THE ROLE OF PHARMACY BENEFIT MANAGERS IN PRESCRIPTION DRUG MARKETS PART II: NOT WHAT THE DOCTOR ORDERED

HEARING

BEFORE THE

COMMITTEE ON OVERSIGHT AND ACCOUNTABILITY HOUSE OF REPRESENTATIVES

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THE ROLE OF PHARMACY BENEFIT MANAGERS IN PRESCRIPTION DRUG MARKETS PART II: NOT WHAT THE DOCTOR ORDERED

Tuesday, September 19, 2023

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

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

Present: Representatives Comer, Jordan, Foxx, Grothman, Palmer, Higgins, Sessions, Biggs, Mace, LaTurner, Fallon, Perry, Timmons, Burchett, McClain, Edwards, Burlison, Raskin, Norton, Lynch, Connolly, Krishnamoorthi, Khanna, Mfume, Ocasio-Cortez, Porter, Bush, Brown, Stansbury, Garcia, Frost, Lee, Casar, and Goldman.

Also present: Representatives Carter, Harshbarger, and Auchincloss.

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

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

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

I want to welcome everyone to today's hearing on the role of pharmacy benefit managers in pharmaceutical markets. This is the second hearing in our series discussing pharmacy benefit managers, or PBMs, and their role in the pharmaceutical market. 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.

PBMs started out as beneficial additions to the healthcare system because they were competing with others to provide clarity to pharmacies, payers, and patients about drug costs, but that environment of competition and transparency is no longer true today. Instead of fierce competition, now just three PBMs control 80 percent of the market, and each of the three major PBMs—CVS Caremark, Express Scripts, and Optum Rx is owned by a major health insurer and is owned by a pharmacy. 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.

This can create incentives to do things that have negative impacts on patients. That is why the Committee's examination of PBMs is a priority of this Congress.

Our concerns were compounded by what we learned in our first PBM hearing held earlier this year in the spring. We heard from Greg Baker, a pharmacist in Jacksonville, Florida, who discussed how he is unable to serve TRICARE beneficiaries in his community. This is because Express Scripts is forcing TRICARE beneficiaries to use specific pharmacies on military bases. We heard from Dr. Miriam Atkins, an oncologist in Georgia, who discussed how PBMs, not doctors, can dictate which drugs the patients can use. They do this through tactics that require a patient to fail on a certain drug before trying another drug and by requiring the use of mail order pharmacies, which can be unreliable and wasteful.

We also heard from Greg Baker, the CEO of AffirmedRx, a transparent PBM that works to provide clear pharmacy benefit services to employers. He discussed how typical PBM practices could be considered price gouging, and gave examples of a cancer drug and the difference in price for a 30-day supply of the cancer drug, Imatinib, at Cost Plus Drugs versus CVS. That difference is astounding. A 30-day supply at Cost Plus Drugs costs $72. That very same 30-day supply at CVS costs more than $17,000. Those two prices are for the exact same prescription. It begs the question, why is one prescription so much more expensive, and what is happening with that extra money?

We know that PBMs regularly engage in spread pricing where PBMs overcharge payers and underpay pharmacies and pocket the extra money. We also know that drug manufacturers pay rebates to PBMs in order to be placed in a favorable tier on a formulary, which can make it difficult for competing prescriptions, often generics, to get on formularies. These practices have real-world consequences and impact constituents in all of our districts. I hope today's hearing provides more clarity into the pharmaceutical market so that Congress can determine what actions are necessary. I want to thank the witnesses, and now I yield 5 minutes to Ranking Member Raskin for an opening statement.

Mr. RASKIN. Chairman Comer, thank you very much for calling the hearing and for your great leadership on this issue. Thanks to the witnesses for coming, and I want to thank the Members on my side of the aisle who have arrived already, and Mr. Auchincloss from Massachusetts who joins us today, who is an expert in the field. It is the second time we have come together to talk about this issue that affects everybody in America: access to affordable medication. And here is the bottom-line value that we are seeking in the wealthiest nation on Earth at the wealthiest time in our history: everybody should be able to afford the medical care and attention and prescription drugs that they need.

In 2021, we spent $4.3 trillion on healthcare in our country, nearly twice as much per capita as the next closest country. Most of our healthcare system is for profit with many big corporations involved making billions of dollars in profits annually. During a multiyear investigation conducted by Committee Democrats, we found that some major pharmaceuticals employed profit-maxi-

mizing pricing practices at the direct expense of the people who rely on their medications to survive.

Today, we are investigating the role of pharmacy benefit managers, PBMs, which are supposed to negotiate lower drug costs and improve the delivery of medication to patients. That is the theory. What we have actually heard is that certain PBM business practices may be favoring more expensive drugs and making it more difficult for patients to get timely and affordable access to the medication prescribed by their doctors at the pharmacy of their choice. In our last hearing, we heard from witnesses who suggested that PBMs and other big health companies are using their enormous market power to maximize their profits at the expense of patients and community pharmacies. As of today, three companies control 80 percent of the PBM market. The same parent companies that own these PBMs also own health insurers and pharmacies, so the parent company can profit at multiple points of access through the healthcare system.

PBMs profit from rebates and fees from pharmaceuticals that want PBMs to include their drugs on insurance plans. PBMs also profit from health insurers directly, which reimburse PBMs when medications are dispensed to patients at the pharmacy. Because of the integrated market, PBM parent companies can also profit from directing patients toward the retail and specialty pharmacies that they own.

In the question of PBM profits versus patients, we need to make sure that patients are coming out on top every single time. The first step is understanding the problem. The Committee's drug pricing investigation shone a light on the way that drug companies have spent years exploiting patients. In the Inflation Reduction Act, Democrats worked to lower drug costs for seniors by allowing Medicare to negotiate prices directly with manufacturers, capping out-of-pocket costs for patients covered by Medicare and limiting the price, for example, of insulin to $35 per vial for seniors.

Today, we have got an opportunity to build on that success. This hearing will help us understand the ways that PBMs add value and improve patients experience, as well as the ways they may not be living up to the hype and contributing to our crisis of drug affordability and accessibility. Given their central role, we need more transparency into how PBMs operate and how their practices might be working alongside others in the supply chain, including Big Pharma, to increase the price of drugs that we all pay. I hope together we can buildupon our drug pricing reduction work so far and move toward the moral North Star here, which is that every person in America should be able to access the affordable medication they need in order to survive and thrive with their families. Thank you very much, Mr. Chairman. I yield back.

Chairman COMER. The gentleman yields back. Without objection, Representative Carter from Georgia, Representative Harshbarger from Tennessee, and Representative Auchincloss from Massachusetts is waived on to the Committee for the purpose of questioning the witnesses at today's Subcommittee hearing.

I am pleased to welcome an expert panel of witnesses, who each bring experience and expertise that will be valuable to today's discussion. I would first like to welcome Mr. JC Scott, who is the

President and CEO of Pharmaceutical Care Management Association. Next, we have Lori Reilly, who is the Chief Operating Officer of the Pharmaceutical Research and Manufacturers of America. Next, we have Mr. Craig Burton, who is the Executive Director of Biosimilars Council and Senior Vice President of the Association for Accessible Medicine. Next, we have Mr. Hugh Chancy, who is the President of the National Community Pharmacists Association. Last, we have Rena Conti, who is an Associate Professor for markets, public policy, and law at Boston University.

Pursuant to Rule 9(g), the witnesses will please stand and raise their right hand.

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 the witnesses all answered in the affirmative, and thank you. You may be seated.

We appreciate all of you 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 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 ask that you please wrap up.

I now recognize Mr. Scott to please begin his opening statement.

STATEMENT OF "JC" SCOTT
PRESIDENT AND CEO
PHARMACEUTICAL CARE MANAGEMENT ASSOCIATION (PCMA)

Mr. SCOTT. Good morning, Chairman Comer, Ranking Member Raskin, and Members of the Committee. Thank you for the opportunity to join today's hearing on behalf of PCMA. We represent the Nation's pharmacy benefit companies which negotiate and administer prescription drug benefits for 275 million insured Americans. For most of this year, there has been a heavy congressional focus on our industry with the expressed goal to reduce high drug prices.

[Chart]

Mr. SCOTT. Yet, as the chart shows, PBMs represent only 6 percent of the drug dollar, and proposed PBM reform bills do not actually address drug prices or lower costs. I am grateful for today's opportunity to talk about why, and we will share that chart if it does not appear on the screen.

Efforts to lower drug costs must start with an understanding that prices are set by drug companies. When a drug company sets its initial price, that dictates costs throughout the supply chain, from the wholesalers' negotiation for discounts, to its markups to pharmacies, to pharmacy acquisition costs, to the amount that the insurance plans sponsor, and patients ultimately pay. PBMs negotiate with drug companies to deliver savings on prescription drugs to patients and health plan sponsors, including employers, unions and government programs like Medicare and Medicaid. These dis-

counts take the form of rebates, and many are surprised to learn that most prescription drugs do not have a rebate.

Ninety percent of prescriptions are filled with generics, and most newly launched brand drugs and specialty drugs do not have a rebate. What is more, study after study has shown that rebates are not correlated with pricing decisions. Government data illustrates this very important point. Prices continue to go up on drugs regardless of how big, small, or nonexistent a rebate is. The idea that PBMs force drug companies to set prices higher is simply incorrect. PBMs pass these savings back to plan sponsors and employers, who have full decisionmaking authority on how best to use rebate savings to benefit the patients enrolled in their plans, whether it be through lower premiums, lower out-of-pocket costs, or more comprehensive benefits.

Our company's mission is to lower costs. We support lower drug company list prices. We promote use of generics. We want a robust biosimilars market. We cheered when several insulin companies lowered list prices for some of their products earlier this year, and we have called on other drug makers to lower their own list prices for needed medications. PBMs also work with over 60,000 pharmacies on behalf of employers and plan sponsors, and our companies rely heavily on this relationship with retail pharmacies to be access points for the patients they serve. That is why at PCMA, we have been advocating to look toward the future state of retail pharmacy, empowering pharmacists to do more to provide care to patients.

No employer, union, or other plan sponsor is under any obligation to hire a pharmacy benefit company. They choose to do so, and you will hear me talk about the importance of choice as a foundational principle. Employers and plan sponsors have unique needs and represent unique patient populations. They choose whether to contract with a PBM and what they want out of that service. They choose how to set up their contract and how to pay for the services, whether it is through fees, shared savings, incentives, or otherwise, and they choose how best to use the savings delivered by their PBM.

For the system to work, employers and plan sponsors have to be empowered not only with choice but with the information they need to make informed choices. At the beginning of the contracting process with the PBM, employers determine what information, disclosures, and audit rights they need. Our industry supports open, transparent exchange of useful information. Our companies comply with the many transparency and disclosure requirements in place at the state and Federal levels, but we do not believe the government should dictate private contract terms between two businesses. Employers should make the call on what information they want to receive, and they should receive it. Mandating public disclosure of confidential information will only invite drug companies to collude and raise drug costs.

In almost every industry, and especially healthcare, the most effective way to lower costs is through increased competition. That is why we must ensure that any misuse of the patent protections meant to balance rewarding innovation and ensuring affordable access for patients is not blocking competition and keeping prices

high. So, I would encourage you to keep two key questions in mind today, would legislation limit choice, competition, and innovation in the markets, and would it actually help lower drug prices? We ask the Committee to take a look at the practices of not just PBMs, but drug companies, pharmacies, wholesalers, plan sponsors, and other stakeholders. High drug prices will not be solved in a vacuum or by singling out one sector, especially not the sector charged with lowering costs, and PCMA is committed to being a positive partner in the policy discussion about how to bring down drug prices and improve patient access.

Thank you for including me today. I look forward to your questions.

Chairman COMER. Thank you. Ms. Reilly?

STATEMENT OF LORI REILLY
CHIEF OPERATING OFFICER
PhRMA

Ms. REILLY. Chairman Comer, Ranking Member Raskin, Members of the Committee, my name is Lori Reilly, and I am here representing PhRMA.

Over the past 23 years, biopharmaceutical companies have brought 750 new medicines to market, including medicines like cell and gene therapies and Alzheimer's treatments. These medicines are helping slow the progression of disease and improving patients' lives, all for 7 cents out of every healthcare dollar, which is what is attributed to brand name medicines. How is that possible? Well, first, insurers do negotiate very significantly with pharmaceutical manufacturers. Typically, rebates exceed 50 percent or more, on average, for prescription medicines. Medicines also face significant competition from other brand drugs. Take, for example, hepatitis C medicines. When they were introduced, within a year there were multiple hepatitis C medicines on the market, which dropped the price by 80 percent.

And last, generic medicines comprise 90 percent of every prescription written today. These medicines typically launch at 90 percent less than brand medicines. All of these things combine to make our system based on one of competition and negotiation. Unfortunately, however, there are aspects of the market that today are not working as intended.

Today, as was mentioned earlier, just three pharmacy benefit managers control 80 percent of the market. They own or are owned by insurers, they have pharmacies, and they also increasingly have physician practices, and they use their leverage to enrich themselves often to the detriment of the patients that they are intending to be serving. There are three different ways that they do this. No. 1, they limit patients' ability to access lower-priced medicines. They make their money on rebates and fees that are tied to the list price of a medicine. The higher the list price, the more money that goes in their pockets. They often deny or limit access to biosimilar and generic medicines. And when branded medicines offered lower priced insulins and lower priced hepatitis C medicines, while they may have cheered, they were reluctant to actually cover them on their formularies. As a result, patients are paying more.

Second, they refuse to pass negotiated discounts on to patients. Negotiated rebates often exceed 50 percent or more, but they insist on making patients pay the full price when they go to the pharmacy counter. In fact, recently, the GAO looked at the top 100 most rebated drugs in Part D and found that in 79 of those medicines, patients paid more than their insurance company did for the very same medicine, in fact, 4 times more than their insurance company did, and that is not an anomaly. In two-thirds of all commercial claims and 92 percent of all Medicare Part D claims, patients are being asked to pay a price tied to the list price of the medicine. This happens nowhere else in the healthcare system. If you go to the hospital or the doctor's office, you pay the negotiated rate, not the high list price.

And last, large consolidated PBMs use their leverage to extract additional profits throughout the supply chain, which means higher costs for everyone else. In addition to rebates, PBMs also get additional revenue by new fees and markups on medicines at specialty pharmacies. A Wall Street Journal article just last week found that PBMs are marking up generic drugs by thousands of dollars. They have also created PBM GPOs to generate new sources of profit through opaque fees that provide no direct benefit to patients.

A study released just yesterday by Nephron Research found that fees that are paid to PBMs have more than doubled in the last 5 years, and these, again, are predominantly tied to list prices. That same study found that 42 cents out of every healthcare dollar goes to PBM, not 6 cents as was just stated by JC. The 6 cents that was quoted by Mr. Scott actually neglects to include the profits that they receive from specialty pharmacies, which is one of the largest drivers of profit that they receive.

So how do we fix this problem? Congress has an unprecedented opportunity to hold PBMs accountable, restore competition, and lower costs, and they can do so in three ways. No. 1, delink PBM compensation from the price of medicine so that PBMs are not incentivized to prefer high list price medicines over lower price medicines; two, require that rebates and discounts be passed on to patients so that patients are not left in the position of having to pay more than their insurer for a medicine; and last, increase PBM transparency so that everyone has a better understanding of how PBMs make their money and where that monies go. Thank you very much.

Chairman COMER. Thank you. Mr. Burton?

