I own a CrossFit gym and a yoga studio. I have coached people from being type 2 diabetic to no longer having to take any drugs because of that. I have seen people lose 40 pounds, go from taking 15, 16 pills a day to taking zero pills. So, while we are talking about the costs associated with our current healthcare system, I think it is wrong for us to not have the really core conversation of we cannot continue down this path. We cannot even field a military. We cannot even field a military and our lost productivity, our healthcare system is failing.

I guess, Dr. Atkins, I mean, do you agree that diet and exercise can solve the vast majority of illnesses facing Americans?

Dr. ATKINS. It plays a role. However, when I have a patient with cancer, my goal is to treat them. I am not concerned about what happened before they got the diagnosis.

Mr. TIMMONS. What is your probability of getting cancer if you are 200 pounds overweight and have not exercised at all? Is it higher or lower than if you are relatively fit?

Dr. ATKINS. It is higher. I do not know the exact percentage, but it is higher.

Mr. TIMMONS. OK. So, it is higher. So again, even cancer, if you are not taking care of yourself, then you have a higher probability, which again, insurance is a game of underwriting risk. And you have to take into account the healthiest person with the least healthy person, and I guess we are just losing this personal responsibility component of all of this. So, what are some ways that we could incentivize health and wellness, and I am going to throw it out?

But, I mean, as far as I am concerned, at some point there has got to be some sticks involved. We have to have carrots to facilitate health and wellness. But you cannot—I always use alcohol, or, I mean, if you drink two handles of liquor a week, you will likely get cirrhosis of the liver eventually. And at some point, somebody is going to tell you, this is the outcome. Where is the personal responsibility in that because they do not have any additional premiums? They had no change in their financial perspective. Do you think that we can find a way to incentivize? Dr. Atkins, again, do you think that we can find a way to incentivize health and wellness and disincentivize unhealthy habits?

Dr. ATKINS. I am sure there is a way, but I do not have an exact answer to that question.

Mr. TIMMONS. Mr. Baker, what percent of the prescriptions that are written are for longer than, let us just say, a month, how many people are chronically taking drugs?

Mr. BAKER. I think we probably see about 65 percent of our medication fills for chronic needs and about 35 percent for acute, so antibiotics or other.

Mr. TIMMONS. And, Dr. Duane, I want my pharmacist to be incredibly competent and awesome. I do not want to know them because if I know them, it means that I have made some decisions to get there. What percent of your clients have you approached? How many prescriptions you fill, do the individuals know your name?

Mr. DUANE. Well, at an independent community pharmacy, I think the clientele may be self-selecting, so I would say that it is much higher. I would say a lot of my patients, the majority of my patients, I would say know me, know my family, know my story, ask about my children.

Mr. TIMMONS. That is more because of a rural population as opposed to—

Mr. DUANE. No, we are more of an urban inner-city population, but, no, I just think it is because what those people are seeking out.

Mr. TIMMONS. OK. Well, again, I just really think that we need to find a way to incentivize good decisions and prioritize diet and exercise because that will bring down the cost of healthcare for ev-

everyone if we have a healthier population, and we do not have 68 percent of the United States population being obese. With that, Mr. Chairman, I yield back. Thank you.

Chairman COMER. The Chair now recognizes Ms. Porter from California.

Ms. PORTER. Mr. Duane, you own Panama Pharmacy. What kinds of things can your shoppers buy besides prescription medicine at your pharmacy?

Mr. DUANE. We have a selection of medical supplies and over-the-counter type items for treating simple illnesses, vitamins.

Ms. PORTER. Let us say a shopper needs vitamins. How does the shopper know how much the vitamins are going to cost?

Mr. DUANE. We have prices on our shelf tags.

Ms. PORTER. They can see the price they will pay.

Mr. DUANE. That is right.

Ms. PORTER. It is just printed right there on the shelf. They can comparison shop, they can choose, they go to the register, and that is what they are charged.

Mr. DUANE. That is correct.

Ms. PORTER. Now, let us say the shopper, in addition to vitamins, also needs to fill a prescription. Can they look at a price tag on a shelf, on a kiosk to find out how much they are paying for the medication?

Mr. DUANE. No, ma'am. There is nothing like that.

Ms. PORTER. So how do they get that information?

Mr. DUANE. Well, they could ask me, and sometimes they do, and I tell them what their insurance is charging them. I suppose I could call their insurance company and ask them as well, but for most people, I think it is just unknown.

Ms. PORTER. Does every consumer who buys the same jar of vitamins pay the same price?

Mr. DUANE. Yes. In my pharmacy, the price is the price, so that is correct.

Ms. PORTER. You do not eyeball consumers and decide who has Aetna and who has Humana and then the vitamins cost a different amount?

Mr. DUANE. No, ma'am. We do not do that.

Ms. PORTER. There is not differential pricing for melatonin based on whether they are being ripped off by Aetna or ripped off by UnitedHealthcare?

Mr. DUANE. That is correct.

Ms. PORTER. What happens if I go to fill a prescription at your pharmacy? Does every customer pay the same price?

Mr. DUANE. No.

Ms. PORTER. Why not?

Mr. DUANE. Well, I mean, it is because of the insurance company that is paying for their drugs.

Ms. PORTER. And who negotiates with the insurance company about whether those drugs are covered and at what price?

Mr. DUANE. Oftentimes the insurance companies themselves negotiate with the manufacturers of the drugs, and that is how they come up with the price that will be charged to the patient.

Ms. PORTER. Then what do pharmacy benefit managers do?

Mr. DUANE. They purport to do that.

Ms. PORTER. Explain.

Mr. DUANE. Pharmacy benefit managers argue that they work with pharma in order to negotiate the best discounts. In my opinion, it sounds like they are talking on both sides of their mouth when they say you have to have us in order to lower drug costs, but, oh, by the way, drug costs have been completely and utterly unaffordable in the same amount of time.

Ms. PORTER. Well, so pharmacy benefit managers, though, they say that they are negotiating prices, where can I go to learn how much they are saving us, saving me, saving our country? Where do I go to find this information to quantify this purported good that they are doing?

Mr. DUANE. I have not seen anything publicly available that reports that.

Ms. PORTER. Me neither. Pharmacy benefit managers do not reveal to either health insurance companies, or patients, or pharmacies exactly who is getting what deal, and they make money at every step of the process. They pocket money from drug manufacturers, they pocket money from pharmacies, they pocket money from health insurance plans, and nobody knows if they are actually driving down the cost.

I believe that there was a time that pharmacy benefit managers maybe did save some money along the way, and I think that is why health insurance companies gobbled them up because now they can profit twice. They can profit once as Big Pharma, as the health insurance company, as Big Pharma, as drug manufacturers, and they can profit again as pharmacy benefit managers. Mr. Isasi, what do you think of this theory?

Mr. ISASI. I think that it depends on which payer. I think in Medicare, we do actually get the information. We know what the prices are, and we know that they are saving us money. And that is what CVO gives us, a score that says if you take them away, prices go up.

Ms. PORTER. But why could not Medicare just negotiate? Why do I need to hire? Is there something, like, special like oil you get rubbed on you when you become a pharmacy benefit manager that you are able to drive a bargain that our government officials cannot do?

Mr. ISASI. Absolutely not, except that when Part D was created, in the law it said you cannot negotiate.

Ms. PORTER. So, Congress created this beast.

Mr. ISASI. That is exactly right.

Ms. PORTER. And it would now be on Congress to rein it back in.

Mr. ISASI. That is right.

Ms. PORTER. Mr. Duane, do you think that PBMs always negotiate a better price than your customers would have paid without insurance?

Mr. DUANE. No, I do not think so. I think that the fact that there are so many discount card programs and cash pay programs are evident of that.

Ms. PORTER. I mean, I have actually asked how much it cost with insurance, gasped in dismay, and then had the pharmacists suggest that I walk over and get a little plastic GoodRx card, and I have heard from other constituents who do that. Since my first

term in Congress, I have introduced legislation to get full pricing information to patients without them having to ask. We cannot stop PBMs from gouging us until we have the information, we need to hold them accountable. Some of that information is upside to what they are actually negotiating in terms of savings, but some of it is down to the consumer.

In two Congresses, I have not had a single Republican join my Lowest Prices for Patients Act, which would require patients to be told whether it was cheaper to get the drug without insurance. I would like to invite any of my colleagues to join me in that legislation. This has been a great showing of bipartisanship, Mr. Comer, but I think we need to deliver solutions together as well.

Chairman COMER. Thank you. The Chair now recognizes Mrs. Luna from Florida for 5 minutes.

Mrs. LUNA. Hey, everyone. Rough day? Yes, that is OK, but my questions will not be that bad. Dr. Duane, how are PBMs antithetical to a patient-centered, consumer-directed healthcare system?

Mr. DUANE. Well, I think that if something was patient centered, then by definition, it will be looking out for the what is benefit of the patient. But I think that you can look at stockholder reports and just the placement of PBM companies on the Fortune's list of richest companies and know that whoever they are looking out for does not seem to be the patient.

Mrs. LUNA. I could not agree more. When PBMs provide contract terms to pharmacies like your own, are you able to negotiate the terms of the contract, or are you forced to take the terms presented to you?

Mr. DUANE. No, I have tried to redline and scratch out terms that I do not agree with and add terms that I think would be mutually beneficial to myself and the patients, and they are universally denied. It is a take-it-or-leave-it scenario.

Mrs. LUNA. So, you really do not have a voice?

Mr. DUANE. That is correct.

Mrs. LUNA. How have PBM clawbacks, which occur when PBMs charge a consumer a co-pay that is higher than the full cost of the drug and then claw back the extra money from a pharmacy, impacted your pharmacy?

Mr. DUANE. It is tough to budget. I mean, it is just like anything else. We are a small business. When I get paid one amount of money and then months later have a very large proportion of that money clawed back, it is very hard to do business like that. It is very hard for me to forecast hiring and retention of employees, things like bonuses, benefits. It makes it almost impossible to do that kind of business.

Mrs. LUNA. So, would it be safe to say that it makes it hard for you to financially plan for your business?

Mr. DUANE. It would be very safe to say that, yes.

Mrs. LUNA. The state of Florida is leading the Nation by recently signing into law comprehensive reforms that will increase accountability and transparency for prescription drug costs. This legislation institutes a series of patient protections to include prohibiting a PBM from forcing a patient to undergo step therapy or failing twice, i.e., the practice of forcing someone to restart a medication

that they know does not work when they switch insurance companies. What impact will this legislation have on your business?

Mr. DUANE. So, I worked with the Florida legislators and Governor DeSantis with this legislation, and it is going to be very impactful to my business and to the patients that I serve. I think that patients will be in a position to what they see is what they get. They will not have surprise billings after the fact. Also, we will not have surprise clawbacks after the fact. I think it will save patients money in passing the rebates along to the point of sale and to lower their out-of-pocket. So, I think that it is a very robust legislative package that the state of Florida passed that is going to do a lot of good for our patients and my business.

Mrs. LUNA. Do you think that this is a good model that we should replicate at the national level?

Mr. DUANE. I think it absolutely is. I think that it eliminates spread pricing. It makes sure that pharmacies can be on a fair level playing field, no matter if they are a small business or if they are a large conglomerate. So absolutely, I think it is a framework.

Mrs. LUNA. And just my last question before I yield back the rest of my time. In some instances, the medications that these patients are forced to have to go back and do again, are these medications treating cancer and terminal illnesses?

Mr. DUANE. Absolutely, they are. Yes, we see that.

Mrs. LUNA. So, it is essentially forcing someone to do something that they know it is not effective and could kill them?

Mr. DUANE. That is correct.

Mrs. LUNA. OK. Thank you, Chairman. I yield my time.

Chairman COMER. The Chair now recognizes Mr. Connolly from Virginia.

Mr. CONNOLLY. I thank the Chair and the Ranking Member for having this very important hearing.

I recently heard from a constituent who is on TRICARE and spent 30 hours trying to secure his wife's prescription for a very serious illness through a PBM named Express Scripts. The constituent found out this prescription was only available through an Express Scripts-owned specialty pharmacy called Accredo. Quoting the constituent, Accredo was initially unable to tell him how much the medication would cost before they sent it. When they finally gave him an answer after 30 hours, that answer, in fact, proved wrong, and he still does not know what the medicine for his wife's lifesaving is going to cost. Dr. Duane, shouldn't consumers be able to get a fairly straightforward answer and not take 30 hours to get the wrong answer on what prescription drug or a drug would cost?

Mr. DUANE. I think they absolutely should, and I think it is doubly wrong when it is someone who signed up to fight for this country, to die for this country, to be given benefits that are commensurate with the sacrifices that they made, only to be told that the amount of hoops that they have to jump through, that the amount of, you know, 30 hours to your point, it is unconscionable.

Mr. CONNOLLY. Dr. Atkins, we have talked about, and you talked about transparency, and I agree that transparency is absolutely essential. But I also believe that if I had cancer and you were my oncologist, I want you making decisions about my treatment and the drugs you prescribe that you think are necessary and effica-

cious with respect to my condition. How do we restore the power of physicians to make decisions instead of bureaucrats at a PBM?

Dr. ATKINS. If you eliminate the PBMs, that would be one major step. And with your patient that spent 30 hours, I pretty much guarantee the physician's office probably spent 8 hours dealing with Accredo before the patient spent 30 hours. They inhibit our ability to take care of patients every day.

Mr. CONNOLLY. Yes.

Dr. ATKINS. If you get rid of that middleman, that will make our lives a lot easier and the patients' lives easier.

Mr. CONNOLLY. Because I think this is important. Is bad enough that they have such monopolistic or oligopolistic control that they influence prices. I think, Mr. Baker, you pointed that out that compared to Europe or other places, we are paying multiples for the same drug more, and in part it is because of this influence, but it is also they are making medical decisions. And in some cases, those are life and death decisions, especially when it comes to Dr. Atkins' patients. Mr. Isasi, what was the purpose of PBMs?

Mr. ISASI. To basically allow for a consolidation and negotiation, to get a better price for drugs.

Mr. CONNOLLY. And has that worked?

Mr. ISASI. The honest answer to that is, it is very mixed. And in, for example, in Medicare, we are getting some better prices, but then there is all of these crazy distortions that are also in play, and we need to solve them. We need transparency, point of service, all of those things.

Mr. CONNOLLY. But, I mean, are the incentives in place for PBMs to want to negotiate lower prices for consumers?

Mr. ISASI. In some instances, they are. For example, in Medicare, there is a requirement under the medical loss ratio, right? So, they cannot actually make more profit.

Mr. CONNOLLY. But put aside Medicare for a minute, what about the rest of us?

Mr. ISASI. The rest of it, particularly for large employers who use them all the time, it is a huge problem because they do not have the information. And there is no way, especially with vertical integration, to track the money flows.

Mr. CONNOLLY. So, what do you think we should do by way of reforming the system to make a better deal for consumers and to maybe make more competitive what is now a near monopolistic kind of system?

Mr. ISASI. Yes. Well, first is expand negotiation for fair drug prices by the government. No question that will have the biggest impact. But second, I mean, you will hear these stories. It is crazy that an organization that was created to negotiate fair price is making money by steering people away from a community pharmacy. That should not be allowed.

Mr. CONNOLLY. Which is why I asked you do you think it has really worked. The intent was good, but listening to all of you testify, it does not seem like the outcome is what was desired.

Mr. ISASI. Right. Right. The tricky thing here is that CBO is going to give you guys scores because there are discounts happening. But these discounts can continue, and we can make sure that they are neutral to, for example, who fills a prescription or

why should a PBM be able to hide its rebate, the money flowing through rebates to a manufacturer. That should be available to the employer who is paying their bill, right? So, there are key reforms that can really change this.

Mr. CONNOLLY. My time is up. Mr. Chairman, I look forward to working with you on bipartisan legislation because I think it is just critical.

Chairman COMER. Thank you, and I think we can do that, and I appreciate that. The Chair now recognizes Mr. Burlison for 5 minutes.

Mr. BURLISON. Thank you, Mr. Chairman. We heard a lot about the evils, the profits of PBMs today. I just kind of want to get an idea, level set, and I will just go in line. Is profit evil? Is it evil to profit?

Dr. ATKINS. No.

Mr. BURLISON. OK.

Mr. BAKER. I would agree it is not evil to profit.

Mr. BURLISON. OK.

Mr. DUANE. No.

Mr. ISASI. Depends on what you are profiting on.

Mr. BURLISON. Is it evil to profit off of patients?

Dr. ATKINS. It is if it risks their life, yes, it is.

Mr. BURLISON. OK.

Mr. BAKER. I think as long as we understand the profits being made and the value we are getting out of said profits, it is not.

Mr. DUANE. I mean, I am a community pharmacy owner, so the profit that we make goes directly back into caring for more patients. In that way, I do not think that profiting off of a particular patient to help more is a problem.

Mr. ISASI. I would say, if you can develop a system that is actually in the profit be in line and actually what is good for patients, that is a great outcome.