STATEMENT OF CRAIG BURTON
EXECUTIVE DIRECTOR
BIOSIMILARS COUNCIL
SENIOR VICE PRESIDENT
ASSOCIATION FOR ACCESSIBLE MEDICINES

Mr. BURTON. Thank you, Chairman Comer, Ranking Member Raskin, and other Members of the Committee. My name is Craig Burton. I am speaking on behalf of the BioSimilars Council and Association for Accessible Medicines. AAM and its Biosimilars Council represent the manufacturers of generic and biosimilar medicines, and we work to expand patient access to safe, quality, and effective generics and biosimilars.

Generics are the backbone of U.S. healthcare. As folks have mentioned, they represent 9 out of every 10 prescriptions filled in the U.S. but less than 18 percent of all drug spending. These are lower-cost FDA-approved versions of brand drugs, and their development cost can range from $5 million to $10 million for a relatively simple product to upwards of several hundred millions of dollars for a complex generic or a biosimilar. And biosimilars, in particular, are critical to future savings. Today, they cost less than half the price of the brand at the time of a biosimilar launch, and, importantly, they are also driving brand prices down.

One of the most important things about generics and biosimilars, though, is that they expand patient access. Since 2015, biosimilar competition has resulted in more than 344 million additional patient days of therapy. It is no overstatement to say that patients depend on generics and biosimilars, but these savings and this access is at risk because of Medicare policy incentives that delay patient access to and savings from new generics and biosimilars.

First, I should note a foundational difference between generic and brand pricing. Brand manufacturers operate in a monopoly environment. They can set high list prices, and they often will negotiate PBM formulary coverage through opaque backend rebates and fees, but generics do not price with the PBM in mind. Rather, generics are pricing as competition for wholesaler and pharmacy stocking, and they price based on discounts and ability to meet desired volume. In fact, generics rarely, if ever, negotiate rebates with PBMs and health plans.

Now, new generics have historically achieved rapid adoption, but that trend is no longer the case. Patients are increasingly blocked from new generics and biosimilars for a period of years, 3 years, in fact, in the Medicare program for new generics to be covered on as many as half of Part D formularies. This delays patient savings, and it is a direct result of Medicare incentives that encourage PBM preferences for high priced brands with high rebates and fees.

Biosimilars also face similar challenges. Humira biosimilars are launching at discounts of up to 85 percent, but the adoption so far has been less than desired. As biosimilars seek to achieve coverage, some are pricing based on a high list price, high rebate strategy. Others are trying to get coverage with a lower list price and a larger discount. And these PBM preferences can be seen in the biosimilar insulin market, where a biosimilar insulin launched with two prices, one high price with backend rebates and one with a 65 percent discount in list price, but PBMs did not cover the lower-priced biosimilar insulin. PBMs stuck with the brand. And if you look at adoption in the insulin market, even though two-thirds of prescriptions written for this product were for the biosimilar, only about a third of those prescriptions were actually filled with the biosimilar. This is because of PBM preferences that blocked adoption of the biosimilar.

To be clear, as we look at biosimilar and generic competition, it is great that everyone is supportive of it, but it cannot simply be a ploy for PBMs to leverage bigger rebates and fees from brand drugs. This is not sustainable. And even when formularies do cover generics, we are seeing those generics increasingly placed on brand formulary tiers with higher co-pays. Today, fewer than half of

generics and Medicare are on a generic tier. This dramatically increases patient costs, more than double the cost the patient out of pocket is spending on generics covered in 2011 and 2019, even though the price of those generics declined by 40 percent over the same time period.

Representatives Kuster, Miller-Meeks, Dunn, and Matsui have introduced legislation to ensure that patients have access to new generics and biosimilars, and that patients do not spend more than necessary for low-cost generics. We encourage Congress to take up this legislation and improve patient access to lower cost treatments. I would be happy to take any questions.

Chairman COMER. Thank you. Mr. Chancy?

STATEMENT OF HUGH CHANCY, RPH
PRESIDENT
NATIONAL COMMUNITY PHARMACISTS ASSOCIATION (NCPA)

Mr. CHANCY. Chairman Comer, Ranking Raskin, and other Members of the Committee, I am Hugh Chancy. I am a pharmacist and co-owner of Chancy Drugs. I currently serve as the President of the National Pharmacists Association. I greatly appreciate the opportunity to speak to you today regarding my experience as a pharmacist and pharmacy owner and how current PBM practices negatively impact my family business and my community.

My family has three generations of pharmacists. My parents, Hubert and Sue, opened Chancy Drugs in 1966 in Hahira, Georgia. Chancy Drugs has since expanded under me and my brother's leadership, and more recently, my son, Patrick, has also taken a leadership role. Chancy Drugs has seven locations and currently employs approximately a hundred people across South Georgia. I am proud of the work that Chancy Drugs has done over the decades providing healthcare to patients in my community. But PBMs put this important work at jeopardy, dictating who has access to our pharmacy, the prices patients pay, what reimbursements pharmacies receives, and what medications are on formulary.

As you know, the top three PBMs control 80 percent of the market. They use the monopoly power to steer patients to PBM-affiliated pharmacies. In fact, a recent report from MedPAC found that vertically integrated PBMs and Medicare Part D appear to pay the affiliated pharmacies more than they do pharmacies like mine. Imagine that. This is leading to higher cost to the Medicare program. Many of my patients who are forced to get their drugs through mail order receive their medications damaged or do not get them on time.

Chancy Drugs has three stores near Moody Air Force Base, which means that we have a lot of veterans as customers. When Express Scripts implemented the changes to the TRICARE pharmacy network last year, many of our patients were negatively impacted. We had one patient in particular who called in tears. She is blind, and we hand deliver her medications to her home in specialty packaging. With TRICARE's changes, she was forced to go to mail order without the specialty packaging, or her elderly husband must drive 40 miles round trip to the pharmacy in Valdosta. Our service members and veterans deserve better.

PBMs employee harmful anti-competitive tactics such as spread pricing and DIR fees. Spread pricing is the difference between how much the PBM pays me for a drug and the higher price that they charge the payer for the same prescription. For years, community pharmacists have said PBMs play spread pricing games, contributing to higher drug costs. Studies of state Medicaid-managed care programs have found that PBMs overcharge taxpayers while pocketing the spread for themselves. In fact, over the last 2 1/2 years, Centene has entered into settlements for up to $900 million for at least 17 states for overcharges to the Medicaid program.

Another tactic PBMs use are direct and indirect remuneration fees. DIR fees have allowed PBMs to pay pharmacies for prescriptions and later clawback thousands of dollars at random. A MedPAC March 2023 report found DIR fees reached $12.6 billion in 2021. That is 33 percent increase in just 2 years. The unpredictability wreaks havoc on my pharmacy's financial health, threatening my ability to keep the lights on. On top of this, our contracts with PBMs are take it or leave it. Some of the most life-sustaining medications are often underpaid by PBMs. Georgia's cost to dispense for Medicaid patients is $10.63, but it is not unusual for PBMs to pay me a nickel. And oftentimes, we have zero dollar dispensing fee on Part D prescriptions.

Because of PBMs, thousands of pharmacies represented by NCPA have gone out of business over the last decade, and it is not only independent pharmacies that PBMs impact. Large chain pharmacies are also closing. In fact, two large grocery stores are closing in my community now. If these large national chains and grocers are having difficulty maintaining pharmacy operations, it is no surprise that small businesses are struggling. Pharmacies are going under while PBMs are getting fatter. CVS, UnitedHealthcare, and Cigna are all part of the Fortune 500 top 20. If the PBM industry continues to go unchecked, there is a severe risk of putting thousands of pharmacies like Chancy Drugs out of business.

In sum, community pharmacies supports commonsense legislative reform to PBMs' harmful practices, which I would be glad to discuss further. I applaud the Committee's bipartisan efforts to shine light on the PBMs through this investigation, and I am happy to answer any questions. Thank you.

Chairman COMER. Thank you. Dr. Conti?

STATEMENT OF RENA M. CONTI PH.D.
ASSOCIATE PROFESSOR
DEPARTMENT OF MARKETS
PUBLIC POLICY, AND LAW
QUESTROM SCHOOL OF BUSINESS

Ms. CONTI. Good morning. I am Professor Rena Conti. I am a Professor of Economics applied to prescription drugs at Questrom School of Business at Boston University. Today, I am honored to address Representative Comer and Raskin and all distinguished Committee Members to discuss the pivotal roles played by pharmacy benefit managers in the U.S. healthcare system.

PBMs are often regarded as enigmatic intermediaries despite the central role PBMs play in the healthcare system. The primary function of PBMs is to create a competitive arena for drug makers.

This arena is built upon PBMs' strategic use of formularies, among other tools, to guide patients toward specific medications. These strategies are intended to foster competition among drug makers. PBMs wield the potential to enhance the efficiency of prescription drug markets, which can ultimately benefit both consumers and payers. Notably, PBMs, through their formulary strategies, incentivize utilization of generic and biosimilar drugs when clinically appropriate. Generic drugs, in turn, offer substantial cost savings for both patients and payers. Use of these strategies do not disturb the incentives for innovation.

Nonetheless, I have some concerns about the potential for PBMs in their current organizational structure to burden our system with additional costs. Branded drug makers may respond to the strategies of PBMs in ways that undermine patient benefit. Branded drug makers offer rebates off of list price to compete within the arena constructed by PBMs. PBMs, in pursuit of their own self-interest, may favor placing branded drugs with higher list prices in preferred formulary tiers.

When drug makers exclusively retain the power to set list prices and engage in formulary competition, as in our system, it can trigger shadow pricing behavior. In the race for superior placement, list prices may skyrocket without commiserate benefit to patients, as confirmed by the House Oversights Committee's recent reports. Such behavior directly burdens all Americans with higher out-of-pocket costs and undermines access, especially for people who are underinsured, including those with high-deductible health plans, and uninsured individuals. It also undermines transparency within the system, essentially disconnecting reimbursement from the acquisition costs of these drugs.

The consolidation of PBMs presents challenges. While mega PBMs may extract deeper rebates from branded drug makers, the benefits of such arrangements often remain with the PBMs themselves and are not shared with consumers or payers. The consolidation of PBMs with health plans does not appear to lower premiums for consumers, nor enhance their medical benefits. Similarly, the consolidation of PBMs with pharmacies does not appear to render generic drugs even more accessible, nor render such services more convenient to access. Moreover, PBM consolidation erodes competition, contributing to increased costs for PBM services and greater opacity in our system. These effects hinder smaller health plans and employers to select services that actually align with their unique health needs.

Developing evidence suggests that some PBMs design formularies primarily to maximize revenues, potentially neglecting the promotion of individual and population health as well as cost reduction. Thus, while PBMs offer efficiencies in our healthcare system, PBMs also pose emergent tasks. Increased transparency in the PBM market would empower consumers and employers to make informed decisions in selecting PBMs, plans, and pharmacies that align with their requirements. Banning spread pricing and requiring rebate pass-through may offer solutions to these intricate challenges. However, I urge policymakers to exercise due diligence as these and related reforms may also yield unintended consequences.

I welcome the opportunity to engage in a meaningful discussion with the esteemed Members of this Committee. Thank you.

Chairman COMER. Thank you very much. We will now proceed with 5 minutes worth of questioning per Member. The Chair recognizes Dr. Foxx from North Carolina for 5 minutes.

Ms. FOXX. Thank you, Mr. Chairman, and thanks to our witnesses for being here. Mr. Scott, in the employer-sponsored market, plan sponsors have a fiduciary responsibility to their employees to provide the highest quality plan for the lowest cost. How do large PBMs help employers fulfill their fiduciary duties?

Mr. SCOTT. Good morning, Congresswoman. It is nice to see you again. Thank you for your time recently to visit on these questions. So, I appreciate your question because it is sort of foundational to what I was getting at in my opening comments, that this is a marketplace where employers and plan sponsors have full choice in how to leverage the value of the PBM. And most of the time, the value that they are looking to derive on behalf of the patients they represent is to bring down the cost of the benefits.

And that can be derived through the negotiation with the drug company to bring down the net cost of the drug, to promote networks of lower-cost, higher-quality pharmacies. All of that generates savings that the employer can then use to expand the benefit, lower the premium, lower out-of-pocket costs, whatever is going to be best for their unique patient population.

Ms. FOXX. Thank you. Mr. Scott, again, Congress has been exploring proposals to reduce the cost of prescription drugs, some of which are included in H.R. 5378, the Lower Costs, More Transparency Act that we hope the House is going to consider this week. What impact would requiring PBMs to pass through all rebates to patients at the point of sale have on overall drug costs, and what would the impact be on premiums?

Mr. SCOTT. Thank you for the question. That is sort of the key consideration here, right? There is an amount of savings that is negotiated. And as long as the price of the drug, the price of the good continues to be high, whether you shift that fully to offset all out-of-pocket cost or you shift that fully to offset premium, then you are just squeezing the balloon and causing cost to rise on the other side of that equation. So, if you moved it all to the point of sale, then you are risking that the premium and the cost of the benefit is going to have to go up.

We saw that effect measured by CBO and OACT at HHS and others around the Trump Administration's rebate rule, all of which is to say this is why it is so important to have flexibility so that there can be a balance struck between keeping the benefit affordable and trying to address out-of-pocket cost at the counter.

Ms. FOXX. Another question, 25 words or less, what is spread pricing, and why should PBMs be allowed to charge insurers more for a drug than what they paid the pharmacy?

Mr. SCOTT. Spread pricing is a form of contracting that the employer can choose for mitigating their financial risk. If I could just use an analogy, so if you are an employer, for example, running a cafeteria, you may say to the vendor, I just want to pay a per person fee. You tell me how much it is going to be per person, and then the vendor has to deal with the cost of the lettuce and the

ketchup and everything that goes into it, or they may say, I will pay you a small flat fee, and I want an exposure to paying for the variability of the things that go into the meal. It is really a financial risk tolerance choice that is being made by the employer.

Ms. FOXX. OK. So why should PBMs be allowed to charge insurers more for a drug than what they paid the pharmacy?

Mr. SCOTT. Well, in that instance, if you pull the analogy through to the pharmacy marketplace, then the PBM can be compensated if it is able to negotiate a better deal with the pharmacy on the cost of a given drug, but the PBM also owns the risk and takes the loss if they are unable to negotiate a better rate with the pharmacy.

Ms. FOXX. Mr. Chancy, what impact does spread pricing have on independent pharmacies?

Mr. CHANCY. The spread pricing is a big problem for us because we are getting underpaid, and then the spread is going to them.

Ms. FOXX. OK. Well, what would the impact of additional transparency regarding spread pricing be for independent pharmacies?

Mr. CHANCY. Well, I think, first of all, clear and transparent reimbursement would be helpful to us because many times we are being underpaid. We are actually being paid below our cost of purchasing the product, so I think that spread pricing has taken away from our reimbursement and making it more difficult for us to serve our patients.

Ms. FOXX. I am going back to Mr. Scott, and I have a short period of time. CVS Caremark, Express Scripts, and Optum Rx, or the big three, own 80 percent of the U.S. PBM market, as the Chairman said in his opening remarks. What impact does this consolidation have on prescription drug prices?

Mr. SCOTT. Congresswoman, it is important to have a variety of different PBM models, whether a large integrated company or a small standalone PBM, which is why it has been good to see the number of competitors in the PBM market expand by 10 percent in just the last 2 years. That provides choice for employers and plan sponsors.

Ms. FOXX. Thank you, Mr. Chairman. I yield back.

Chairman COMER. I now recognize Mr. Lynch for 5 minutes.