Mr. BURLISON. I am glad that, Dr. Atkins, you and Dr. Duane said that it is not, because I am sure, Dr. Atkins, you would agree that your firm does not lose money every year, year after year, correct?

Dr. ATKINS. We cannot stay in business and take care of patients if we lost money year after year, so yes.

Mr. BURLISON. And you are not guilty of the profits that you make. I do not think you should.

Dr. ATKINS. No.

Mr. BURLISON. Same thing with you, Dr. Duane.

Mr. DUANE. That is correct. Right.

Mr. BURLISON. OK. So, I think what we have established there is that there is maybe a difference between the profits that you make, the profits that a PBM makes, correct? What gives them the ability to make such egregious profits?

Dr. ATKINS. I think they just took the ability. They did not ask anyone. They just made up their own rules.

Mr. BURLISON. They made up these laws?

Dr. ATKINS. They make their own rules.

Mr. BURLISON. Mr. Isasi, did they make up these laws?

Mr. ISASI. No, Congress created laws that are allowing all of these abuses to take place.

Mr. BURLISON. Yes. In fact, I would contend, I kind of like your line of logic, is that if PBMs are the monster, this place is Dr. Frankenstein, OK? This place has totally turned the healthcare industry from a free market into a total sick industry, and first, we did it by things like occupational licensing. We force patients to have to go to Dr. Atkins specifically for treatment-related oncology. Then we added on things like requiring health insurance companies to be mandated to provide XYZ, you name it, everything in the book, including all the pharmaceuticals. And then whenever we get angry, and say, look at these doctors, they are making so much money, how are they making so much money, we have got to pay through insurance, we added another law, right? And then we say these insurance companies are making so much money.

What is Congress' answer? Let us add a law that says everyone has to buy insurance. That will fix it, and then we overregulate insurance companies to the tune where—how many choices in the marketplace are there? How many insurance carriers? Mr. Baker, how many insurance carriers?

Mr. BAKER. There are three that dominate, but then there are a lot of significantly smaller—

Mr. BURLISON. There are three. If people are going to make so much money, why are there only three companies that want to do it?

Mr. BAKER. Well, again, I think there are a lot of companies that want to do it. It is just hard to break in when those—

Mr. BURLISON. Because of this place.

Mr. BAKER [continuing]. Everything.

Mr. BURLISON. Because of this place and government regulations. So, my question is, we created this monster. We did it through government regulations. Do you really think that this place has the answers to fix it? Mr. Isasi?

Mr. ISASI. What I would say is it has a moral obligation to fix the problem they created. It has a moral obligation to do that.

Mr. BURLISON. And by adding more laws?

Mr. ISASI. No, by addressing the distortions that people are leveraging.

Mr. BURLISON. So, would you say peeling back some of those laws that we have added?

Mr. ISASI. Well, for sure, the first law we should peel back is the ability of the government to negotiate a fair price for American families.

Mr. BURLISON. Well, let me ask you, Mr. Isasi. If we eliminate PBMs today, who would benefit, other than patients? Some people say patients.

Mr. ISASI. No question, drug makers would benefit.

Mr. BURLISON. Drug makers. I mean, in one way, you could say this meeting was brought to you by Pfizer because if there is one company that will make money, it is pharmaceuticals because no one will be there to negotiate with them. I am looking for things to eliminate laws, to bring this healthcare industry back to a market force so that patients know the prices, and we do not have to force them. Let me ask, Dr. Atkins, you are all in favor of price transparency. Are you transparent on your prices and your profits with patients?

Dr. ATKINS. I am transparent on how much I pay for the drug, but I do not know what the insurance paid.

Mr. BURLISON. I am talking about your services. Do you have a menu and you tell patients when they walk in what they are paying?

Dr. ATKINS. No, because it is different for every insurance carrier.

Mr. BURLISON. Right, because the market does not have to because people do not make choices at that level. The employer made the choice for them through the three or four insurance companies that are available. Thank you, Mr. Chairman. I yield back.

Chairman COMER. Thank you. Yes. The Chair recognizes Mr. Auchincloss.

Mr. AUCHINCLOSS. Mr. Chairman, I appreciate the opportunity to waive on to the Committee for this hearing as the rent-seeking and self-dealing of pharmacy benefit managers has been a focus of mine.

What we have heard today and what has been the thrust of major proposed Federal legislation to date has been really about transparency, and transparency is necessary, but it is not sufficient. And to that end, myself and many others in Congress have been drafting much more pointed legislation to address point-of-sale rebating, spread pricing, DIR fees, specialty pharmacy steering, improved NADAC reporting, patients' assistance legalization, prior authorization reform, and more.

And yet, Wall Street and the Big Three PBMs believe they can shrug off this legislation and other proposed reforms, and do not take my word for it. A recent JP Morgan Equity Research report argued that Cigna and CVS investors, for example, should not overreact to state and Federal scrutiny noting that although, "Legislation is on the rise, we believe the PBM industry can digest these changes."

Mr. Baker, I am worried that JP Morgan is right and that the vertical integration of PBMs with insurers and retail pharmacies fortifies them against piecemeal actions, even strong ones, like the ones I mentioned. Should Congress take a comprehensive approach to reform so that we are not just squeezing the balloon but actually fully popping the gross-to-net bubble?

Mr. BAKER. I think that is an excellent question that has so many layers, it is hard to give one linear answer. I do fundamentally believe that the market can take care of itself if the market is given the right rules to follow. And right now, these large PBMs, because you do not know where the money is going, they have full control. They have the ability to do what they want. It goes against the American public.

Mr. AUCHINCLOSS. So maybe instead of saying "transparency," we should be saying "alignment of incentives."

Mr. BAKER. I think that would make sense.

Mr. AUCHINCLOSS. And that we need this comprehensive suite of reforms all at once so that we are not squeezing one part or the other, but really doing root cause reform. I have been encouraged to that end that the FTC recently expanded its investigations into the anti-competitive practices of PBMs to include yet another element of their vertical integration and market concentration, which

are group purchasing organizations, have not been talked about enough, I do not think. These are like PBM's PBMs, and these GPOs—Ascent, Zinc, Emisar—were formed by the PBMs after President Trump's proposed reforms to prescription drug rebates, and have kicked into high gear in recent years as the Democrats have started to crack down on the dysfunctional system under the Biden Administration. Two of these PBM GPOs are headquartered overseas, despite PBMs being a uniquely American phenomenon, in Switzerland and Ireland, both famous for both tax and opacity arbitrage.

Mr. Baker, while these GPOs are opaque, even by PBM standards, and that is saying something, and the FTC investigation is just beginning, do you think it is likely that these GPOs have been formed to do the following three things: generate revenues and fees that will not need to be passed on to plan sponsors; two, permit tax arbitrage; and three, provide a hedge against U.S. reforms to PBM pricing practices?

Mr. BAKER. I think those are three very good reasons that I would create a GPO, two of which would be overseas. Yes, sir.

Mr. AUCHINCLOSS. Yes, and I want to put the PBMs on note right now. You are not going to be able to offshore your thievery, OK? That is not going to stand in the United States. The FTC is coming after them, and they are going to have the full support, I expect, of both sides of the aisle on that.

Mr. Isasi, I would say in this hearing and in your written testimony, probably the most vigorous defender to date in this hearing of the PBMs, you say in your testimony that, "Some drug costs are lower than they otherwise would be because of PBMs. And yet, the trend line in the United States averaged across all pharmaceuticals has been for gross prices to rise and net prices to fall." In other words, PBMs have done a great job of negotiating for themselves because the delta between gross and net feeds their profits, but a bad job of negotiating for patients whose out-of-pocket costs are based on gross prices. Again, their out-of-pocket costs are based on gross prices in this country. So just to be very clear, who determines the out-of-pocket exposure of a patient, the drug manufacturer or the insurance company?

Mr. ISASI. The insurance company.

Mr. AUCHINCLOSS. The insurance company does. It is, to me, both a violation of medical best practice and immoral to say to patients who have paid their premiums to insurance companies that when a doctor prescribes them a medicine that they need, that they have to have out-of-pocket cost. We should have zero out-of-pocket costs for medically prescribed drugs in this country, and let us be very clear about who is making that out-of-pocket requirement. It is insurance companies, not drug makers.

Chairman, I yield back. Thank you again for your affordance.

Chairman COMER. Thank you for being here. Before I yield to the next questioner, I want to say that this will be the last question for a bit. They called votes, so we are going to recess. It should not take very long, and then 10 minutes upon the vote series ending, we will reconvene here and finish the questions, and then provide a wrap up.

So, the Chair now recognizes the distinguished member from Tennessee, Mr. Burchett.

Mr. BURCHETT. Thank you, Mr. Chairman. As the last person up here for a little bit, you all have to act surprised and delighted at my questions and act like they have never been asked before. Dr. Atkins, thank you, ma'am, putting up with all of these men up here today. I appreciate you, ma'am, and I want to ask you a question. What pharmacy is associated with your medical practice?

Dr. ATKINS. We have an in-house dispensary.

Mr. BURCHETT. OK. Have any of your patients' medications been denied or delayed due to pharmacy benefit manager practices?

Dr. ATKINS. Yes.

Mr. BURCHETT. OK. Is there any financial incentive for pharmacy benefit managers in favoring expensive medications over generic medications?

Dr. ATKINS. Yes.

Mr. BURCHETT. Thank you. Dr. Duane. I assume that is the way you pronounce your name, Duane.

Mr. DUANE. It sure is. Yes, sir.

Mr. BURCHETT. All right. Good. Dr. Duane is the owner of one of the oldest independent pharmacies in Jacksonville, Florida and, I might add, the birthplace of the greatest rock and roll band of all time, Lynyrd Skynyrd.

Mr. DUANE. Yes, sir.

Mr. BURCHETT. Can you explain some of the benefits of independent pharmacies to me briefly?

Mr. DUANE. We can be a center of the community. We are more than just giving medications to persons. We are acting as a repository of information for our patients that come here, what doctor in the community they may be able to connect with, or what they could use over-the-counter for certain conditions that maybe they cannot get in to see their physicians.

Mr. BURCHETT. I am glad to hear you say that. One of my pharmacists back in Knoxville—I like very much, guy named Hank Peck at Longs Drugs Store, he is that—you see the folks coming in and they say, well, I got this, you know, I need a lip balm or something, and he is more than just the guy behind the desk throwing out pills, so I appreciate that. But these pharmacies contract with pharmacy benefit managers to participate in the pharmacy benefit managers' networks. Is that correct?

Mr. DUANE. Yes, sir, that is right. I have to contract with the PBM in order to bill them and take their plan.

Mr. BURCHETT. OK. Is it difficult for an independent pharmacy to participate in a pharmacy benefit manager network?

Mr. DUANE. I would say it is difficult to participate in the process collaboratively. They can give us a contract, and if we accept the terms, then we are in. If we do not accept any of the terms, then we are out. There is no negotiating.

Mr. BURCHETT. OK. Could you also explain what the DIR fees are?

Mr. DUANE. So, DIR fees are a way for, really, more opacity in the program. We get paid a certain amount of money, and then weeks, sometimes months, sometimes more than a year later, we

get the money taken back, and it is very opaque as to how and why those decisions are made.

Mr. BURCHETT. What impact did that 107,400-percent increase, and my staff told me that is not a misprint, in these fees from 2010 to 2020 have on the healthcare system?

Mr. DUANE. Huge. An absolutely indescribable amount of chaos in that we really cannot adequately plan for the next week, next month, the next quarter because of the amount of money being taken aback.

Mr. BURCHETT. OK. It gets to the point where these folks were trying to be nice but are acting like a bunch of dirtbags, in my opinion. They really are. I mean, this is pathetic. And the DIR fees, they have had a negative impact. You have already stated that, correct?

Mr. DUANE. Absolutely. Tremendously negative impact.

Mr. BURCHETT. OK. Thank you. Dr. Atkins, what pharmacy is associated with your medical practice?

Dr. ATKINS. We have our own in-house dispensary.

Mr. BURCHETT. You told me that already. I am sorry, ma'am. I got mixed up on my questions. I apologize, and I was overcome by you and dealing with the rest of these knuckleheads all day. This is just for the general bunch. Could the pharmacy benefit manager practice be harmful to patients' health?

Dr. ATKINS. Yes. They inhibit care and try to tell us how to practice medicine when they do not have a license.

Mr. BURCHETT. Right, and it is somebody driving a four-legged mahogany, as I like to say. They are behind the desk somewhere. Are the benefit managers compromising patients' health in exchange for profit?

Dr. ATKINS. Yes.

Mr. BURCHETT. What should we do? What do you think should be the end result? Should we do away with these things completely? I mean, they were created to do good, and then obviously the dirtbags took over and greed took over. What do you all think?

Dr. ATKINS. Well, one thing we have talked today that the top three control 80 percent, and the next three control another 16. So, six companies control 96 percent, so we disband that, got rid of the oligopoly, that may help a little bit.

Mr. BURCHETT. OK. If we just passed a rule that said do away with the whole daggum thing, could you all manage it? Would you all not turn into a bunch of greedy dirtbags and we would have to have you all back up here again?

Mr. ISASI. Well, the prices would go up.

Mr. BURCHETT. Prices would go up.

Mr. ISASI. Prices would go up.

Mr. BURCHETT. Do you agree with that, Dr. Duane?

Mr. DUANE. No, I do not think necessarily. I mean, I think that competition would breed just like anything else. So, I mean, no, I do not agree with that.

Mr. ISASI. But let us remember that they are competing against a very small, concentrated group of drug manufacturers and try and negotiate price. So, this idea that they are consolidated gives them more bargaining power, but to the point, like, there are all these other ways they are trying to make money now. They have

nothing to do with negotiating good price, and those things have to be eliminated, right? And, for example, they should be neutral to where you are getting prescription. Is it a community pharmacy?

Mr. BURCHETT. It should be what? I have run over time.

Mr. ISASI. Neutral.

Mr. BURCHETT. Neutral, OK.

Mr. ISASI. Neutral. Those are examples of ways in which they should make sure that cost sharing for patient at point of care is based on the price that is being paid, not on the list price. There are very clear reforms that would actually put them back on track to do what they are supposed to be doing.

Mr. BURCHETT. Thank you, Ranking Member, Chairman. I have gone over my time. Thank you all very much.

Chairman COMER. Thank you very much. And due to votes, the Committee will be in recess until 10 minutes upon the ending of the last vote.

[Recess.]

Chairman COMER. The Committee will reconvene. The Chair recognizes Mr. Langworthy for 5 minutes.

Mr. LANGWORTHY. Thank you very much, Mr. Chairman, and I want to thank all of our witnesses for being here today to discuss such an important topic to millions of Americans.

In my district, community pharmacies demonstrated in real time during the COVID pandemic the value of their service to the communities that they serve. Our community pharmacies have local connections to other services available in the community to help deal with social determinants of health such as nutrition, financial assistance, transportation services, and offering free delivery of medications. Our community pharmacists make up the backbone of small-town America, and we need to address anti-competitive tactics used by PBMs and move toward an environment where both can thrive.

Dr. Duane, have you experienced PBMs steering patients away from your pharmacy?

Mr. DUANE. Yes. That is a pretty common occurrence that I experience. We especially experience it in some of the managed-care plans. I have a patient that lives three doors down from where my pharmacy, and instead she has to ride a bus from the bus stop right in front of my pharmacy down to a large chain pharmacy because we are not offered participation in that contract.

Mr. LANGWORTHY. Do you think that PBMs owning pharmacies that compete with you is a conflict of interest?

Mr. DUANE. It is a tremendous conflict of interest. I think, if anything else, the thing that has probably been a little undersold by me today in my comments is the conflict of interest issue. I mean, anytime you have your direct competitor also setting your prices, I do not know how you can invite anything but you know bad things to happen.

Mr. LANGWORTHY. Can you or anyone on the panel explain what DIR fees are?

Mr. DUANE. Yes. So, DIR fees are in Medicare program. And what it amounts to is, we would get paid one amount of money, and then sometimes months or even a year or more later, we would

have the PBM come back and clawbacks a quite substantial part of that money, and it wreaks havoc on our ability to budget.

Mr. LANGWORTHY. And what are the impacts of direct and indirect remuneration fees on your business?

Mr. DUANE. I mean, it is hard to plan for things. It is hard to make sure that we are going to have enough money in the bank to make payroll to see if we want to expand, hire another pharmacist, move into a clinical service, a non-dispensing service. Anything like that really gets put on hold when you are not sure if the money that is in your bank account today will actually be there in a month or whether it is going to be clawed back.

Mr. LANGWORTHY. Now, how far down the line might those DIR fees get clawed back?

Mr. DUANE. There are some cases where it is more than an entire year after that claim could be adjudicated.

Mr. LANGWORTHY. So that customer might not even be one of your customers anymore. They can come back and take those fees?

Mr. DUANE. I have had payments clawed back from claims that I know that the patient is deceased at the time that they clawed the money back from me.

Mr. LANGWORTHY. Do you believe that there would be any impact of eliminating those fees entirely?