Mr. LYNCH. Thank you, Mr. Chairman, and thank you for holding this hearing. In a previous Congress, I was actually the Chair of the Subcommittee on the Federal Workforce, where we conducted an extensive investigation into the role of pharmacy benefit managers with respect to the prescription drug pricing under the Federal Employees Health Benefit Plan.

The FEHBP is the largest employer-sponsored group health insurance program in the world. We have got about 8 million Federal employees, retirees, former employees, and their family members, so it is often considered sort of the gold standard when it comes to affordable health insurance. Importantly, our investigation found that the FEHBP employee members, retirees, and active employees were paying up to about 45 percent more for its prescription drugs. Even with that collective power of 8 million people in a healthcare plan, they were paying 45 percent more for prescription drugs than any other agency, and it was because we relied on PBMs to negotiate the prices.

When we tried to figure out what the rebate system was that was leading to this unfairness, the PBMs fought us on the issue of transparency. We were trying to find out, OK, how do the PBMs actually work this rebate system. Why is it not transparent? They fought us tooth and nail in court, and one claiming that it was a proprietary advantage that they had, and so we cannot get full transparency on that. Ms. Reilly, you talked about that in one of your points. How do we get at that? I know some states have individually brought lawsuits. I know Maine has, Texas has, Ohio has. There are states all over the country that are trying to find out the same thing, like, what does a PBM pay for their drug, and why are they charging so much more to employees or to insured parties? Can you talk about that a little bit?

Ms. REILLY. Absolutely. Thank you for the question, and there are a number of pieces of legislation that Congress is considering: one, the PBM Sunshine and Accountability Act, which is a bipartisan bill that Members of this Committee are sponsors of. I think that would go a long way to providing some sunshine into the various fees that PBMs collect and where that money goes.

As you rightly pointed out, there are a number of fees, not just rebates that PBMs collect. The report that I referenced just released yesterday from Nephron showed that what is happening now, I would argue, is shape-shifting in the PBM market. As Congress and state legislators have begun to shine a light on rebates and the significant dollars associated with rebates, more plan sponsors are demanding that those rebates get passed through to them. So PBMs have set up PBM GPOs, often located offshore, and they collect a number of opaque fees. It is hard to find any direct patient benefit to these fees, and I think it would be enlightening for folks to know just how large and significant these fees are today and how much they have grown in just the last 5 years.

Mr. LYNCH. Great. I just want to illustrate one of the absurdities that we found here. So here we have 8 million people in an insurance plan, that collective bargaining power, the weight of that plan. We found that the PBMs were operating individually with CVS and the drug companies, offering another program to the general public. So, somebody off the street could come in and pay $10, and there was a whole formulary of drugs that were available for $9.99.

Our members that are paying all this money for insurance, 8 million of them paying into this plan went in and they paid more than someone coming in off the street. So, we were telling our members do not tell them you have insurance. Just tell them you are a stranger. You do not have insurance. You will get a better price from the PBMs than you would with Federal employee health insurance. Ridiculous, and it is because of the scam that is being perpetrated by the PBMs. In some cases, the Federal employee with insurance was paying $200 more for the same drug that the PBM was offering to the general public walking off the street for $9.99. It is just absolutely maddening.

And I think we have an area here, Mr. Chairman, where we can actually work together and have some bipartisanship, I dare say, on this. I think the sponsors of this legislation from your side and ours are on the side of the angels, and I heartily support their effort, and I yield back. Thank you.

Chairman COMER. Thank you, Mr. Lynch. And I agree 100 percent on bipartisan agreement and cooperation moving forward. The Chair now recognizes Mr. Sessions from Texas for 5 minutes.

Mr. SESSIONS. Mr. Chairman, thank you very much. Mr. Chairman, I would like to, if I could, at the beginning of this put in the record a report from McKinsey & Company called, "Improving Patient Adherence through Data-Driven Insights." I would like to ask that that is in the record.

Chairman COMER. Without objection, so ordered.

Mr. SESSIONS. Mr. Chairman, thank you very much. Our witnesses today have provided, as well as the Members, a lot of interesting information. And, Mr. Scott, I know that a lot of it is aimed at the business model that you and your companies have established. But it is very apparent to me that competition is one of those factors that is not part of your equation for the marketplace, and the marketplace would be consumers, and consumers in the United States of America need to be able to count on the U.S. Congress, the laws of this country. But I think across the board, the marketplace represents an agreement by large companies and small companies to offer a competitive model where it would be available and best for the consumer.

We have people who showed up today with a small pharmacy. We have Ms. Reilly who is here with large pharma companies, and they both see the same anti-competitive model that is employed in this marketplace. Dr. Conti, please tell me what you think would happen if there were full marketplace access? Would prices and the competitive model be better?

Ms. CONTI. So, by definition, the market that we have set up is pro-competitive. PBMs clearly are producing savings for Americans and pushing Americans to use generics and biosimilars when they are available. That is a good thing. We all win from that. However, the competitive pressure that is potentially eroding patient access and affordability is related to vertical integration between PBMs and pharmacies or PBMs and plans. It is in those arrangements where we think premiums are not going down, and potentially patients are paying more at the pharmacy counter.

Mr. SESSIONS. Would it be your testimony today because I heard Ms. Reilly allude to this, I believe directly land on it, that it is the PBMs' model that they want to control the marketplace? That I would consider this to be anti-competitive. What would you say, Dr. Conti?

Ms. CONTI. I would say, again, these vertically integrated plan and PBM models are complicated and may create perversity, harming us, individual patients. At the end of the day, however, drug makers do set the prices of their drugs, and the list prices are what patients pay out of pocket. So, I would say both the drug makers, especially branded drug makers, and the PBMs here are both at fault for imposing costs on us.

Mr. SESSIONS. Well, we just heard from several Members of Congress about an investigation a few years ago where actually it was determined that the PBMs controlled far greater than I believe what you are giving reference to, the actual price, giving preference in a marketplace through their market advantage, and that is what I would like to focus on for a minute. Ms. Reilly, I believe that you

see this clearer than most of us here on this Committee. We are not new to this issue, but I think you have landed on really the equation. And that is that I believe that these PBMs, the largest ones that control 80 percent of the marketplace, can use their size as an anti-competitive behavior against the marketplace. Could you amplify that?

Ms. REILLY. Absolutely. And I would agree with you wholeheartedly that there is significant evidence from the OIG, from the Federal Trade Commission, from GAO, and a number of others of a number of different practices that PBMs utilize, No. 1, to make it harder for companies to reduce the list price of their medicines. So, while it is true our companies set the list price of the medicine, PBMs are responsible for setting the terms of coverage and access and cost sharing that patients have, and their preferences do matter.

And when companies have attempted to lower their list price, as they did with insulin and hepatitis C medicines, that was not met with cheers, as JC testified, but rather oftentimes exclusions from formularies as a result of doing that. They often also do not prefer biosimilars and lower price generics, as I referenced in my testimony. The *Wall Street Journal* just this past week noted that they often overcharge by thousands of dollars generic medicines at their specialty pharmacies. So, I believe there is a pattern of behavior that has been well documented by economists and government agencies to demonstrate the large challenges that today exist with PBMs that are working not for the benefit of patients, but to the detriment of patients.

Mr. SESSIONS. And I would add too—Mr. Chairman, I know I am almost over my time, if not over—and that is I believe that PBMs use their competitive market advantage to hold others out of the marketplace, notwithstanding their own gift that they have provided themselves. So, Mr. Chairman, I intend to be a part of trying to bring some sanity to this, and that would be through transparency, but I really do appreciate Mr. Scott coming here. I think that the model with PBMs could work, but you cannot use your competitive size against other companies coming to the marketplace as our private pharmacies.

Even somebody as big as Albertsons, I think, they find themselves on the back side of these three largest companies who use, in my opinion, anti-competitive behavior, which should be against the Federal law. Mr. Chairman, I yield back my time.

Chairman COMER. Thank you, Chair. I now recognize Mr. Krishnamoorthi from Illinois for 5 minutes.

Mr. KRISHNAMOORTHI. Thank you, Mr. Chair. Mr. Scott, you said in a PCMA website post from February 14, 2023, "We can once again state unequivocally the independent pharmacy market is stable," correct? That is what you said in that post, correct?

Mr. SCOTT. That sounds correct. Yes, sir.

Mr. KRISHNAMOORTHI. Sir, according to the FTC as well as Fortune magazine, the number of independent pharmacies has gone down from 23,000 in 2010 to about 19,000 right before the pandemic, and it has not done that much better since. Mr. Chancy, I see in your testimony you say PBMs wreak havoc on independent pharmacy's financial health. Isn't that right?

Mr. CHANCY. That is correct.

Mr. KRISHNAMOORTHI. And one of the main reasons are what are called DIR fees, direct and indirect remuneration fees, correct?

Mr. CHANCY. Yes, sir.

Mr. KRISHNAMOORTHI. And those often amount to fees that basically claw back any amounts of money that were paid to the pharmacies to dispense drugs in the first place, right?

Mr. CHANCY. Yes, sir.

Mr. KRISHNAMOORTHI. According to the Centers for Medicare and Medicaid, CMS estimates that DIR fees have gone up by 91,500 percent between 2010 and 2019. You do not disagree with that, right?

Mr. CHANCY. I do not.

Mr. KRISHNAMOORTHI. And, Ms. Reilly, that does not contribute to stability in the independent pharmacy market, does it?

Ms. REILLY. It does not.

Mr. KRISHNAMOORTHI. So let me talk about patients for 1 second. The FTC is conducting a major study of PBMs currently. They have initially released some of their findings in a recent statement from the summer. Here is what they said. They said the following. "One patient told us she was required by her health insurance carrier to go through PBMs' specialty pharmacy, which significantly delayed medication she vitally needed to ensure she could have her baby." She says, "I may have lost the pregnancy because of the delays." Now, Mr. Chancy, that is consistent with your experience with specialty pharmacies, isn't it?

Mr. CHANCY. Yes, sir.

Mr. KRISHNAMOORTHI. Another finding from the FTC. This is dated again July 20, 2023. This is from an owner of an independent pharmacy: "To keep up with the costs of PBM practices and the ever-increasing cost of prescription drugs while keeping the pharmacy doors open, my mom, a pharmacist, was not able to pay her own wage for 4 months in 2019." Now, Mr. Chancy, is that consistent with your own experience?

Mr. CHANCY. Yes, sir, it is.

Mr. KRISHNAMOORTHI. And that obviously is not a sign of stability among independent pharmacies, is it?

Mr. CHANCY. No, sir.

Mr. KRISHNAMOORTHI. Now, the FTC at one time actually sent out letters that stated that at the state and local level, any efforts to increase transparency and disclosure for PBMs was somehow against the best interests of consumers. Now, they sent 11 letters out in the last 20 years. On July 20, they officially withdrew support for those various letters.

Let me just tell you about some of those letters very briefly. They said, "Freedom of choice provisions at the New York state level actually increased pharmaceutical costs for patients." They withdrew support from that letter. Another letter that they wrote on September 7, 2004, again from the Federal Trade Commission to California State Legislature, said that, "These particular bills that you are pursuing with regard to disclosure requirements hurts patients." The FTC has withdrawn support from that letter, and the list goes on and on and on. I have all nine—I am sorry—all 11 let-

ters here. This is garbage. The FTC has now officially withdrawn support from all of this guidance.

Mr. Chair, I request permission to enter remnants of these letters into the record.

Chairman COMER. Without objection, so ordered.

Mr. KRISHNAMOORTHI. That is what we have from the FTC. The FTC is conducting a wide-ranging study into what PBMs are doing in wreaking havoc on independent pharmacies and hurting consumers, and I can not wait to see that study. Thank you so much, and I yield back.

Chairman COMER. Thank you. The gentleman yields back. The Chair now recognizes Ms. Mace from South Carolina for 5 minutes.

Ms. MACE. Thank you, Mr. Chairman, and I applaud my colleague across the aisle. We want consumers to have choices, competition, and lower prescription drug prices. I am going to dive in here. I have several questions, and I would just appreciate just primarily yes or no answers from our witnesses today. We do not have a lot of time this morning.

My first question goes to Mr. Scott. You say in your written testimony that PBMs lower prescription costs by encouraging the use of more affordable alternatives to brand drugs such as generics? Is that correct?

Mr. SCOTT. Yes.

Ms. MACE. Can you also confirm that PBMs negotiate rebates with drug manufacturers in an effort to reduce the cost of those drugs?

Mr. SCOTT. Yes.

Ms. MACE. In March 2019, the Journal of American Medical Association expressed concern that your member businesses often exclude low price generics from coverage. Are you aware of those claims?

Mr. SCOTT. I am aware of the claims but not the specific study.

Ms. MACE. Interesting. In a purely competitive environment, I would usually say the market would take care of such anti-competitive practices. Is it true that Caremark, Express Scripts, and OptumRx make up about 80 percent of the industry? Yes or no.

Mr. SCOTT. No.

Ms. MACE. These are "yes" or "no" questions. So, they are not 80 percent of the industry. What percentage then would it be?

Mr. SCOTT. I believe there are three companies that make up 80 percent of the industry, Congresswoman.

Ms. MACE. And they are which ones?

Mr. SCOTT. Express Scripts and the two that you mentioned.

Ms. MACE. OK. That was the question.

Mr. SCOTT. I am sorry. I misheard you.

Ms. MACE. OK. Thank you. If you have three companies making up the vast majority, that is not really competitive at all of an industry. All right. Ms. Reilly, when does the patents for branded drug expire?

Ms. REILLY. Patents for medicines are just like patents for any other product. It is 20 years.

Ms. MACE. OK. People generally assume that a drug becoming generic will result in a price decrease. Our witness representing the PBMs alleges that they help reduce cost for consumers. In your

experience, do PBMs often exclude low price generics from the list of covered drugs?

Ms. REILLY. Yes.

Ms. MACE. Do PBMs often exclude lower-cost generics in favor of high-cost branded drugs, effectively eliminating the benefit of the short patent on drugs?

Ms. REILLY. Yes.

Ms. MACE. Do you believe they do this to cash in on drug rebates at the expense of patients?

Ms. REILLY. Yes.

Ms. MACE. All right. Mr. Chancy, this past session in my home state of South Carolina, they passed legislation that I worked on a number of years ago, which banned PBMs from permitting pharmacists from discussing more affordable alternatives. Have you or any pharmacists you know experienced these types of restrictions?

[No response.]

Ms. MACE. What was that?

Mr. CHANCY. Yes.

Ms. MACE. OK. You also expressed concerns that PBMs, which are often vertically integrated with their own pharmacies, are using their pricing power to harm independent pharmacies. Is that correct?

Mr. CHANCY. Yes.

Ms. MACE. And are you aware of a whistleblower lawsuit against CVS Caremark alleging that they sought to block generic competition?

Mr. CHANCY. Yes.

Ms. MACE. Do you believe these practices are commonplace across the PBM market?

Mr. CHANCY. Yes.

Ms. MACE. Do you believe that restrictions on pricing and rebates would result in more generics being prescribed at your pharmacies and a reduction in prescription drug costs?

Mr. CHANCY. Yes, I do.

Ms. MACE. Yes, I would agree. More competition in the market is better for every consumer. Less overreach from government, more competition in the private marketplace is better for everybody. Thank you, Mr. Chairman, and God bless you. I yield back.

Chairman COMER. Thank you. The Chair now recognize Ms. Lee from Pennsylvania.