Mr. DUANE. I think the impact would be tremendous. You know, in 2024, I think that the fees are going to move to the point of sale so that they will not be retroactive, but I really think that that only solves a portion of the problem. By eliminating the incentive for, again, my direct competition to assess, you know, arbitrary fees on the business, that is what would be most impactful to our ability to predict what we can do with our staffing levels and our operation in general.

Mr. LANGWORTHY. And to sum up, in the pharmacy world, would you say that most independent pharmacies suffer at the expense of PBM practices, which you know, some call monopolies?

Mr. DUANE. Yes, we absolutely do suffer, and it is to the detriment of our patients and their health.

Mr. LANGWORTHY. OK. And last, Dr. Atkins, specialty pharmacies serve patients who suffer from complex conditions, and their medicines are usually brand name and single source drugs. PBMs are shifting the high-cost drugs to their own pharmacies to turn a higher profit. What should Congress do to address this directly?

Dr. ATKINS. One easy solution might be if I have the drug in my dispensary in my practice, we could fill it there because usually when we fill it onsite, it is better for the patient and also more economical.

Mr. LANGWORTHY. OK. Thank you very much for all of your testimony, and thank you, Mr. Chairman. I yield back.

Chairman COMER. The Chair now recognizes Mr. Goldman from New York for 5 minutes.

Mr. GOLDMAN. Thank you, Mr. Chairman, and thank you very much for holding this hearing. It is certainly much more constructive and much more helpful than digging into the finances of a President's family, so I am happy that we are trying to do something meaningful here.

Last year, the Committee Democrats issued a report discussing the ways that PBM formularies disproportionately require patients to pay out-of-pocket for certain methods of contraception. And, Mr. Chairman, I would ask unanimous consent to enter into the record the Democratic Oversight Committee staff report, titled, "Barriers to Birth Control: An Analysis of Contraceptive Coverage and Costs for Patients with Private Insurance."

Chairman COMER. Without objection, so ordered.

Mr. GOLDMAN. Thank you.

Mr. GOLDMAN. Now, the report found that products most likely to face out-of-pocket costs are newer products and products that are most appropriate for patients with distinct medical needs. But the report also found that one of the significant causes for the failure to provide contraceptives under the ACA at no cost to the patient was a practice that is often called fail first step therapy and prior authorizations, which can be a barrier for patients trying to access medications despite the fact that their doctors deem medically appropriate, that they have to try a different perhaps lower cost prescription medication or contraceptive prior to that.

And I am concerned about the PBMs' role in this and that the PBMs are engaged in an effort to restrict reproductive healthcare. Mr. Isasi, maybe you can talk a little bit to how the fail first step therapy is intertwined with the PBMs role in setting either price targets or access to various prescription medication?

Mr. ISASI. Sure. Well, to begin with, we have to be a country where when a drug is identified as important for your health and well-being, that you can receive that drug and not have a barrier put in between you and accessing that drug, and that is what we stand for at Families.

The problem is when we continue to allow the drug manufacturer to price gouge and then we put PBMs in the middle and say now negotiate a price, right? Part of the negotiation for them, part of the effect of that is to put one drug, prefer it, steer people that way so they can get the discounts for that drug that they have negotiated. When you take away the ability for them to do that, it is harder for them to negotiate a discount, but it really hurts the people for whom those drugs are the ones that are needed.

Mr. GOLDMAN. And given that many PBMs are owned by insurance companies, obviously there is an incentive for the insurance companies to pay less for a medication to solve a particular issue if they can. How does that impact the ultimate decision about what medication to prescribe to any given patient?

Mr. ISASI. It is a real mess. Honestly, it is a real mess because remember, we also live in an environment where doctors can make more money if they prescribe a more expensive drug. There are so many conflicts of interest in the system. So, ultimately, what we need is the right drug to get to the patient and not have all these conflicts of interest. And you are describing one, the PBM conflict, but there are a lot of other ones too. And we know that Americans are getting prescribed a drug that costs \$1,000 when an aspirin could be just as good or better, right? There are a lot of perverse incentives in the system.

Mr. GOLDMAN. And Dr. Atkins, on the ground in dealing with patients, can you describe for us how fail first step therapy and prior

authorizations actually impacts the care that you can give to your patients?

Dr. ATKINS. Sure. I will start with fail first. I will give an example of a patient with metastatic breast cancer. There was a medication I wanted to give her called a CDK4/6 inhibitor. I wanted to give her that one particular drug. Her PBM said, no, you cannot give her that one, you can give her this one, but if she fails this one, you can give her the one you want to use. Well, per the National Comprehensive Cancer Network guidelines that we use for oncology every day, if you get one CDK4/6 inhibitor and fail it, you do not give them another one because it is the same type, same class of drugs.

That, and then we have the issue with the anti-nausea medicines for people who are getting chemotherapy. If we want to give them one drug, they have to fail it and get really sick. And then the PBM will say, OK, you can use the drug you want to use to prevent this patient getting sick. Those things, inhibit care, slow down care, cost patients—

Mr. GOLDMAN. Even when you know what the side effects will be and you have a way of solving for those side effects, you are not able to give the compensatory drugs to offset the side effects until they actually experienced those devastating side effects?

Dr. ATKINS. Correct.

Mr. GOLDMAN. Wow, thank you. That is pretty shocking, and I now yield back.

Chairman COMER. The Chair now recognizes Mr. Grothman from Wisconsin.

Mr. GROTHMAN. Yes. First of all, I am going to ask you a question that is entirely on point. You probably do not know the answer, but I have been trying to find the answer. Do any of you guys know how much a hospital makes off of prescription of remdesivir? You probably do not have any reason to.

[No response.]

Mr. GROTHMAN. OK. On to the next question. I guess we will start with Dr. Duane. You can pass if you give it to somebody else. How much, and I know it must vary wildly from drug to drug, but if I go to the pharmacy and get \$200 for the drugs, how much you think, on average, the pharmacy benefit manager makes up for that?

Mr. DUANE. I would not be able to hazard a guess. I mean, I think that depending on what they have for the rebates and things like that, they could make a whole lot of money or, you know, on a generic drug of the same price where there is zero rebate, they probably would not make very much money.

Mr. GROTHMAN. Like, could you even guess wildly any one of those?

Mr. ISASI. Well, we have studies of this, and University of Southern California just put one out and said for a drug that costs \$100, the profit to the drug maker is \$26, and the profit for the pharmacy benefit manager is \$2.

Mr. GROTHMAN. Do you guys agree with that?

Mr. DUANE. The average rebate on a brand name drug is much higher than two percent on \$100, so I do not know that study, but I would not see it that way.

Mr. ISASI. But the rebate is not the profit. The rebate is just part of the cash-flow.

Mr. GROTHMAN. OK. We will give this one to Mr. Baker. PBMs act as the middleman between drugs manufacturing payers, right?

Mr. BAKER. Correct.

Mr. GROTHMAN. After negotiations occur and agreements are made between entities, where are those discounts going? Are they making their way back to the patient or not, do you think?

Mr. BAKER. A portion of them are, yes. What portion, we do not know. I guarantee it is not 90 percent. It is probably not 80 percent. So, there is still a significant amount of money kept in the middle that just kind of disappears and does not help patients or anybody else who is fundamentally aligned with trying to drive down costs,

Mr. GROTHMAN. You feel it is going to the PBMs, or where do you think it is going?

Mr. BAKER. I think it is going to the shareholders of those organizations, yes.

Mr. GROTHMAN. OK. Do you think PBMs are using the drug rebate payments to promote the use of more expensive brand drugs?

Mr. BAKER. Every day. Absolutely.

Mr. GROTHMAN. OK. Do you think rebates that a drug manufacturer pays to PBM can, therefore, lead to an increase in the price of drugs?

Mr. BAKER. Yes, sir, I do.

Mr. GROTHMAN. Explain how that happens.

Mr. BAKER. Basically, if there is a generic drug available that is on the market, and there is a brand drug available on the market for the same disease or condition, call it, what we typically see is a lot of times the PBM is going to prefer the brand name drug because they get those back in manufacturer payments and rebate dollars. They get a pill from, you know, most times overseas. Then what money actually gets repatriated back into the United States and, you know, helps drive down costs, nobody really knows if it is the right percentage or not. So, it gives them the ability to create this opacity in the system to drive profits themselves, and nobody really knows what that profit is.

Mr. GROTHMAN. It seems like consolidation of PBM market lines up with the subsequent rise in drug prices. How often do you hear customers complain about high price prescription drugs?

Mr. DUANE. I mean, I have my customers complain about the high price of prescription drugs all the time. You know, when you see people that are on these coinsurance plans, where they have to pay 20 percent. I mean, 20 percent of a larger price is a larger price, so as these prices go up the list prices, so, too, they are out of pocket.

Mr. GROTHMAN. I will give you a general question. If you could straighten this out to your liking, how much do you think cost of drugs would fall in America, basket of drugs?

Mr. DUANE. I mean, I know that there is a proposal in the Medicaid program to anchor Medicaid prices and dispensing fees to an evidence-based marker. And I think the CBO scored that at a billion dollars over 10 years, and that is just in the Medicaid space.

So, I think in the commercial space, you would see a very big multiplier of that.

Mr. GROTHMAN. OK. I would like to thank you for being here. I do try to get around my district and I have a lot of small towns in my district. I like to stop in on the pharmacies similar to what you guys have. If the pharmacy does not have a CVS or Walgreens on the front, I ask to see the pharmacist. I always get things similar to what you folks have been telling me today. So, I would like to thank you for coming over here, and I hope, on a bipartisan basis, something positive comes out of the Committee. I would also like to thank the Chairman. It is unfortunate we have not had a hearing like this in the Committee since I have been here, but finally, we got a Chairman who is not afraid to take this on, so thank you very much.

Chairman COMER. Thank you. The Chair recognizes Mr. Moskowitz from Florida for 5 minutes.

Mr. MOSKOWITZ. Thank you, Mr. Chairman. I, too, want to echo the sentiments and appreciate the Chair's indulgence and the Committee for holding the hearing. You know, it is nice that we can look at something like this and probably a lot of other topics of oversight in which we will find bipartisan agreement. It should not be a breath of fresh air when it happens, wish we have did a little more, but it is good that we are here today.

You know, a lot of my colleagues have focused on cost, and one of my previous colleagues, Representative Crockett talked about supply, and I want to talk about that because, obviously, I think it is directly related to cost. And so right now, Mr. Chairman, there is a significant shortage in some chemotherapy drugs, and as someone whose father passed away from cancer, I was the Director of Emergency Management at the time during COVID. My dad got diagnosed with stage IV pancreatic cancer, and so I had to leave that job to go spend time with him. I got 18 months. I got 18 months to be with him based on his diagnosis and based on just the available treatment. I know there are other people on this Committee who have lost people to cancer, obviously our own Ranking Member being diagnosed with cancer. But, you know, there is a shortage in chemotherapy drugs.

And what is amazing to me is that after COVID, after we had significant supply chain issues, we spent \$7 trillion-plus dollars during COVID in a bipartisan basis at the end of the Trump Administration, beginning the Biden Administration, passing all pieces of legislation, and yet we have done little to fix supply chain issues in medicine.

According right now to the FDA drug shortage data base, chemotherapy drugs are in the top five of shortages. One of those drugs is a drug called cisplatin. The reason I know cisplatin is that literally was a drug that my dad was on. That was a drug that extended his life. And, you know, I do not know that Americans know that 80 percent of the active ingredients in all drugs is made overseas. It is made in India, and it is made in China. The idea that we are still relying on China for medication after COVID seems to just boggle the mind.

Cisplatin and another drug called carboplatin, manufacturing delays at several pharmaceutical companies are largely to blame

because there are quality control issues in these other countries. In a March report from the U.S. Senate Committee on Homeland Security and Government Affairs, this is a direct quote from that report: "Neither the Federal Government nor the industry has end-to-end visibility of the pharmaceutical supply chain. The lack of transparency limits the Federal Government's ability to proactively identify and address drug shortages."

We do not even know when a drug shortage is going to happen, and as a result of which we cannot address it because it catches us off guard because we have no visibility into the problem. If there is a plant and they make a certain drug, and they go down because, you know, they are retooling the line, and there was no planning to put enough of that drug on the shelf, we run out. We saw this in the formula instance where we lost a plant and we had a massive formula shortage. Now we are having it with chemotherapy drugs.

I was literally contacted by a resident in my district when this issue started happening. She has breast cancer. She has treatable breast cancer. Her chemotherapy treatments were moved because they did not have the drugs. Three weeks. She is waiting 3 weeks now for treatment she was supposed to have last Monday, which she will now get on June 5. I think it is long overdue that the FDA explained to us why we continue to have a problem with supply chain, why have we not fixed the problems, or what are the problems so that Congress can figure out how to fix them.

Mr. Chairman, I appreciate your time. I appreciate the indulgence. I yield back.

Chairman COMER. Thank you. The gentleman yields back. The Chair recognizes Ms. Harshbarger from Tennessee for 5 minutes.

Ms. HARSHBARGER. Thank you, Mr. Chairman, and thank you for taking a leading role in investigating PBMs. Look, I have been a pharmacist for 36 years, and it is good to see you all there. We get two pharmacists, physician. It is fantastic, let me tell you. I will tell you this, PBMs have not cured one disease. They have not insured one American life, have they, or saved a life. They have not done any of that, and to have the power that they have over our healthcare system is unbelievable. I have been following this for 30-plus years, and now my son runs the pharmacy, so I understand, Dr. Duane, when we talked in the hall exactly what you are going through.

Mr. Baker, it is good that we have a pharmacist that is also the head of a transparent PBM, and that is almost an oxymoron, a transparent PBM, but we need companies like yours to expose what is going on. The Federal Trade Commission has recently subpoenaed the group purchasing organizations affiliated with CVS and Cigna, expanding the Agency's probe into the PBM industry. These organizations contend that they are using their size to gain leverage and counter price hikes made by pharmaceutical manufacturers. Do you agree these organizations are helping improve drug affordability, the GPOs?

Mr. BAKER. I do not think that they are.

Ms. HARSHBARGER. I do not think they are either. Glad to hear that. I have another question for you, Mr. Baker. You spoke about price gouging. As these PBMs and/or GPOs talk about saving

Americans money, their profitability continues to grow, while overall prescription costs are increasing for about everybody. The traditional PBM industry creates formularies which include drugs that can be approved, but increasingly, they are excluding more and more medications. Everything that both sides have said, I agree with, except some of the things talked about the Inflation Reduction Act and Big Pharma, OK?

Physicians are now being told by PBMs what they can and cannot prescribe for their patients, and it has been said before they are practicing medicine without a license. In your opinion, do these formularies drive to higher clinical quality at lower cost, or are they just another mechanism for PBMs to create pools of profits?

Mr. BAKER. They are another mechanism by which PBMs create pools of profits.

Ms. HARSHBARGER. Totally. Absolutely. Thank you for clarifying that. Dr. Atkins, it is good to see you again. You know, I asked both HHS Secretary Becerra and CMS Administrator Brooks-LaSure at separate Energy and Commerce hearings to work with me in solving the problem CMS has created in restricting delivery of cancer drugs to your patients. Although they both said they would, they ignored my pleadings and 50 other bipartisan pleadings from other Members to fix this situation. Can you please comment on how even restricting a caregiver access to picking that patient's cancer medicine up hurts patient care?

Dr. ATKINS. It definitely hurts patient care because many patients with cancer do not feel well.

Ms. HARSHBARGER. Yes.

Dr. ATKINS. They may not have transportation. And so, if their family member or designated person who is in their chart under the HIPAA law is not able to pick the medication up for them, they will not be to get the medication because some patient just cannot get in. And that will certainly hurt the patient, hurt the outcome.

Ms. HARSHBARGER. Yes. I mean, I had a story the other day where someone had reached out to me and said they could not get a patient to be compliant. Once they got him compliant, now they cannot get his medication delivered. So that is going to cause a breach in therapy, and he may become resistant to that drug therapy. There are whole lot of factors involved in that.

And, Dr. Atkins, this is another thing that I have been made aware, and I am going to talk to Energy and Commerce about this, too. We hear more and more about attempts by PBMs and your insurers to white bag cancer drugs. And I do not know if you gentlemen understand what that is, but it is sometimes an abusive-payer-mandated drug distribution model that often circumvents hospitals' supply chain controls by requiring patient medications to be distributed through a narrow network of specialty pharmacies that are often directly affiliated with the payer. That is white bagging. Do you agree with white bagging? How does this impact your patient care, Dr. Atkins?

Dr. ATKINS. I do not agree with white bagging, and fortunately, right now our practice is able to avoid white bagging. We refuse to do it because it is just not safe. We get our drug from someone that we trust. We mix it ourselves.

Ms. HARSHBARGER. Yes.

Dr. ATKINS. So, we know that it is safe. We cannot risk something that is shipped in. And another example, we run about 250 patients through my office. We have three locations. One is about 250 per day, another is 100, and another is 150. We cannot manage 200 different bags of medication—

Ms. HARSHBARGER. Yes.

Dr. ATKINS [continuing]. And location per day.