Ms. LEE. Thank you, Mr. Chairman. Our Nation is facing an inequality crisis not seen since the Gilded Age. At its core is the unprecedented corporate greed that has inflated prices, giving massive bonuses to C-suite executives and left the American people struggling. The harm, of course, falls disproportionately on black, brown, marginalized, and poor folks who are already struggling the most. Our healthcare system is one of the worst offenders with some of the deadliest caused from big pharma, to pharmacy benefit managers to big insurance companies and "nonprofit hospital monopolies" that abandon communities like mine. Every level of our healthcare system is being exploited to drive money straight into stockholders' pockets. For example, it appears that PBMs are leveraging their role at the center of the healthcare system to extract profits from players at multiple points. Reporting even sug-

gests that the fees PBMs charge to drug manufacturers increased by 51 percent over a 2-year period.

Ms. Reilly, what types of fees do PBMs charge your members, the Nation's biggest pharmaceutical companies, and how do those fees get passed on to customers?

Ms. REILLY. They charge a number of fees. I would argue most of those fees are quite opaque, meaning that they are not known necessarily to many folks, including the plan sponsors, their data fees, and all sorts of fees that oftentimes pop up out of nowhere, and, as you mentioned, have increased significantly. And I would argue, they provide no direct benefit to the patients.

Ms. LEE. Thank you. In your members' experience, are the fees charged by PBMs tied in any way to the list price of a drug, and how does this affect the price the consumer pays?

Ms. REILLY. Yes. I would say in virtually every instance, these fees are tied to the list price of the drug, which, as you suggest, the higher the list price, the larger the fee, the larger the rebate, the more money that goes into the pocket of the PBM.

Ms. LEE. Thank you. Your organization, which represents Big Pharma giants from Bayer to Pfizer, and, until recently, represented opioid pushing Purdue Pharma, is running an aggressive ad campaign blaming PBM rebate practices for high drug prices. What motivated that campaign, and how much did you all spend on that campaign?

Ms. REILLY. Well, what motivated the campaign is to shed light on the practices that have been pervasive over the past many years, which is PBMs overcharging patients at the pharmacy counter, not passing, you know, the significant rebates, over $200 billion a year, back to the patients to lower the drug prices they have.

Ms. LEE. How much did you spend on it?

Ms. REILLY. I would have to get back to you. I do not know the total amount spent on that ad campaign.

Ms. LEE. OK. Thank you. The United States pays by far the highest prices for prescription drugs in the world. Pharma member Novo Nordisk is charging Americans with diabetes $12,000 for Ozempic, while the exact same drug can be purchased for $2,000 in Canada. Pharma member, Eli Lilly, is charging Americans nearly $200,000 for Cyramza to treat stomach cancer, a drug that can be purchased in Germany for $54,000. Pharma member, Sanofi, is charging America over $200,000 for Caprelsa to treat thyroid cancer, a drug that can be purchased in France for $30,000. Pharma member, Gilead, is charging Americans with non-Hodgkins lymphoma $424,000 for Yescarta, a therapy that can be purchased in Japan for $212,000. Ms. Reilly, do you really expect this Committee to believe that the blame lies entirely with PBMs and not also with your members?

Ms. REILLY. I would say all of the prices that you quoted are list prices for the medicines.

Ms. LEE. Was rhetorical, but I do have another question. Why are several of your member companies suing to stop the Federal Government from negotiating drug prices through the Inflation Reduction Act?

Ms. REILLY. I would be happy to answer that question. We have strong concerns about the constitutionality of the IRA provisions that were passed. No. 1, they violate the separation of powers because Congress delegated too much authority to an outside——

Ms. LEE. What are your concerns about negotiating drug prices does your company have about allowing the Federal Government to negotiate drug prices?

Ms. REILLY. Was not negotiation, and let me be clear. It is a misnomer to call it negotiation. These are the choices our companies face. The government sets the price of a medicine. It is a take-it-or-leave-it-price. If we choose not to pay the price that the government offers us, we face two options: one, a 1,900 percent tax on the sale of every single medicine sold, or we can——

Ms. LEE. Well, it seems that the American people are receiving that tax right now on prices that are incredibly over expensive, so thank you so much for cost. Mr. Scott, I would also like to hear your take on this, your claim that PBMs use the fees they charge drug manufacturers and pharmacies to create cost savings in the system. Can you give me some concrete examples because it sounds to me like they are using these fees to churn an additional profit.

Mr. SCOTT. Yes. I think we could look specifically at the Medicare Part D Program where it has been documented that virtually 100 percent of the rebates that are negotiated are passed back to the Part D plan sponsors, and we have seen that deliver a steady low premium for Part D beneficiaries over a number of years.

Ms. LEE. Thank you. I am taking my time back up, but I want to end by saying these profits for big corporations grow, the American people suffer. It is despicable that more than 500,000 households go bankrupt each year because of medically related debts. Healthcare is a human right. It is about time we started treating it that way. I yield back.

Chairman COMER. Thank you. The Chair now recognizes Mr. LaTurner from Kansas for 5 minutes.

Mr. LATURNER. Thank you, Mr. Chairman, and welcome to all of you joining us here today.

Mr. Chancy, we have seen examples in the past of PBMs engaging in spread pricing where the PBM charges payers more than what they reimburse the pharmacy and then pocket the difference. In my home state of Kansas, accusations of this practice were recently settled for $26.7 million. How difficult is it for pharmacies to tell that they are being reimbursed less than what the payer is paying to the PBM?

Mr. CHANCY. We are not always aware of how much they are charging the payer, but I will give you an example. I worked with a self-insured company in my area, and we had a specialty drug that we filled for that company and the next field they mandated to go to the PBM. The PBMs wanted to approve the rate for me. They ended up charging the company $300 more when it went to their mail order. So, we see instances like that that happen, so we know it is there.

Mr. LATURNER. But you would assume that it is happening, and you do not know it a lot of the time.

Mr. CHANCY. That is correct.

Mr. LATURNER. Yes, I assume that happens quite a bit. Mr. Scott, do you believe that additional transparency in the price setting of prescription drugs is important?

Mr. SCOTT. Yes, transparency can be beneficial.

Mr. LATURNER. Just last week in the *Wall Street Journal*, Mr. Scott, they ran an article on the price of Imatinib, the generic form of the cancer drug, Gleevec. According to the report, this drug went generic in 2016 and can be bought today for as little as $55 a month. But if you happen to have CVS or Cigna, the same drug can cost as much as $6,600 a month. The article makes the claim that this in large part is due to the role of PBMs and PBM-owned pharmacies. How would you respond to the claims laid out in this article, Mr. Scott?

Mr. SCOTT. Thank you for the question, Congressman. I saw the article as well, and I would start by level setting that the PBM's goal is always to manage to the lowest net costs for the drugs that they are offering to patients in any particular plan. I know there were some survey data as a part of that *Wall Street Journal* article that conflated what is listed in the Medicare Plan Finder, which is the maximum possible highest contracted rates, which does not really show what the average patient pays out-of-pocket. Our goal is lowest net cost.

Mr. LATURNER. I understand your goal. If you will just address the contents, what I just said, that when the generic can be bought today for as little as $55 a month, but if you have CVS or Cigna, it can cost as much as $6,600 a month. How can you explain that to the American people?

Mr. SCOTT. Without having the specifics on a particular drug, if you look——

Mr. LATURNER. Let us stipulate that it is true. How is that fair? Would you agree that it is——

Mr. SCOTT. There may be multiple versions of the same generic drug at different price points and also different issues about supply availability which have to be taken into account.

Mr. LATURNER. So, you would say there is a scenario by which that it would make sense and be fair and reasonable that it could cost $55 a month for generic, but if you have CVS or Cigna, it is $6,600 a month. There is a scenario in your mind where that makes sense and that is fair.

Mr. SCOTT. There are scenarios where other factors beyond cost come into consideration, and in those outliers——

Mr. LATURNER. Granted, but that big of a delta?

Mr. SCOTT. Well, in those outliers, I think the plan sponsor has to be very thoughtful about benefit design and out-of-pocket exposure for patients on that drug.

Mr. LATURNER. You said in your testimony that choice and flexibility in the market are a foundational principle for effective prescription drug coverage and delivery. Does the fact that the three largest PBMs currently make up 80 percent of the market not run counter to that foundational principle of choice and flexibility?

Mr. SCOTT. Actually, the trends that we are seeing are more and more entrants in competition in the PBM marketplace. And that choice and flexibility has benefited by having large companies that can provide certain services as well as smaller individualized com-

panies that provide more tailored services. That is the definition of having different models to choose from for any given employer.

Mr. LATURNER. Eighty percent, three PBMs?

Mr. SCOTT. Oftentimes you will see some larger PBMs be able to use that scale, which is really important in negotiating with large drug companies to be able to have broader populations of patients and beneficiaries that they represent in order to help bring down the net cost of the drug. So, scale can matter as a value proposition for many employers when they are choosing their PBM.

Mr. LATURNER. Lori Reilly, are new generic drug suffering as a result of PBM coverage decisions to prefer higher price drugs with high rebates over lower list price drugs? Can you give an example of this?

Ms. REILLY. Yes, I think there is evidence of that. We saw it with not just new generics, but lower-price brand medicines that have entered the insulin example, the hepatitis C example, where our manufacturers have issued lower price products in the hopes that those would get picked up by the PBMs because they would be lower cost to the consumer because everyone says they want pharma to lower their list prices. When we actually do lower their list prices, they do not get covered by the PBM.

Mr. LATURNER. Really quick, just answer the question quickly. Has market consolidation enabled and incentivized them to negotiate higher rebates?

Ms. REILLY. Yes, I think actually negotiation works in the system. The challenge is how does those rebates get passed on to the patient that needs them, and I think that is what is broken in the system.

Mr. LATURNER. Thank you. I yield back, Mr. Chairman.

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

Ms. NORTON. Thank you, Mr. Chairman. Professor Conti, as Americans, we are the global exception when it comes to drug prices because we face exorbitant prices for lifesaving prescription drugs. During the Committee's first hearing on pharmacy benefit managers in May, Dr. Miriam Atkins, an oncologist, described a situation in which one of her patients was sent a $1,000 bill for a drug as part of cancer treatment. Dr. Atkins explained that patients are unable to afford this cost, "just will not take the medication," and then "that will affect their life expectancy." Professor Conti, how do high drug prices harm patients that seek lifesaving care from their providers?

Ms. CONTI. Thank you so much for the question. Financial toxicity is real. It is real among Americans who are facing a dry diagnosis and treatment of cancer and other conditions. Our evidence suggests that more than 40 percent of people with some types of blood cancer are facing financial toxicity that makes them choose between filling their medications and paying their rent. This is a real concern and one that is affecting patient's health and their ability to take care of themselves and their families.

Ms. NORTON. Thank you, Professor Conti. I have another question for you. According to one outside group, and here are some astounding statistics, one-half of U.S. adults say they have difficulties affording healthcare. It is half the people who live in this country

—and 1 in 3 adults ages 60 to 64, and 1 in 5 adults aged 65 and older—paid more. And here is another astounding number: more than $2,000 annually and out-of-pocket costs for the healthcare. I do not know how they do it.

High prescription costs can have a devastating effect on patients and families. Last Congress, President Biden signed into law the Democratic-led Inflation Reduction Act. Under this law, out-of-pocket costs for patients covered by Medicare Part D will be capped at $2,000 per year starting in 2025. This will improve the lives of 1.4 million Americans covered by Medicare. It will lead to substantial savings for patients who need expensive medications. Professor Conti, in addition to saving patients money, how will the Inflation Reduction Act's drug pricing reforms improve long-term health outcomes for Americans seeking care?

Ms. CONTI. Thank you so much. The IRA provisions are a substantial evolution in access to prescription drugs for Americans. Right now, seniors have greater access to insulin based on IRA provisions. Seniors also have better access to vaccines that prevent serious illness. And finally, Part D redesign will extend access to patients for 49 million Americans, starting in the next year. This is a major, major step forward for population health and individual health as well.

Ms. NORTON. Thank you, Dr. Conti. I yield back.

Chairman COMER. The gentlelady yields back. The Chair now recognizes Mr. Burlison from Missouri for 5 minutes.

Mr. BURLISON. Thank you, Mr. Chairman. We have heard a lot about the 80 percent number, and while it sounds extremely disturbing, I just looked up, in the short time that I have had, various marketplaces. Are you aware, Mr. Scott, that Lowe's, Home Depot, and Menards compose 87 percent of the home improvement market?

Mr. SCOTT. That sounds right.

Mr. BURLISON. That is terrifying. Terrifying. Can you imagine the impact on consumers? Oh my goodness. Can you imagine how much that they are putting the squeeze on Black & Decker and DeWalt, right, because if DeWalt and Black & Decker want to sell their products, they have got to deal with Lowe's and Home Depot, right? Maybe what we should be doing, Congress, is studying the spread or the pricing that Lowe's or Home Depot have on some of the products that they are selling, like Black & Decker and DeWalt, because we want to make sure that we, the consumers, are taken care of, right? That is what this place is all about: the government stepping in to take care of the consumers. Wouldn't it be interesting if Black & Decker and DeWalt decided to enter into a campaign? That is really what they need to do.

Ms. Reilly, let me ask you this. How much has your industry spent in television advertisements demonizing PBMs?

Ms. REILLY. I do not know the exact amount. Happy to report back.

Mr. BURLISON. Well, I have an article that I will submit to the record that pharma spent over $9 million on anti-PBM advertising. Mr. Chairman, if I could submit that to the record.

Chairman COMER. Without objection, so ordered.

Mr. BURLISON. Thank you. Mr. Scott, I am actually interested in what we can actually do to reduce cost. In my opinion, and I might be the only one on this Committee who has actually been in the position of negotiating with PBMs of deciding what PBM that we are going to use and purchase or enter a contract with over 100,000 lives, and I can tell you, if you are in that situation, you know there is choice. There are a lot of PBMs to choose from, and not a single one is coming to the table saying we are going to increase your cost for your patients. Every one of them is bringing down those costs, so as the employer, I am telling you that eliminating the opportunities of PBM will only increase the premiums for those insured.

So, the question that I have within the 2 minutes, Mr. Scott, what can we actually do that would reduce the costs of pharmaceuticals?

Mr. SCOTT. Thank you, Congressman, for the question, and I would say a couple of things. I think you are exactly identifying one of the primary value propositions that employers measure a PBM on, which is are they going to be able to bring down my net cost and help me to provide affordable benefits. And the PBMs, as has been recognized, I think, have a very strong track record of delivering about $145 billion in value for the system every year through that work of negotiating discounts.

Where we sometimes get caught up is when we see that the balances I referenced in the use of patent system is being leveraged in inappropriate ways to keep new competitor drugs off the market. Where there is no competition, it is a lot harder to leverage that to negotiate savings on behalf of plan sponsors. Looking at some of those patent practices, we think, would be an important step to really making that a competitive marketplace.

Mr. BURLISON. What about the dynamics with the biosimilar drugs? Is there a lot of opportunity with that?

Mr. SCOTT. Absolutely. And I think we have seen that in the few instances where biosimilars have already come into the marketplace. Humira is a great example of where the competition is only coming online this year, and we can analyze what happened in the competitive marketplace so that it was not on the market sooner. But as those have come into the market, they are having a positive effect on bringing down the cost of the originator products and providing more affordable options dedicated to plan.

Mr. BURLISON. Thank you. The way I see it, Mr. Scott and others, is that this is similar to what Netflix has done to the entertainment industry. Netflix was a great disruptor. It negotiated with the entertainment industry en masse because of their large subscriber pool. What is ridiculous to me is that if Blockbuster came here, they would probably be screaming in front of Congress that they are having to close to the huge membership pool of Netflix and that Netflix drives everyone to their product. Thank you, Mr. Chairman.

Chairman COMER. Thank you. The Chair now recognize Ms. Brown from Ohio for 5 minutes.

Ms. BROWN. Thank you, Mr. Chairman. In this country, far too many people are forced to choose between paying for their medications and keeping the lights on. This impossible choice is a crisis

largely manufactured by Big Pharma and pharmacy benefit managers. In 2021, Oversight Committee Democrats published a result of a 3-year-long investigation into pharmaceutical companies' drug pricing and found pharma giants target the United States' market, exploiting taxpayers with higher prescription drug prices than anywhere else in the world. Our investigation found in the past, Big Pharma has taken advantage of Medicare's inability to negotiate and hike prices on patients to the tune of $25 billion over a 5-year period. That was just for the seven drugs we investigated.

As a result of Democrats passing the historic Inflation Reduction Act, which was signed into law by President Biden, Medicare is now finally able to negotiate directly with drug manufacturers to bring down the price of lifesaving prescription drugs. President Biden is putting dollars back into the pockets of American families and Big Pharma on notice for decades of unchecked price gouging. So, Dr. Conti, I want to ask you, how will Medicare's negotiation of drug prices lead to lower out-of-pocket costs for seniors?

Ms. CONTI. Thank you so much for the question. IRA passage is a major evolution in access to prescription drugs for Americans, and especially for seniors. We expect that insulin-dependent diabetics will receive immediate savings at the pharmacy counter and improved access, so will adults seeking vaccines and their children seeking new vaccinations to prevent serious illness. And seniors who are covered under Medicare Part D will directly benefit from Part D redesign, improving access and improving both their individual health, but also population health.

Ms. BROWN. Thank you. And Dr. Conti, how will Medicare's ability to negotiate lead to better health outcomes for millions of seniors and patients with disabilities?

Ms. CONTI. Sure. We expect that approximately, what, $3.4 billion in out-of-pocket costs were imposed upon American seniors with the 10 drugs that are slated for negotiation first this year. Lowering those costs even 20 percent at the pharmacy counter will expand access and hopefully lead to better individual outcomes and population health.

Ms. BROWN. Thank you, and you kind of led into my next question. Can you expound on the significance of these 10 drugs?

Ms. CONTI. Sure. Approximately 10 million Americans are taking those drugs currently, and we expect that, again, their cost savings at the pharmacy counter will amount to approximately 20 percent, maybe more. That will be significant savings for them and, again, lead to greater access in using these drugs.

Ms. BROWN. Thank you, Dr. Conti. So, President Biden's announcement regarding these 10 drugs is just the start. Thanks to the Inflation Reduction Act, Medicare will be able to negotiate the price of even more lifesaving drugs in subsequent years, an additional 15 drugs starting in 2027, another 15 in 2028, and another 20 each year afterwards. We must build on the successes by increasing access to affordable and equitable healthcare and requiring comprehensive transparency rules in drug pricing. If my Republican colleagues truly wants to reduce staggering drug costs, they should join with the Democrats to build on the achievements of the Inflation Reduction Act. And with that, I yield back. Thank you.

Chairman COMER. The gentlelady yields back. The Chair now recognize Mr. Higgins from Louisiana for 5 minutes.

Mr. HIGGINS. Thank you, Mr. Chairman. I appreciate the panelists for being here today.

It is a really painful discussion for my constituents and my family back home. I feel that our Nation, in many ways, has betrayed our biblical responsibility to care for our elders. It is a real problem. The Word tells us, "Cast me not off in the time of old age, forsake me not when my strength faileth." I am not sure how does PBMs sleep at night. It is an issue. Our elders are like treasures. They are commonly frightened. They have no financial stability, too commonly alone.

They are constantly receiving confusing letters in the mail from insurance companies and doctor's bills and benefit plan offers and wild promises from this company and that agency and the other offer. They might think this is funny. You find it funny, talk to me in the hallway. We will see how that conversation goes. We are talking about our elders in our country that deserve to be respected and cared for. And one of the last remaining remnants of what America was when we cared for our elders was our pharmacists, and our pharmacists have been driven out of business by PBMs and the cost of medicine. Let me see another giggle, you will meet a side of me you do not like.

Mr. Chancy, you have been in the pharmacy business for generations, sir. That is what your statement clarifies. I recall growing up the seventh of eight children. I was born in 1961. My father, we raised and trained horses. We did not have money. We did not have health insurance. What you know we had, we had a doctor, we had a pharmacist, and we get injured, injury was common in a life like that, would get to the doctor, my dad would pay him cash. There was no middleman. There was no government bureaucracy. There was no insurance restrictions and mandates. There was my family, there was the doctor, there was the pharmacist, and it was a formula that worked.

Mr. Chancy, you come from that background, it sounds like, sir. Yes, I am quite sure you recall those days, your grandparents and your parents. I am going to turn the floor over to you. Tell us from your heart from your story of how this deep pain is being brought into your community, especially to the homes of your elders, by the monopolistic power of these PBMs and the cost of healthcare medicines by elders. I will give you my remaining minute, Mr. Chancy.

Mr. CHANCY. Thank you, sir. I grew up in a small town, and my father was a pharmacist, and he cared for the people in that community. We had relationships with them, and they depended on us, and it was back in the day before we had PBMs. It was all cash, and we charged to those patients that could not pay for it at the time. And there are four counties in the state of Georgia that the only accessible healthcare practitioner is a pharmacist. There are no doctors. There are no hospitals or anything. And if we do not do things to change, if we do not have PBM reform, then we are going to have pharmacy deserts, not just in rural America, but in the cities.

So, it is critical that we make some reform that is going to allow us to stay in business and take care of the seniors like you are

talking about. It is critical for us to be able to do that. Under the system we have now, we are restrained, and you talk about wreaking havoc on our business. In 2018, we paid $865,000 in DIR fees. In 2022, that almost doubled, and this year alone, I am at $1.2 million just through July. Now, that is taken away from jobs, and that is taken away from opportunity in small communities that I live in. So, I think there needs to be a lot of reform. We need to have clear transparent pricing, and we also need to stop the ability for the PBMs to be steering patients to other pharmacies where they do not have a relationship and people are not there to care for them.

Mr. HIGGINS. Thank you, Mr. Chancy.

Mr. CHANCY. Thank you.

Mr. HIGGINS. Mr. Chairman, my time has expired. I yield.

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

Ms. BUSH. Thank you, Mr. Chairman. St. Louis and I are here today in defense of patients, pharmacies, and healthcare providers. Before I came to Congress, I worked as a nurse in a hospital and a community mental health agency. I had to worry every single day about whether my patients could afford the medication that I knew they needed. It is an awful part of an otherwise extremely rewarding profession.

We know that PBMs play a critical role in the pharmaceutical supply chain, but that does not mean that drug manufacturers are being let off the hook. Big Pharma plays a leading role in drastically and unethically raising the cost of lifesaving medications for the sake of profit and for the sake of greed. Notably, only three companies

—OptumRx, CVS Caremark, and Express Scripts—make up a staggering 80 percent of the PBM market, which we have heard earlier. Three companies play a central role in making decisions about what medications are covered by healthcare, insurance plans, and the cost of those medications.

PBMs negotiate pricing with drug manufacturers and use these negotiations to determine which medications are covered on someone's insurance formulary. The difference between life or death is a series of shady contracts struck between the drug manufacturer, the PBM, the insurer, and the pharmacy. The end result of this complicated design is patients are expected to shell out thousands of dollars in out-of-pocket medical costs, even for lifesaving prescription medicine. Professor Conti, how does PBM control over drug formularies affect the medications patients are able to receive at the pharmacy?

Ms. CONTI. PBMs steer patients to use, in general, the cheapest and most effective drug for them. That includes over a 90-percent utilization of generics and biosimilars when they are available. This benefits patients, and it benefits their health.

Ms. BUSH. My understanding is that PBMs consider formularies, though, as sensitive business information. PBM decisions about which medications to cover and how to sort them into tiers or rankings are generally not available to patients, and as a nurse, I was never able to get that information early. I had to wait until

they sent us the book, and this was very devastating and horrifying for so many of our patients.

Professor Conti, if a patient does not understand why a specific medication is chosen for inclusion on a PBM formulary, how will they know that the price that they are being asked to pay at the pharmacy is a fair price?

Ms. CONTI. They will not.

Ms. BUSH. Thank you. It is clear both the PBM and the pharmaceutical industries are in desperate need of reforms that increase transparency and reduce costs for patients and for pharmacies. In fact, Barnes-Jewish Hospital, the largest hospital in Missouri and the largest private employer in my district, has the following to say about their experience with PBMs: "Often pharmacy benefit managers create additional financial and administrative challenges for many providers, pharmacies in particular, and delay or deny patients' access to the medications they need." The biggest hospital system in the state of Missouri is at the mercy of PBMs. They often require step therapy treatments or burdensome prior authorizations before covering medications ordered by a healthcare provider, which is devastating to patients and their care. They lose jobs, they lose homes, they can lose children because they are now unstable on medications. And I am speaking to that being a mental health nurse that watched it happen to my patients over and over again. They were stable, and then the new formulary came out.

Insurance companies, PBMs, and Big Pharma are deciding what medications patients should take, not patients with their doctors. These obstacles compromise patient care at every single turn by denying patients the lifesaving medications and the treatments that they need. As a nurse, I have seen it over and over with the patients I have cared for, as I said, who were stable on medication, some for decades. Their care was upended when their PBMs and insurance companies decided that their medication was not profitable. The health and well-being of the people of this country lie in the hands of industries represented right here today.

How can we be confident that these companies are acting in the patients' best interest if they face so little competition? People with terminal illnesses, disabilities, seniors, and our most vulnerable members of our community deserve more. I implore my colleagues on both sides of the aisle to enact sensible legislation to drastically reform the PBM industry and get drug prices under control once and for all. Thank you, and I yield back.

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

Mr. PALMER. Thank you, Mr. Chairman. Mr. Burton, I have got some questions for you. How do the rebates affect the biosimilar market, and be as concise as you can because I have got a few others.

Mr. BURTON. Absolutely. Simplest way to look at it, biosimilars right now have a choice: they can price, keep a high price and offer a rebate, or they can drop their list price which benefits patients, but dropping their list price is not getting them on formulary. So, they have a choice of engage in the rebate games, which has a chance of getting them on coverage, or have a lower list price which benefits patients but is not being covered by PBMs.

Mr. PALMER. So, what you are saying is this has a negative impact on patients.

Mr. BURTON. Yes, sir.

Mr. PALMER. Well, let me ask you this. The passage of the Inflation Reduction Act permitted the Centers for Medicare and Medicaid to negotiate the prices of some prescription drugs covered under Medicare Part D. As the Senior Vice President of the Association for Accessible Medicines, Mr. Burton, how will the Inflation Reduction Act's government price-setting scheme affect patient access to lower-cost generic and biosimilar medicines, in your opinion?

Mr. BURTON. Yes. We are concerned that the negotiation provisions of IRA could undermine generic and biosimilar competition. They could reduce incentives for generic and biosimilar entry. Depending on how the price is set by CMS, that could actually end up rewarding the brand and giving the brand more of a monopoly for a longer period of time, if it reduces incentive for generic entry.

Mr. PALMER. But it also reduces the number of different types of drugs that some patients might need. Would that be an accurate statement?

Mr. BURTON. So, I believe the way IRA works, as they choose products, generics and biosimilars are looking for certainty. In order to invest, I mentioned biosimilars can cost several $100 million to develop. Without knowing what products will be negotiated and what the negotiated price will be, it becomes challenging for a biosimilar manufacturer to make that investment commitment years before that price is ever negotiated. And we believe that biosimilars and generics, at the end of the day, will drive prices lower than anything CMS negotiates through this scheme. We think there is a long track record showing that.

Mr. PALMER. So, what you are saying to the Committee is that this price setting could impact the availability of generics and certain biosimilars.

Mr. BURTON. Yes, sir.

Mr. PALMER. OK. I think that it stands to reason then that it would make these drugs less available to patients. Can you explain how that works because a moment ago you were talking about if they are not listed.

Mr. BURTON. Yes.

Mr. PALMER. That seems to indicate to me that it makes them less successful to patients because they are not going to be covered, but if they are listed, it is going to make them more expensive to the patient, so it is a confusing game that is being played. But the thing that I do not want to get lost in this is that the patient is not the No. 1 concern here.

Mr. BURTON. I think that is right. I think if you look at the market as it stands today, the biosimilars that are on the market are not being preferred. They are not being driven by PBMs. PBMs are not driving coverage of biosimilar insulin. They are not driving coverage of the biosimilar Humira. If we look forward at what will happen under an IRA price-setting approach. There seems to be an assumption that a brand drug will stay on that market in perpetuity. That is probably not going to be the case. So, you need biosimilars. You need generics to be able to come onto the market

to fill that which, frankly, pushes the brand into other markets into pursuing new therapies. It is that dynamic, that competitive dynamic that we are concerned could be lost.

Mr. PALMER. I really appreciate your response to the questions. I appreciate all of the witnesses being here and the unanimity that I think I see here in this Committee in regard to this issue. With that, Mr. Chairman, I yield back.

Chairman COMER. The gentleman yields back. The Chair now recognizes Ranking Member Raskin from Maryland for 5 minutes.

Mr. RASKIN. Thank you, Mr. Chairman. I want to thank Mr. Palmer for his line of questioning and for that point that he just made because I agree very much that there is a real consensus on this Committee about a major problem the American people are facing. And I heard it in Ms. Bush's comments and Mr. Higgins' comments, too.

Mr. Scott, let me ask you something. You said something that just struck me. You said that your mission was to lower prices for patients? Did I get you right when you said that?

Mr. SCOTT. To lower costs.

Mr. RASKIN. To lower costs for patients. There is such confusion in this field, and I want to get it straight. You are a private for-profit company, right?

Mr. SCOTT. The companies we represent are largely not——

Mr. RASKIN. The PBMs are private for-profit companies that you represent, so isn't everybody's mission really to make money? And if they can make money by lowering costs, they will do it, but your mission is really to make money for the shareholders, right, for your component members.

Mr. SCOTT. Right. The companies are only going to be profitable if they are accomplishing the mission of lowering costs for the people who hire them.

Mr. RASKIN. So, I guess that is the question I want to ask you. In July, a MedPAC report found that PBMs had taken in over $50 billion in drug manufacturer rebates that were not shared with patients at the counter in 2021, $50 billion that were savings that were made, that it is rebates from manufacturers that were not passed on. And I know you made a very compelling case that there is a lot of money being made by the manufacturers and that represents most of the costs, and all that might be true. That might be a separate problem for a separate hearing, but isn't it the case that there were $50 billion in 2021 that your members got in rebates that were not passed on to the patients?

Mr. SCOTT. The rebate value can benefit patients in a number of ways. It is up to the plan sponsor to decide if that is by making their healthcare benefit more affordable and keeping their premium down, adding other elements to the benefit because they have those savings, like adding vision or dental, or applying that to help offset their out-of-pocket cost at the pharmacy counter. And that is a balancing act the plan sponsor has to determine as they are designing their benefit.

Mr. RASKIN. Yes. I mean, you are not disagreeing that sharing a greater portion of the rebate dollars would lower costs at the drug counter and, thereby, increase people's adherence to the drug protocols.

Mr. SCOTT. I think it is a very reasonable conversation to have about whether those tradeoffs are being balanced correctly and all.