Ms. HARSHBARGER. Absolutely. It is more convenient to the patient, and, well, my time is up Chairman. I have got more questions, but just know that we sympathize and we are hitting them on Energy and Commerce, Oversight, and Ways and Means. It is going to come to an end, and we are going to come to a valid solution for this. Thank you, guys.

Chairman COMER. Thank you. The Chair recognizes Mr. Garcia.

Mr. GOMEZ. Gomez.

Chairman COMER. That is the second time I have done that. Mr. Gomez. I was looking down at Garcia. I apologize.

Mr. GOMEZ. No, no. No worries.

Chairman COMER. Sorry. It is my bad.

Mr. GOMEZ. First, how do I say this in as polite a way as possible? My colleagues on the other side of the aisle, the Republican Majority, is talking about controlling drug pricing and drug costs for the American people. That is great. I want them to do that. But this is in the midst of a context of what we are dealing with when it comes to the debt ceiling catastrophe that could occur any day now. And my Republican colleagues, in order to get cuts in programs that are helping support the American people every single month, are playing with fire. So, I just do not feel that it is sincere when it comes to reducing costs for pharmaceutical drug prices for the American people because if it was, they would not be holding the American people hostage, especially when it comes to Social Security and Medicaid and Medicare.

One single fact: about \$40 billion is paid to Medicare Advantage insurers and Medicare Part D prescription drug plans on the first of every month. So, if the Republican default occurs, those are the programs are going to be impacted. The same people that we are trying to support and reduce drug costs for, they are going to cause so much more harm in the short and long term. So, if they want to help reduce drug costs, pass a clean debt ceiling limit increase, and stop trying to undermine all these programs that help the American people. And a Republican default on the national debt would be a tragedy that we would be feeling for months, if not years, and the people that will be suffering are the American people and even globally.

And while we are at it, let us maybe stop trying to repeal the Inflation Reduction Act, which made historic cuts to drug costs. The Inflation Reduction Act capped out-of-pocket costs for patients covered by Medicare Part D at \$2,000 per year, benefiting over 1.4 million Medicare beneficiaries annually. And I would like to enter into the record, data analysis conducted by the Oversight Committee Democrats demonstrating the cost-saving benefits of inflation reduction costs for millions of Americans across the congressional districts.

Chairman COMER. Without objection so ordered.

Mr. GOMEZ. If the Inflation Reduction Act's drug pricing reform provisions had been in effect in 2020, Medicare beneficiaries would have saved a total of \$4.5 billion in reduced premiums and out-of-pocket costs. Nationwide, the total savings from the Inflation Reduction Act's drug price reform provision would have amounted to nearly \$15 billion in 2020 alone. For far too long, Americans have paid too much for lifesaving prescription drugs. They have been forced to navigate a complex healthcare system just to access affordable and quality healthcare.

Mr. Isasi, in addition to saving Americans money, how would the Inflation Reduction Act's drug pricing reforms improve long-term health outcomes for Americans seeking care?

Mr. ISASI. Well, thank you for the question. There is no question the No. 1 barrier right now for Americans is the price of prescription drugs, and the IRA will lower prices on some of the highest spend drugs in Medicare. It is going to be huge benefit for seniors, and then importantly, it took those savings and reinvested in the Medicare program.

So, for the first time ever, seniors now have a cap on their annual drug expenses of \$2,000. That is enormous. That is enormous. It also provides for free immunizations and a host of improvements for low-income Medicare beneficiaries. One of the things the law did that was so powerful was it finally stopped price gouging by Big Pharma, and then it took those savings and made really important investments in our seniors.

Mr. GOMEZ. And that is one of the main points is that we have passed things to control saving. I am not saying do not deal with these other issues because the drug pricing system is complex. And each part of it increases the cost when it comes out-of-pocket costs for seniors and all Americans, especially when it comes to repealing the Inflation Reduction Act and then playing with fire when it comes to the debt ceiling limit. A Republican default would be devastating, and all this talk about controlling drug costs will be for naught. With that, I yield back.

Chairman COMER. The gentleman yields back. The Chair now recognizes Mr. Buddy Carter from Georgia.

Mr. CARTER. Thank you, Mr. Chairman, and thank you for holding this hearing today. I am sorry I did not get to sit through the majority of it. I had another committee that I had to chair, so I could not leave, but it is probably just as well because I have only been here for about 20 minutes, and I think my blood pressure is increased probably 100 points in that period of time.

To begin with, let me clarify something that my colleague Mr. Grothman asked one of the witnesses about how much a price of a drug goes toward the pharmaceutical manufacturer and how much goes to the PBM. I would like to submit for the record a report by the Berkeley Research Group that shows that 37 percent—only 37 percent—of the price of a drug goes to the pharmaceutical manufacturer, which begs the question, where does the other 63 percent go?

Chairman COMER. Without objection, so ordered.

Mr. CARTER. Thank you. Second, we talked about, again, my colleague asked about spread pricing and what can be done about it. Actually, I have a bill up tomorrow in Full Committee with the En-

ergy and Commerce Committee that will prohibit spread pricing in Medicaid and that will help us tremendously. Hopefully we can expand that later on into the commercial market, but right now we can get it through Medicaid, and that will be something that will help us.

Dr. Atkins, you mentioned white bagging. I was down at MD Anderson in Houston probably a couple of months ago. And they were just up in arms about the white bagging and how they were having to deal with that, and what a problem it was for them, and they are being forced to do it by the PBMs. And it is just something that is an obstacle to care, and they cannot in good conscience. They do not know that this is a valid prescription or a valid drug and that it is formulated correctly. They have to do it in-house in order to be able to do that. So white bagging, as you point out, is a serious, serious problem.

The other thing since I have been here, again, I am certainly glad I was not here the whole time. Lord, I would never get through. But you talked about the IRA and about the prescription provisions that were in the IRA and how good they are. I think they are awful. I think they are the worst thing that has ever been done in the way of prescription drug pricing. The CBO, which of course, is nonpartisan, and looks at the economic and results of legislation. The CBO estimated that as a result of the prescription provisions that are in the IRA that we can expect anywhere from 15 to 20 fewer cures in the next 30 years as a result of that. Fifteen to 20, that is not from me. That is from the CBO.

Now, I would ask you, which of the 15 or 20 cures is that going to be? Is it going to be the cure for cancer? Is it going to be the cure for Alzheimer's? Which one is it going to be? So, I just have to disagree, respectfully, the prescription provision in IRA is something good.

Wow. It flies when you only have 5 minutes, but I will tell you, as you know, and, Dr. Duane, I want to ask you this because I have practiced pharmacy for over 40 years. I started when I was 10 years old as that explains that, but I practiced for over 40 years. I was the one, like you, who had to tell the patient how much the medication costs, who had to add to watch the senior citizen make a decision between whether they are going to buy the medicine or whether they are going to pay for groceries. I was the one who watched the mother cry when she could not afford the antibiotic for a child. Now, you have naval bases within your area, and recently, Express Scripts, through TRICARE, has limited participation in that program. Has that impacted you and your pharmacy?

Mr. DUANE. Yes, sir, it has by quite a lot. We were dropped from the TRICARE network, along with ten plus 1,000 other pharmacies. And yes, we have Naval Station Mayport. We have Naval Air Station Jacksonville, and it has been a big impact. We have patients who really want to come with us, to continue to come with us in the TRICARE program. We cannot do it. Now, of course, some of them can. They choose to pay out-of-pocket, and they still come to my pharmacy because they appreciate the level of service that we give, but they pay out of their own pocket. They cannot use a TRICARE benefit.

Mr. CARTER. And these are our heroes. These are our veterans and their families who have served our country, and they are being told by a PBM that they cannot get medications from what I suspect they have been getting it for years from you, generations.

Mr. DUANE. Yes.

Mr. CARTER. I had the same thing happened to me, literally patients in tears. I have only got just a few seconds left. Dr. Atkins, I have to ask you. All of this is egregious, but it is especially egregious in the oncology world, especially with the specialty pharmacies, and you are seeing this chart behind me. I meant to mention this as well.

[Chart]

Mr. CARTER. This shows you the vertical integration. You see how busy it is. That is what the vertical integration is, but, Dr. Atkins, you have seen it. You have seen where the PBMs are directing that your patients go to their specialty pharmacy to get the medication, which, as you know, and, Dr. Duane, you know as well, oftentimes, they just throw up their arms, and they just do not get it. Any comment, Dr. Atkins?

Dr. ATKINS. That is correct. If I give the patient a medication in my office, I know they walked out the door with a drug. If I will wait for it to be mailed to them, I do not know if they got the medication. I do not know if the medication is safe. I do not know how long they sit on their porch. A lot of moving factors going on. It is just not safe for patients.