Mr. RASKIN. All right. A small handful of players dominate the PBM market and have outsized power. Three companies—CVS Caremark, OptumRx, and Express Scripts

—control 80 percent of the PBM market. Each of the three holds a staggering amount of power. CVS Health reports to CVS Caremark. Its PBM provides pharmacy benefit services for more than 110 million people. The question is whether these companies use their market power to enrich themselves at the expense of the patients and other players in the healthcare system. And the high degree of market consolidation is intrinsically troubling, but we are also seeing increasing integration of PBMs with other institutional players in the healthcare system. Each of the three big PBMs are owned by a parent corporation that also owns a major health insurance company, a specialty pharmacy, and a medical services provider. We basically have something like government-controlled healthcare, but without the government, we are having entire systems grow up.

Professor Conti, can you explain how this high degree of market concentration could allow PBMs to prioritize their profits over keeping prices low across the system? And I wonder if you could respond to Mr. Scott's point about how there might be other benefits that are masks that are actually being given to the patients?

Ms. CONTI. Sure. Our system is predicated on competition. Vertical consolidation between PBMs and plans can erode the competitive benefits to consumers both in terms of lowering costs but also expanding benefits. There is emerging evidence suggesting consolidation does not produce lower premiums, and it does not produce more expanded access to drugs, particularly drugs that people depend on to manage their current disease.

Mr. RASKIN. Isn't that the whole premise of antitrust economics?

Ms. CONTI. Sure. So, consolidation can improve access and lower costs, more bargaining power can produce lower price concessions that expands access. However, in this particular market, we are not seeing evidence that expanded consolidation is driving prices lower.

Mr. RASKIN. Do you have a theory as to why it is not working that way? And forgive me, Mr. Chairman, I will yield back after this?

Chairman COMER. The Chair now recognizes——

Mr. RASKIN. If she could answer that question, yes, sir.

Chairman COMER. Feel free to answer the question.

Ms. CONTI. Sure. Vertical consolidation is very tricky. There is a lot of economic theory that suggests it can be perverse.

Mr. RASKIN. Thank you. I yield back, Mr. Chairman.

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

Mr. FALLON. Thank you, Mr. Chairman. As a Member of Congress that represents a rural area and there are increasing numbers of people leaving to go into the suburbs in the cities, and the folks that are left that are representing rural areas, I think we need to increase our vigor and fierceness. And one of the concerns I have, of course, being a strong proponent of the free market is

also the accessibility of rural healthcare. And the free market, as we all know, is founded on choice, and that choice is between products and services, and the consumer makes that choice ultimately. And why the free markets work is because it is working, in theory, the right way. The market is competitive, and the price is manageable.

But when you have three PBMs controlling 80 percent of the prescription drug market and they are becoming larger every day, this is not really free market. It tends more to lean toward cronyism. And so, what is particularly hurting in the rural areas like my constituents are there are fewer pharmacy options, the medium and small pharmacies are being bought up by the larger ones, and the increasing vertical integration that we are seeing in the system exacerbates that issue.

So, in fact, the big three PBMs controlling the market, each one of them is also integrated with an insurance company. So, one tool we are seeing PBMs use to manipulate the market is called co-pay accumulators. And essentially, real simple, I mean, it does not matter if I am paying out-of-pocket, say, $1,000, or I get a coupon, or a charity is paying for it. That $1,000 I spent should go toward my deductible. And that is, I think, one of the reasons why we have seen 20 states ban co-pay accumulators, and Puerto Rico and my home state of Texas just did the same thing. So the Texas legislature, of which I served there for 8 years, has recently banned them. And, Ms. Reilly, I wanted to ask you if you could speak to how co-pay accumulators are used by the PBMs, and how they impact what our constituents pay.

Ms. REILLY. Yes, absolutely. Thank you for the question. So, the way co-pay accumulators work is that, at times, patients, as has been noted by the Committee, struggle to afford their medication. They may need a medicine that is on the high tier of a formulary where they are asked to pay oftentimes 40 percent based on the list price of the medicine. For many patients, that is not access. As a result, pharmaceutical manufacturers often provide assistance to patients in the commercial market to help better afford those medicines. And so, patients use that assistance when they go to the pharmacy counter to lower what they pay out-of-pocket in order for those patients to actually get the medicines they need.

The way accumulators work is that the PBM siphon the money off of that assistance. They take it for themselves, and they do not allow those resources to count toward the patient ever getting through potentially their deductible or hitting their out-of-pocket max. So, what oftentimes happens is patients find themselves mid-year, they have exhausted all the financial assistance that is on the card that has been provided to them. They realize they have made no progress toward meeting their out-of-pocket cap, and they are left with the unenviable decision of whether or not they can take their medicine or not.

As you noted, 18-plus states, including the state of Texas, have banned those. There is legislation in Congress called the HELP Copays Act, which would make this a Federal requirement that these types of programs can no longer be in existence to ensure that patients get the help they need because unfortunately, too often today, costs are left out of reach because of PBM formulary

design because PBMs are demanding that patients pay either the full list price of the medicine before they reach their deductible or, after their deductible, asked to pay a percentage of the list price of their medicine, not getting the benefits of negotiation, and then they turn around and take the assistance from the patient as well. It is not a good system. It is not working on behalf of patients, and I would encourage this Committee and others to look at the HELP Copays Act to make this a national prohibition.

Mr. FALLON. Do you think that it is fair to say that that the way in which the system works now, that the co-pay accumulators are essentially allowing the PBMs to double dip?

Ms. REILLY. Yes, absolutely. They get discounts and rebates from the pharmaceutical manufacturer for that. They then take the resources that the patient is providing them as well as the money off of the copay card, and take that money, too. So, they are getting it from both ends, which is why study after study has found that patients are often being asked to pay more, sometimes significantly more than the insurance company or PBM has for that medicine.

Mr. FALLON. Well, it makes sense that 18, 20-some-odd, something of that number of states have banned this practice.

Ms. REILLY. Absolutely.

Mr. FALLON. And hopefully we can look at that in a bipartisan fashion here in D.C. Mr. Chairman, I yield back.

Chairman COMER. The gentleman yields back. The Chair now recognize Ms. Stansbury from New Mexico for 5 minutes.

Ms. STANSBURY. Thank you, Mr. Chairman, and thank you to the Ranking Member and to all of our witnesses.

As somebody who is the primary caretaker of a member of my family, I have to say that this morning's Committee hearing has been pretty disturbing. And I think it is really important that the American people understand that there are private for-profit corporations that are getting in the middle of our family members getting lifesaving care, getting access to medications that are necessary and that their doctors have prescribed, and that it is for profit. It is to line the pockets of private corporations. This is not about healthcare, but it is also important, and I want to take a moment as we return back to that issue, to acknowledge the work that we have been doing to take on Big Pharma.

In fact, lots of folks have mentioned this this morning, but last year, we took on Big Pharma and we won, in fact, with the passage to the Inflation Reduction Act. We not only lowered certain prescription drug costs, like putting a cap on insulin—for example, if you live with diabetes, you now have your insulin capped at $35 a month—but it also empowered Medicaid to negotiate these certain prescription drugs and especially lifesaving drugs like blood thinners, which my family member who I take care of is on.

And so, it is important that the American people know how important this is for tackling prescription drug costs, and because we know so many of our family members are living paycheck to paycheck or Social Security check or Medicaid/Medicare reimbursements in order to survive. But that is why I find this practice of PBMs interfering in patient care so disturbing, and I really want to dig in and help people understand this because I think it is hard

when you get into all the jargon to really understand the visceral aspect of this.

So, Dr. Conti, I know, you have talked about this a lot this morning, but I want to take the American people on a ride to the doctor. In New Mexico, which is the state that I represent, sometimes it takes months to get in to see a specialist. We have a severe shortage of healthcare providers in our state, especially in our rural areas, so you are waiting months. You finally get in to see the doctor. You wait hours. You have driven hours to get to the doctor. You get your prescription. The doctor calls it into the pharmacy. You drive down to the CVS or the Walmart or wherever you pick up your prescriptions, and you get told at the counter that you can not have the medication that you have waited months to have prescribed—months.

And what I do not think most folks understand is that there is some group of individuals sitting in a corporate boardroom somewhere in America making that call, telling your pharmacy that they can not give you that drug, that lifesaving drug that your mother, your father, your grandfather waited for months to get. I mean, it is really outrageous when you think about it that folks are putting profits over the health and livelihoods and well-being of our family members, so you go. You are about to pick up this prescription. You are told you can not have it, and let me understand this. So, these PBMs are negotiating directly with the drug manufacturers. Is that correct?

Ms. CONTI. That is correct.

Ms. STANSBURY. And part of why they determine whether or not a certain drug gets put available for a specific pharmacy is that they are making a claim that it saves costs for the pharmacy or for the doctor, for the patient. But at the end of the day, the drug manufacturers are actually providing rebates to these companies that they get to pocket as a part of the profit margin that they make on these drugs. Is that right?

Ms. CONTI. Yes. Drug makers set the list prices of their drugs, but the discounts and rebates accrue to the PBMs and their subsidiaries.

Ms. STANSBURY. Right. So here we are, we are at the drug counter, we are trying to pick up this lifesaving drug that we have waited months for, and I am told that I can not pick up this medication for my mom who needs it because some corporate company manager has said I am going to make more money if we do not allow this drug to be sold at that pharmacy. Is that correct?

Ms. CONTI. I would say formulary exclusions are actually quite rare, but what happens at the pharmacy counter is that the price that is charged the patient can be exorbitant. And that is a function of both drug makers setting very high prices and PBMs not preferencing those drugs and the formulary to provide access to patient.

Ms. STANSBURY. So, this is actually a really interesting point because I have had this exact experience. In fact, a family member of mine was recently in the hospital, and when we went to go get the drug that was prescribed for them, it was going to cost $400 out of pocket. And that was because a private for-profit corporation had made a decision that it was more profitable for them to pocket

that profit than to serve our communities. So, Mr. Chairman, I am grateful that we are having this hearing. We desperately need to regulate and to address this issue because, as Representative Bush said, literally, lives depend on it. And with that, I yield back.

Chairman COMER. Thank you. The Chair now recognizes Mr. Grothman from Wisconsin for 5 minutes.

Mr. GROTHMAN. Sure, we will go with Mr. Chancy. How do PBMs negotiate drug pricing and reimbursement rates with community pharmacies, and what factors influence these negotiations?

Mr. CHANCY. Well, we are not actually involved in any of the negotiation on the pricing, and I am not quite sure how they come about what they do. We have a pharmacy service organization that actually negotiates or works out the plans with them. We have very little negotiations at our point.

Mr. GROTHMAN. OK. Does Ms. Reilly want to answer that? Would you have an opinion on how this happens?

Ms. REILLY. About how negotiation happens——

Mr. GROTHMAN. Right.

Ms. REILLY [continuing]. Between PBMs and pharmaceutical companies?

Mr. GROTHMAN. Right. How do they arrive at it?

Ms. REILLY. I am not party to those negotiations, but as I understand it, companies start with the list price, which is set by the manufacturer. They enter into a negotiation with the PBM. As I said before, the PBMs are solely responsible for setting the parameters of what their prescription drug benefit looks like. They determine if our medicine gets covered. I would just counter what Dr. Conti said about 850 medicines are actually excluded from formularies on a yearly basis. That number has shot up increasingly over the number of years, so it is actually a large number that is excluded.

Mr. GROTHMAN. Can you tell me why it shot up?

Ms. REILLY. It is a way for PBMs to try and drive greater rebates. So, they tell a company if you do not give us a rebate of this amount, we will exclude you from the formulary so that will cover your competitor product. So, they set the terms for what their drug benefit looks like, how much patients pay out-of-pocket, what tier of the formulary they are on, how much coinsurance they may have to pay. And then pharmaceutical manufacturers have to negotiate in order to try and get their drug approved in order to hopefully get their medicine on the preferred tier so that patients can actually access it at a reasonable price.

Mr. GROTHMAN. OK. I will give you another question. Insulin prices have been a growing concern for Americans. How have PBM practices, such as rebate negotiations and formulary replacements, impacted the affordability of insulin for patients with diabetes?

Ms. REILLY. Thank you for that question. Actually, the net price of insulin has actually decreased from 2007. We are actually lower today in terms of the net price of insulin than we were in 2007. But most patients have not necessarily felt that, again, because PBMs insist on charging patients a full list price of the medicine, not the negotiated rate. The typical insulin has a rebate of about 84 percent lower than what many patients are being asked to pay.

So, our companies have come forward. They have offered lower price versions of insulin in the hopes that those lower price versions would actually get covered on formularies, and typically, they have been rebuffed. The PBMs have not had an interest in putting lower price insulins on the market. All three of the insulin manufacturers earlier this year came forward and, starting January 2020, for all or offering insulin to patients, be it commercially insured or uninsured, for $35 a month as a way to circumvent the current system, again, where patients are often overcharged for medicines like insulin and made to pay the full undiscounted price when they go to the pharmacy counter.

Mr. GROTHMAN. Mr. Scott, how would you respond to that?

Mr. SCOTT. I would say a couple of things on insulin and then on the negotiation process. On insulin, as Lori noted, drug companies did happily lower the list price on a number of those products. And my understanding is that there is access being provided to those through the PBM formularies.

But essentially, what we are conflating here is not only did the list price come down, but did the net cost come down to the same low discount level because the PBM's job, when the PBM is negotiating with a drug company, is to try and get the competitors to each offer the discount. And whoever is going to take that net cost to the lowest point, that typically is what gets the formulary placement, if all the clinical considerations are equivalent. And a number of PBMs, I would also point out, have even, prior to those companies lowering their list prices, put programs in place to cap or limit out-of-pocket costs for insulin specifically to patients on plans.

If I could, Congressman, just respond to the earlier questions that you asked some of the other panelists. I have talked a little bit now about how we negotiate with pharma, and there is also a separate negotiation with the pharmacy. And Mr. Chancy makes a good point that oftentimes 83 percent of independent pharmacies are part of pharmacy services' administrative organizations that collectively bargain on behalf of thousands and pharmacies together with the PBM to help them negotiate favorable contract terms. So, I think that is a good point to highlight.

Mr. GROTHMAN. OK. The final question for Mr. Burton, how can Congress ensure that PBMs prioritize the inclusion biosimilars in formularies and promote their use to reduce healthcare costs?

Mr. BURTON. So, I think there are a number of opportunities. The simplest that we have encouraged that Representatives Kuster, Miller-Meeks, and others have introduced, would real simply require that Medicare plans prefer new generics and biosimilars when their price is less than the brand price. This still gives PBMs the opportunity to negotiate for a lower price. It still allows brands to exclude generics and biosimilars from the formulary. They just have to do so based on by lowering their price. So, I think what is getting lost in this discussion of lowest net is lowest net cost to whom. There is a lot of discussion of lowest net, but that is to the PBM, to the plan sponsor. That is not benefiting the patient, and I think we have to get this back to what gets the lowest cost medicine to the patient.

Chairman COMER. The gentleman's time has expired. The Chair now recognizes Mr. Casar from Texas for 5 minutes.

Mr. CASAR. Thank you, Chairman. Today, I really appreciate that we are having this Committee hearing to investigate drug pricing and the role that different actors in the system play in the exorbitant drug costs that our constituents pay. Americans spent $333 billion on prescription drugs in 2017, and by 2027, that number, by some reports, is projected to increase by about 75 percent. To me, that shows, and this hearing shows how there being so much self-interest in the system can hurt the patient's interest and that this is something we have to reform at all levels.

And so, before we get to my questions, I do want to go on the record about the important work that Democrats have done on this issue. The Inflation Reduction Act passed by Democrats in the Congress signed by President Biden, one, empowered the executive branch to negotiate drug prices paid by Medicare, and two, use those savings to cap out-of-pocket costs. That was an important step. There is more we need to do on issues of PBMs, on issues of drug pricing. But on this important bill that was signed and has gone into effect, so many people are going to be benefiting from these sorts of changes. But we hear oftentimes in the halls of Congress, from my colleagues on the other side of the aisle, that Medicare negotiating lower drug prices is going to reduce innovation because Big Pharma's profits may go down, and I just have trouble fully believing and understanding that. I appreciate that we have people from all across the industry here with us today.

Ms. Reilly, if I understand correctly, you represent many of the large drug manufacturers. Do you know how much the top five pharmaceutical companies made in profit last year?

Ms. REILLY. Not off the top of my head, I do not.

Mr. CASAR. The information that I have pulled up has that the answer is about $82 billion in profit last year from the top five pharmaceutical companies. Professor Conti, of the 210 prescription drugs approved by the FDA between 2010 and 2016, do you have a sense about how many were supported likely by taxpayer funding?

Ms. CONTI. Likely all.

Mr. CASAR. Yes. My understanding is that it is all of them. To me, we need to both address any kind of self-dealing that we see in PBMs. I appreciate that we are tackling that issue, but I also think that we should be looking at the entire picture and making sure that we are making sure that we are investing in innovation and research but also the enormous amount of profit that we see is also directly impacting the huge prices that everyday people have to pay. Negotiating drug prices, it is going to reduce the deficit and save seniors money, and if we end up going to a Medicare-For-All system eventually, those savings will accrue overall to the American public.

Now turning to the question of PBMs, we have heard that there can be these charges, direct and indirect remuneration fees, known as DIR fees, weeks after a medication is sold at a pharmacy. These can sometimes be unpredictable fees, can be challenging for independent and community pharmacies. DIR fees that PBMs charge have increased by large amounts, in some reports by thousands of percent, 100,000 percent in the past 10 years by some reports.

During Dr. Dwayne's testimony, it sounded like DIR fees and other fees that PBMs charge pharmacies can constrain the ability of independent pharmacies to stay in business. Dr. Chancy, how did DIR fees affect your members' ability to stay open and serve patients?

Mr. CHANCY. Thank you for the question. As I alluded to earlier, especially when the DIR fee started originally, they almost doubled every year. And in the last few years, from 2018 to 2022, it almost completely doubled in our small business, and this year through July, it is almost where it was last year, so we have seen a huge increase in DIR fees this year. This is the first year I think I have gotten calls from eight or nine of my colleagues in the Georgia area, they do not know how they are going to make it. They are already concerned about the underwater reimbursement they are getting, and they are real concerned about what is going to be happening in 2024. We already are seeing the plans with lower reimbursement next year, and they are having a hard time surviving this year. So, it is critical because there are going to be small businesses like mine that are not going to make it through this situation.

Mr. CASAR. Well, I appreciate it, and I look forward to working with anyone on this Committee on bipartisan efforts to address all of the different parts of the system that need to be addressed. Thank you to each of you for your testimony, and I yield back, Mr. Chairman.

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

Mr. BIGGS. Thanks, Mr. Chairman. Ms. Reilly, can you tell us what the profit was for PBMs last year?

Ms. REILLY. No, but it was higher than for pharmaceutical companies.

Mr. BIGGS. Mr. Scott, what was PBMs' total?

Mr. SCOTT. PBMs represent about 6 percent of the drug dollar. Four percent of that goes to paying——

Mr. BIGGS. Yes. What I want to know is how much did you guys make last year.

Mr. SCOTT. I do not have a dollar figure. I can tell you it is about a two-percent margin on average.

Mr. BIGGS. Did you make more than the Big Pharma?

Mr. SCOTT. I do not know the answer to that question.

Mr. BIGGS. OK. I had hoped that you would respond. Mr. Chancy, you said that you guys are in the community pharmacy or you guys use a pharmacy service organization. How many community pharmacies are in this pharmacy service organization?

Mr. CHANCY. I think, and the one that I am involved in, it is over 7,000.

Mr. BIGGS. Seven thousand, and who do they negotiate with? Are they negotiating with PBMs? Are they negotiating directly with pharmaceutical companies?

Mr. CHANCY. They are negotiating directly with the PBMs.

Mr. BIGGS. With the PBM themselves. OK. Great.

Mr. CHANCY. Correct.

Mr. BIGGS. Thank you. I have got questions for everybody. I just do not have time for everybody. Sorry about that. And then, Dr.

Conti, in your written testimony, you said PBMs act as intermediaries that bargain on behalf of payers for lower prescription drug prices while receiving payments from drug makers, right?

Ms. CONTI. That is correct.

Mr. BIGGS. And then you said that PBMs create an arena for retail prescription drug maker competition. How do they create that arena for drug retail competition?

Ms. CONTI. Essentially, drug manufacturers bid using rebates to enter into coverage on the formulary.

Mr. BIGGS. OK. And you mentioned some benefits to consumers and payers through promoting access to drugs. Can you expand on that a little bit?

Ms. CONTI. Sure. Formularies push patients to use low-cost, safe, and effective drugs, largely generics and biosimilars when they are available. That reduces costs for us all and also expands access.

Mr. BIGGS. And yet, this is not a foolproof system, especially, I take it, from reading what you said what some of the others have included is this vertical integration. Is that the biggest problem with the PBM system?

Ms. CONTI. I would say that patients not being able to access drugs that are most beneficial for their specific condition is the most pressing concern.

Mr. BIGGS. I am sorry. I was going to ask is that because of the vertical integration, or is that because the PBMs are engaged in some kind of conduct, or is that because of the Big Pharma engaged in some kind of conduct? Where does that lie?

Ms. CONTI. Sure. I would say the blame lies in multiple places. No. 1, drug manufacturers set the list prices of their drugs many times at prices that are just simply too affordable for us all.

Mr. BIGGS. You mean unaffordable for us all?

Ms. CONTI. Right. Sure. So, I mean, so there are drugs that are now priced at higher than a college education, for example. That is excessive.

Mr. BIGGS. Does that have anything to do with these discounts or rebates that they are giving, or what is the feature for that?

Ms. CONTI. Drug prices are set high in the United States because simply drug manufacturers can charge them, and we will pay them.

Mr. BIGGS. And who pays that? Is that through the insurance companies themselves, or is that through the government paying? Is it both?

Ms. CONTI. Yes, it is both.

Mr. BIGGS. OK. We have talked about Medicare being able to negotiate for drugs directly. Is that any way analogous to PBMs negotiating?

Ms. CONTI. Yes. Essentially, our system is based on this competition. PBMs are acting as agents for us all, negotiating lower drug prices, and getting patients to use lower price just as safe and effective drugs when available. However, our system is eroding that activity by expanding or forestalling generic competition altogether or, frankly, not providing access to drugs that are needed at the pharmacy counter.

Mr. BIGGS. And, Mr. Burton, you included something. I am glad Dr. Conti touched on generics because you said patients are in-

creasingly facing barriers to access to new generics and biosimilars as a result of formulary decisions to delay or block coverage. Expand on that, please.

Mr. BURTON. Let me give you two examples. We have tracked coverage of first generics. These are the first generics on the market in the Medicare program over the last 6 years. It now takes at least 3 years for new generics to achieve formulary coverage on as much as half of Medicare formularies.

Mr. BIGGS. OK. So, you have talked about formularies.

Mr. BURTON. So, they are launching. They are not being covered for 3 years.

Mr. BIGGS. Right. OK. And you are attributing that to PBMs, if I am not mistaken.

Mr. BURTON. Absolutely.

Mr. BIGGS. I am sorry, Mr. Chairman. How about the development of generics in and of itself? We have got problems with the development of generics on the front end and then listing in the formularies.

Mr. BURTON. Yes. So, a lot of this comes back to the incentives. And if a new generic or a new biosimilar is not going to be able to be covered, if a biosimilar that cost $300 million to develop is not going to be able to get the market adoption necessary to get that return on investment, then it is not going to be developed, and we have seen manufacturers exit the biosimilar market. We have seen them decide it is actually easier to develop a brand drug and get their return on investment there because they are not getting the adoption in the commercial market to date.

Mr. BIGGS. Mr. Chairman, thank you so much.

Chairman COMER. The Chair now recognizes Mr. Garcia from California for 5 minutes.

Mr. GARCIA. Well, thank you, Mr. Chairman. Thank you to our witnesses that are here.

Certainly, there has been a lot of finger pointing that is going on between the PBMs, of course, and our big pharmaceutical companies. It has happened here today at this hearing. I just think it is important also to note who the big PBMs are. We have been hearing the term "PBM" a lot. We are talking about CVS Health, Cigna, United Health, a lot of these large PBM companies.

We know that last year, the three major PBMs, which I just mentioned, here in the U.S. made almost $30 billion in profits. That is a 483-percent increase over just the past decade. And I am glad there has been bipartisan support and input on how to deal with this approach and ensure that the American public, of course, gets better cost for them when they are receiving the medication that they deserve and need.

These are serious conversations about antitrust regulations, about enforcement. It has been noted multiple times that PBMs control almost 80 percent of the entire market, which is enormous. PBMs also integrate with insurance companies and pharmacies to funnel businesses to their own pharmacies and retailers, but the big picture here is a lot of finger pointing. I want to share, you guys, one of my absolute favorite memes, which, to me, this is a perfect example what has actually been going on as it relates to the American consumer.

[Chart]

Mr. GARCIA. We have our pharmacy benefit managers pointing at Big Pharma and Big Pharma pointing back at our pharmacy benefit managers. Now, there is also a reason why Pharma is spending millions of dollars over here to trash PBMs. Let us also distract the American people from their central role in driving up costs while stuffing their own pockets. The eight Big Pharma players—AbbVie, Amgen, Bristol Myers Squibb, Eli Lilly, Gilead, Johnson & Johnson, Merck, and Pfizer—earned $110 billion in profits in 2022 and, by the way, according to the Senate Finance Committee, paid only 2 percent in taxes. And so, I want to make sure that these companies are called out by name on both the Big Pharma side and also the PBM side.

On the 5-year period, from 2016 to 2020, pharmaceutical companies raised the prices of branded prescription drugs by 36 percent. That is 4 times the rate of inflation. From 2016 to 2020, the 14 leading drug companies spent $577 billion on buybacks and stocks, which is $56 billion more than they spent on research and development over the same period of time. In 2021, 10 major pharmaceutical companies that made over $100 billion in profits—$100 billion in profits—that is a 137-percent increase from the previous year. So, both Big Pharma and PBMs are at fault, as we saw in that meme, so I want to make that just clear today for this hearing.

Professor Conti, isn't it true that pharma manufacturers have specifically collaborated with PBMs to block generics from coming to the market and leaving consumers with higher prices?

Ms. CONTI. Yes.

Mr. GARCIA. And is it also not true they use their market power to obtain contract terms with payers, PBMs that limited or blocked generic competitors from being covered?

Ms. CONTI. We believe exclusions are rare. There are approximately 20,000 drugs sold in the United States every day and only a handful are excluded. However, generic forestalling of competition is real, and the GAO has just produced a report suggesting that it is increasing over time.

Mr. GARCIA. And I think what is really critical here is that if we are going to have actually reform here within this incredibly important part of the kind of American economy and people's healthcare, that reform is going to happen on both sides. It has got to happen on both sides. One thing that is concerning, and that has been about this hearing and other conversations around this topic, is that pharma and House Republican allies have also fought meaningful action on drug price reform and negotiation for decades.

Now, President Biden and House Democrats passed the biggest prescription drug reform in decades in the Inflation Reduction Act that was brought up multiple times today, and every, by the way, single Republican voted against it. So, all of these comments about some of my colleagues feeling bad or sad for our American seniors or those that need medications, they voted against actually the Inflation Reduction Act, would actually help and it is helping this issue today.

Now, Democrats have expanded negotiating for the best price for prescription drugs and Medicare. Again, Republicans opposed that.

And Big Pharma, as we have heard today and have heard in their former public statements, are suing to overturn that, which is quite shameful, honestly. We have capped the cost of insulin at $35 for those on Medicare. To remind you folks, all the leading Republicans running for President, including Donald Trump and Ron DeSantis, have promised to repeal that, and so we have a lot of work to do here.

I want to finally, Professor Conti, can you reiterate again why negotiating drug prices is so critical?

Ms. CONTI. Bottom line, it will reduce the price of drugs at the pharmacy counter and expand access. This should improve individual's lives and also population health.

Mr. GARCIA. Thank you so much. That concludes my time. I want to submit to the record of this article by the *Wall Street Journal*, which came out September 11, 2023, just recently on generic drugs, why they should be cheap, but why insurers are charging thousands of dollars for them, and so let us submit that. Mr. Chairman, I yield back.

Chairman COMER. Without objection, so ordered, entered into the record.

Chairman COMER. The Chair now recognizes Mr. Perry from Pennsylvania for 5 minutes.

Mr. PERRY. I thank the Chairman. Ladies and gentlemen, appreciate your time. I am not here to vilify anybody. I am trying to figure out some answers. My bosses, the people I represent, want access to affordable pharmaceutical products, and they know that the cost keeps going up. It has become unaffordable, and they do not know why. They just know that they can not afford it. And so, I am not here to point fingers at anybody. I am here to try and get a couple of answers.

I represent a few independent pharmacies that are still hanging on, and we are not saying anything bad about the other ones that do good work as well for the community. But for independence, where people find value in seeing the same person that their parents saw or that they went to when they were a child, there is a trust there, but the independence, seem like they struggle. Well, I know they struggle, right, with the DIR fees, changes to Federal programs like TRICARE, and it does not seem fair.

My question on behalf of, I think, these independent pharmacies to both the manufacturers and the PBM, so this is directly to you, Ms. Reilly and Mr. Scott. Why do PBMs, or maybe the PBMs do not. I do not know who does. Why is it that pharmacies are required to dispense brand when approved generic is a fraction of the cost? How does that happen? Why does that happen?

Ms. REILLY. Well, as I have mentioned before, the PBMs are solely responsible for setting the formularies that exists for a health plan, so they decide what medicines get covered. They decide how much patients ultimately pay for those medicines, and oftentimes they make a choice to cover a medicine. And there are lots of government reports to show this where they prefer medicine with a high list price over a lower price generic or biosimilar medicine.

Mr. PERRY. I am sure Mr. Scott has an opinion.

Mr. SCOTT. I do, Congressman. Thank you. In fact, generics are not usually placed on higher formulary tiers. Our companies have

championed the dispensing of generics, which has contributed greatly to the fact that 90 percent of prescriptions dispensed today are for generic drugs. And in fact is, our companies contract with independent or chain pharmacies. One of the things that we are incentivizing through value-based contracts is for them to encourage more uptake of generics, so we have a very proven track record on that front.

Mr. PERRY. So, who is requiring? How does the brand get put into this is what the person can get and not the generic? How does it happen then?

Mr. SCOTT. There may be instances where the first generic comes to market and has the positive competitive effect of having the originator drug, cut their cost down to a lower level, and the PBM is always going to favor the lowest net product.

Mr. PERRY. Because I will tell you, sir, my pharmacists are telling me there are countless—I do not know, right

—but they are telling me, and I trust them. I do not know why they would tell me otherwise, but there are countless examples where the brand is the one that is prescribed as opposed to the generic. And it sounds like you are saying this is an episodic thing, but it sounds to me, according to them, like this is an epidemic issue. And, ma'am, do you have something to weigh in on here?