Mr. CARTER. Absolutely, and it is all about the patient. Look, I am not opposed to anybody making money. It is capitalist society. I get it and understand that, but I am telling you, PBMs bring no value whatsoever to the healthcare system, no value. At least pharmaceutical manufacturers put money back into research and development. PBMs do not do that. This is highway robbery. They are, as the Attorney General of Ohio has said, they are gangsters. We need to stop them, and I cannot thank you enough, Mr. Chairman, for having this hearing and for bringing this to light. And I yield back.

Chairman COMER. The gentleman yields back. And let me say it was very important for us to include two members from the Energy and Commerce Committee, you and Ms. Harshbarger, because we want to work with you all to solve this problem and I appreciate your attendance today.

Now I would like to, before I recognize the Ranking Member, enter into the record, three things: first of all, a coalition letter from healthcare groups pertaining to PBMs, a statement by Patients for Affordable Drugs Now pertaining to PBM, and a statement for the record from the Pharmaceutical Care Management Association.

Without objection, so ordered.

Chairman COMER. Now I would like to recognize Ranking Member Raskin for closing remarks.

Mr. RASKIN. Thank you very much, Mr. Chairman. I want to start by thanking all of our witnesses for their excellent participation today in what was a super productive hearing. Mr. Chairman, I want to thank you for calling this oversight hearing on a serious public policy problem that all Americans are interested in and in-

vested in. And I think we showed that we can have some differences of perspective and nuance and emphasis, but still converge around a basic sense of a public policy crisis. And we have got one here, and we used our common sense, and so I want to thank you for showing really what oversight hearings should be like.

I want to just start by saying one thing my friend, Mr. Carter, I do not know if he left, but I looked up the statistic that he was invoking, and it is a little bit different. Inflation Reduction Act, which we obviously defend on our side of the aisle, reduced to \$35 a month what people on Medicare are going to pay for their insulin shots, if they are diabetic. Cap overall out-of-pocket cost, \$2,000 a year when some people are paying, you know, five times that for their prescription drugs and so on.

But the CBO found that the changes in the bill that were made would lead to 15 fewer drugs reaching the market over the next 30 years, or about 1 percent of an estimated 1,300 in that time. So, I think he was saying 15 to 30, or 20 to 30 a year, and this looks like 15 fewer drugs reaching the market over the next 30 years, 1 percent of that 1,300 expected.

In any event, look, we now all know that only three PBMs control 80 percent of the market. They administer prescription drug benefits for more than 260 million Americans. And this market dominance gives them an extraordinary amount of power, which enables them to determine which medications patients can access and at what cost. They can direct patients to use certain pharmacies, and often we have seen they direct patients to use their own pharmacies.

And this is because of the three major PBMs that control 80 percent of the market are owned by a parent corporation that also owns a major health insurer, a specialty pharmacy and a medical services provider. This kind of vertical integration—PBMs health insurers, pharmacies, and medical service providers all being owned by the same parent company—is ripe for monopoly, abuse, and conflict of interest. It sets up a scenario where practices among some of the largest PBMs benefit themselves and their peer companies at the expense of patients and the expenses we have heard today of independent pharmacies.

We have also learned today about the shocking lack of transparency in PBM pricing practices, which still makes much of this shrouded in obscurity and ambiguity. I appreciate that this hearing gives us an opportunity to better understand how they do operate within the healthcare system. And I look forward to further work on making these opaque relationships and practices far more transparent so we can properly reform them.

We also learned about the ways that the Big Pharma companies, the ones that actually set the prices for these medications, are continuing to take advantage of the American consumer and American taxpayer by pricing lifesaving medications way out of reach for most people. It is critical that we build on the work of the Inflation Reduction Act to stop abusive practices and make sure that every person in America can access the affordable care and medication that they need.

I would like to enter into the record before I conclude, Mr. Chairman, a statement from Patients for Affordable Drugs Now regard-

ing the need for greater transparency and the role that PBMs play in the healthcare system.

Chairman COMER. Without objection, so ordered.

Mr. RASKIN. And with that, I yield back to you, and thank you again.

Chairman COMER. I want to thank the Ranking Member. I want to, again, thank our witnesses for being here. Let me say that I think today's hearing was very substantive and very positive. Congress has talked about this issue for a long time. They have studied this issue, but I think what you are going to see moving forward, and I hope that this Committee has a big role in that, is actual action. It is time. It is past time to do something about the pharmacy benefit manager.

This Committee is not known for its bipartisanship. This Committee was not assembled to be the most bipartisan committee in Congress, but we were assembled to provide oversight. And I think both leaders, both Leader Jeffries and Speaker McCarthy, put people on this Committee that were sincere about trying to determine waste, fraud, and abuse in the Federal Government.

And when you look at problems that every American has, the cost of prescription drugs is at the top of the list, but I do not think you can have a sincere hearing on prescription drug costs without talking about the PBMs. And this is the first time we have had a Committee hearing in the six-and-a-half years I have been in Congress on actual PBMs, dedicated to PBMs. And there is a sincere desire on this Committee to do something about that, and I think that was proven today.

And I think that we can work together, Mr. Ranking Member, not just our Members, but our staff on trying to come up with a bipartisan solution. And we want to work with our friends in the Energy and Commerce Committee. They obviously have legislative jurisdiction over anything that would come through Congress pertaining to PBM reform.

The one thing I want to mention, you know, we talked about pharmaceutical companies, and I am not defending the pharmaceutical companies, but there is a difference between the pharmaceutical companies and the PBMs. The pharmaceutical companies, especially when you are talking about making a profit, the pharmaceutical companies theoretically invest in research and development because we all want to find innovative solutions to new drugs or to new diseases and new illnesses. And I think that we have a success story here in the United States with our pharmaceutical companies in trying to do that. They invest in research and development, and that is, I would assume, how they spend some of their profits.

The PBMs do not do that. And even though I am free market guy, the margins that we showed on some of these drugs and the difference between your PBM, Mr. Baker, and other PBMs, that is ridiculous. That is waste, fraud, and abuse. That is fraud to the consumer. That is waste for the Federal Government, whether it be on Medicare, whether it be in private healthcare.

So, I think there are some areas where we can agree. Price transparency, that is something that we should all agree on. I think we have bipartisan agreement on that. DIR Payment Reform,

at best reform, I am going to be very friendly here. That is something that we can address in Congress. And I think most of us would agree PBM should not be vertically integrated, and I know there is an investigation now, but I think that is something that Congress needs to play a role in fixing.

So, you know, I have asked a lot of stakeholders about PBMs because this is an issue that has weighted importance in rural areas. Ms. Balint even said that we do not have a lot of chain pharmacies in our area. We depend on mom-and-pop pharmacies. And the pharmacist when describing PBM, used words like “extortion.” It is less than flattering words with respect to how PBMs extract money, steal customers, at the very least steal intellectual property, from mom-and-pop pharmacies.

So, you know, this is a huge problem, and someone made the statement—I think it was you, Mr. Baker—that many patients talk to their pharmacist a whole lot more than they talk to their family physician, and I think that is a very accurate statement. I know it is in Kentucky. So, we do not need to do anything that would prohibit mom-and-pop pharmacies from providing quality healthcare to their customers, and unfortunately, that is what the PBMs are doing, maybe unintentional—we will give them the benefit of the doubt—but it is what is happening.

And, Dr. Atkins, no cancer patient should ever have to worry about finding a PBM to get their medication and be delayed days, weeks, or even months for medication. I mean, I cannot imagine the worry that that would compound on a cancer patient.

One of the things I want to mention, the PBM Association expressed frustration that they were not invited to this hearing. I think this is the first hearing, and what I would like to do, Mr. Ranking Member, I would like for us to huddle up, our staffs huddle up, and try to come up with some potential solutions that we can agree on both sides and then have the PBM Association come back and get their take on it, because the one of the things that the stakeholders have told me, we actually need PBMs. My friend Buddy Carter said we did not. More people tell me we do than we do not. But if we do need them moving forward, then we need to fix the problem, and I think that we have the ability to do that. I think there is a sincere desire on both sides of the aisle to do that.

So, we thank you for being here. I think this will be a very valuable Committee. This was a substantive hearing, and I look forward to coming up next with some solutions to the problem. So, in closing, again, I want to thank our panelists for their important and insightful testimony today.

With that, and without objection, all Members will have five legislative days within which to submit materials and to submit additional written questions for the witnesses, which will be forwarded to the witnesses for their response.

Chairman COMER. If there is no further business, without objection, the Committee stands adjourned.

[Whereupon, at 3:13 p.m., the Committee was adjourned.]