Ms. CONTI. Sure. The preponderance of evidence suggests that that behavior is actually quite rare.

Mr. PERRY. So, what would you contend? Is it the manufacturer? The next question, I will tell you, and maybe you can, Mr. Burton, you can weigh in here is, if you watch TV, and probably all do, sadly, you are going to be deluged with ads about things that you can not pronounce. You have no idea what the heck they do. And I just did a little research, and we are talking about hundreds of millions of dollars in prices for ads. We are encouraging people to go talk to their doctor and get this drug for this malady, and, of course, it is the list of all the things that are going to go wrong with you if you take it and so on and so forth.

But where does that money come from, right? They come from customers, right? Doesn't it come from customer? Ma'am, Ms. Reilly, doesn't that come from customers who are, some are on the margins, right, can barely afford the medicine. They are being prescribed the brand instead of the generic, and the brand is on TV spending hundreds of millions of dollars saying buy this brand.

Ms. REILLY. I do not know of any instance where a company is advertising a brand medicine when there is a generic that is available. That typically does not happen. The purpose of advertising is to make people aware of new drugs that may come to the market. It is intended to make people aware of symptoms that they may have but may not know why, in fact, they have the symptoms, to encourage a conversation with the doctor. At the end of the day, though, it is up to the doctor to make the decision about what medicine is most appropriate for that patient, and we think it is important for people to have conversations with the doctor.

Mr. PERRY. Sure. So do I.

Ms. REILLY. But ultimately, the doctor should be in charge.

Mr. PERRY. I agree. Mr. Chairman, with your indulgence. Mr. Burton, can you weigh in on this whole conversation here?

Mr. BURTON. Absolutely. So it is, in a lot of cases, coming back to lowest net cost to whom: cost to the PBM or cost to the patient. So, there has been a lot of discussion of insulin.

Mr. PERRY. I notice that instead of price, it was cost, cost to whom. That is important.

Mr. BURTON. Right.

Mr. PERRY. Can you elaborate on that?

Mr. BURTON. So, if we look at the biosimilar insulin market. Biosimilar insulin is priced two-thirds, 65 percent lower list price than the brand insulin. And if we look at the best way to judge adoption in this market is looking at new-to-brand prescriptions, new-to-brand prescriptions in that Lantus market are 65 percent of those prescriptions are written for the biosimilar, but only 30 percent of the prescriptions that are actually filled are for the biosimilar, because what is happening is those prescriptions for the biosimilar are hitting blocks and utilization management from the PBMs that push the patient to the branded product.

Mr. PERRY. All right. Well, thank you. My time has expired. I just do want to say this. We appreciate what you do in the larger sense because we all want to have access to these lifesaving treatments. That having been said, having government intervention and price fixing only discourages the research and development necessary to have things that saves people's lives, and so none of us here want our constituents, our bosses, to pay higher prices. But I would think that on my side of the aisle, and I will speak for myself in particular in my case, I do not think that government determining these things is the answer. And on the insulin front, we had companies that were willing to manufacture below the cap, who are maybe now being put out of business because of the cap. That is the beauty and the fallacy of government. They solve a problem by making another problem, and that is why we are opposed to government price fixing, not because we want our constituents and our bosses to pay more. That is indeed the exact opposite. With that Mr. Chairman, I yield.

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

Mr. FROST. Thank you, Mr. Chairman. One moment. All right. Everyone in this country deserves access to medicine at a price they can afford. PBMs are one part of the problem, but we should not forget the massive role that Big Pharma plays in this, and my colleague, Mr. Garcia, had the very funny meme that he put up, which is 100 percent true. Big Pharma drug companies are watching this hearing, relieved that Republicans are putting all the blame on PBMs and that the $9 million spent in attack ads on PBMs is paying off.

Mr. Chairman, I seek unanimous consent to enter into the record the Oversight Committee's Democratic staff report culminating the Committee's 3-year investigation into the pharmaceutical industry, which found that drug companies engage in anti-competitive behavior and exploit our healthcare system to make record profits at the expense of sick Americans.

Chairman COMER. Without objection, so ordered.

Mr. FROST. Thank you. With this investigation, they found some very important information. I think it is important people read

about it. Professor Conti, as an expert on drug pricing and affordability, can you tell us, would breaking up PBMs without addressing the drug manufacturers' role guarantee that drug list prices will fall to more affordable levels?

Ms. CONTI. No. In fact, we expect prices will go up.

Mr. FROST. OK. What are some of the tactics that drug companies have used to enrich themselves?

Ms. CONTI. Certainly, setting list prices and taking year-over-year price increases on these list prices is enriching themselves and harming seniors and other Americans who depend on those drugs. In addition, forestalling competition in the form of generic and biosimilar competition is, again, enriching themselves without providing benefit to the American public.

Mr. FROST. President Biden's Inflation Reduction Act allowed Medicare to negotiate directly with drug manufacturers, kept out-of-pocket patient costs, and put a life-changing monthly cap on insulin of $35. Professor, how can this Committee build on the work of President Biden's Inflation Reduction Act to help make prescription medication even more accessible and affordable?

Ms. CONTI. Two ways. First, expand access to all insured individuals and uninsured individuals for those lower prices, and second, by promoting transparency and competition throughout the system.

Mr. FROST. Thank you so much. I would love to hear my Republican colleagues commit to holding a hearing on both PBMs and drug companies. I think it is important that we hold both accountable, and there is a lot of work that needs to be done there. Last year, drug companies, like Johnson & Johnson and others, continued to launch medicines at sky high prices, with the average cost of a new drug being more than $220,000 a year. And just last week, Republicans on this Committee sympathized with Johnson & Johnson, allowing them a representative to sit here and complain and air out complaints on citizens, holding them accountable.

So, I think it is important that we look at all the bad actors in this, and I think PBMs and drug companies are both bad actors and part of the reason why we have Americans deciding between medicine and rent, medicine and food. And we can not talk about the people who negotiate the prices without talking about the people who set the prices, and I think both are very important. Thank you. I yield back.

Chairman COMER. The gentleman yields back. I will recognize myself now for 5 minutes of questioning.

Mr. Scott, I want to reexamine what Mr. LaTurner briefly touched upon, and that is just a question why one of your members CVS would charge $17,700 for a 30-day supply of Imatinib when transparent pharmacies charge $72 and still make a profit. Is that normal behavior by the PBMs? Is that an anomaly? Why would that scenario happen?

Mr. SCOTT. I believe it is an outlier situation, Congressman. As I mentioned to Congressman LaTurner, the job of the PBM is to manage to the lowest net cost across all the drugs that they are negotiating for. Of course, they have to take into account other issues about supply and clinical effectiveness and all of those other questions. I can not speak to that specific drug. I know for Gleevec, that there are any number of different generic competitors at dif-

ferent price points out in the market at different levels of supply, but I think it is an outlier.

Chairman COMER. When it has been mentioned earlier about PBMs—fill in the brand name—when they could fill a generic instead that would be cheaper and save money for everyone, is that because the PBMs get a higher DIR fee from the brand name?

Mr. SCOTT. No. Typically, what I would assume would be happening there is that the actual net cost of the brand is coming in lower than the cost of the alternative and then lower net cost drug is being favored. And that net cost benefits the plan sponsor, the employer, who is deciding then how to use that savings to benefit the patients they represent.

Chairman COMER. Well, we will touch on that——

Mr. RASKIN. Mr. Chairman, could I followup on your question?

Chairman COMER. Go ahead.

Mr. RASKIN. Thank you for yielding for a second. You keep talking about lowest net cost, and it is been pointed out that that is different from lowest consumer price. If we are interested in benefiting patients and consumers, why should we care about lowest net cost to you? Would you explain that?

Mr. SCOTT. Right. It is not lowest net cost to the PBM because the PBM is essentially negotiating those savings for the employer, whoever hires them, and the amount that the patient pays out of pocket at the pharmacy counter is a function of that employers benefit design. So, are they using the savings from that lower net cost drug to try and make the benefit affordable for everybody that benefits the patient, or are they using it to say you are not going to have out-of-pocket cost on these particular drugs? It is the tradeoff that is been decided there.

Chairman COMER. Mr. Scott, that is not consistent with anything that our research has found, and we are going to continue to investigate PBMs. And I know you represent the PBMs, and we wanted you to be here at the table because you all made some tweets in the last Committee hearing. We will mention one of those momentarily. But in communicating with all the stakeholders that we have communicated with and met with and spent hours, and we do not agree on a whole lot on this Committee, but we agree that PBMs need to be reformed significantly, especially from a transparency standpoint.

Ms. Reilly, I want to turn to you now. Generics are usually less expensive than brand name, right? Why is that?

Ms. REILLY. Well, you know, when a brand name medicine comes to market, it often takes 10 to 15 years, often in excess of $2 billion, to bring a product through. Ninety percent of what we do fails, so the likelihood of bringing a brand name product to market is quite low. On the contrary, generic medicines, they do invest some money, obviously, to bring a medicine to market, but it is almost as if we have baked the cake, and we hand over the recipe. And then——

Chairman COMER. Let me ask you this. What role do drug manufacturers have in setting drug prices?

Ms. REILLY. We set the list price of a medicine, which is the starting point for negotiation with a pharmacy benefit manager. And then we have to negotiate with PBMs, some of which nego-

tiate, you know, for more people than entire countries like France. They have a lot of leverage, as we have talked about earlier today because——

Chairman COMER. OK. Let me cut you off for time sake.

Ms. REILLY. Sure.

Chairman COMER. In our last hearing, we heard expert witness testimony on how PBMs use rebates and formularies to steer patients to certain drugs and that high rebates lead to high list prices. PCMA, represented by Mr. Scott, tweeted during our first hearing that rebates are completely unrelated to high drug prices, and I believe he said that. Now, Ms. Reilly, is that accurate that rebates have no impact on drug prices?

Ms. REILLY. That is contrary to lots of folks, including the OIG, the Federal Trade Commission, Senate Finance Committee report, and others.

Chairman COMER. Can you explain how rebates impact the price of pharmaceuticals?

Ms. REILLY. Well, as I said before, you know, we do set the list price, but the preferences of PBMs do matter. They set the terms of negotiation. And again, there have been multiple studies that have shown that PBMs typically prefer medicines with high list prices, in part because they make their compensation in part based off of the list price. Whether that is a rebate or a fee, it is tied to the list price of the medicines. The higher the list price, the more money in their pocket.

Chairman COMER. Exactly. And just to be clear, who in the market benefits the most from rebates?

Ms. REILLY. I would argue the PBMs, insurers.

Chairman COMER. PBMs benefit the most from the rebates, and that is something that I believe there is bipartisan support in this Committee at least to reform that, and we would love to continue to have discussion with all the stakeholders. Both Republicans and Democrats on this Committee are going to continue to work to try to come up with a meaningful solution.

I do not believe just increasing transparency is going to do a whole lot. We are in close communication with our friends on the Energy and Commerce Committee. I know there are several bills over there. We are waiting to see what happens over there, while at the same time we are going to continue to investigate and try to come up with meaningful solutions to reform the PBMs and all the problems that we have heard today from both sides of the aisle about PBM abuse. And I believe that we can hopefully get something done in a bipartisan manner.

My time has expired. The Chair now recognizes Mr. Mfume from Maryland for 5 minutes.

Mr. MFUME. Thank you. Mr. Chairman, I want to thank you and Ranking Member Raskin for calling us back together on this issue. The first hearing was an eye opener, and this one seems to be the same way. I think there is a lot of finger pointing here, but what we are not seemingly able to do is for anybody to take any real blame or responsibility for a terrible, terrible situation that is affecting people all across this country. As I said during that last hearing, people are hurting while companies are profiting.

PBM profits have increased rapidly even as lifesaving medications continue to be unaffordable and inaccessible for many people across this country. However, because PBMs operate in this opaque and impenetrable manner, the specifics about PBM practices are not well understood, such as their contracts with pharmaceutical companies, such as their rebate structures, such as their spread pricing. It is all kind of hocus-pocus for the average citizen, who just knows that they are paying more and are often told that they can not get a drug that has been prescribed by their doctor because some other party has made a decision that that is not to be the case.

PBMs, in my opinion, sometimes have more to say about drugs than the actual doctors, so I am going to do a couple of things here. Professor Conti, I want you to think for just a minute. I am going to come back to you about specific PBM business practices that you believe can increase transparency as we know it. I am one of those that believe you open the window and you let the sun shine in, and so I am a big advocate for transparency. I want you to think about your own suggestions in that regard and your own considerations.

I do want to make it clear, though, that it seems that from our discussion today and our previous discussion that we know two things that we knew before: PBM profits are soaring, and second, PBMs' position in the drug supply chain puts them in a place where they can and do exert enormous influence on all the players who are part of that. Dr. Chancy, two quick things from you, and I would appreciate if you could, because of time, a "yes" or "no" answer. Renumeration fees have increased 33 percent in 2 years. Yes or no?

Mr. CHANCY. Yes.

Mr. MFUME. And how much of a burden has that put on you and others like you in a very short amount of time?

Mr. CHANCY. It is a huge burden.

Mr. MFUME. And I want to ask you also as we think about those renumeration fees, you had mentioned in your testimony, as I understood it at least, that your perspective is a drowning perspective, and that what is happening in rural America and what is happening even in urban America has brought together two sets of constituents that want real relief. Could you just tell me for a quick second if you have got an idea about how to break that or what this Congress ought to be doing with respect specifically to renumeration fees?

Mr. CHANCY. Well, I think the remuneration fees are critically impacting the small businesses. We are going to see a change of that come first of the year. What my colleagues are concerned about is what that is going to do the first 3 to 6 months of the year when they have those fees that are added back, but they are also reducing the cost of the reimbursement on the drugs.

Mr. MFUME. OK. And one other quick thing here. Mr. Scott, I appreciate your testimony. I know who you are representing, but I really got offended when you said that drug companies happily lowered the cost of insulin. That is an outright misrepresentation. If they were happy about doing it, it would not take the U.S. Government to make them to do it. They fought every step of the way. So, I want to correct that aspect of the record. While that may be your

opinion, it is not one that I share, and it is not akin to what the truth is as we know it.

Mr. Chairman, I am holding a report as a comprehensive overview of the healthcare industry and our society released last year that says a number of things that underscore what we are hearing today that I would like to have unanimous consent to be entered into the record. And I have a study of the operation of the generic drug market by the Maryland Prescription Drug Affordability Board that I also would ask unanimous consent to have entered into the record.

Chairman COMER. Without objection on both requests.

Mr. MFUME. Ms. Conti, would you take a second to respond?

Ms. CONTI. Sure. Formulary replacement behavior that erodes the use of generic and biosimilar drugs should be investigated. Other contracting practices that, again, contribute to the forestalling of generic and biosimilar competition should also be investigated; and then, finally, most favored nation clauses in contracts that reduce the ability of generic drugs to enter the market or to compete and/or reduce PBMs' ability to negotiate the lowest prices on behalf of America.

Mr. MFUME. Thank you, and thank you, Mr. Chairman. My time has expired.

Chairman COMER. The Chair now recognizes Ms. Harshbarger from Tennessee for 5 minutes.

Ms. HARSHBARGER. Thank you, Mr. Chairman. Thank you for the panelists for being here today. Mr. Scott, I will start with you. Would you agree that lowering prices paid by prescription drug plans is not the same as lowering prices that patients pay at the counter? Yes or no.

Mr. SCOTT. Not always.

Ms. HARSHBARGER. And, in fact, pharmacy and drug manufacturer discounts treated as DIR do not lower drug prices at the counter. Isn't that correct? Yes or no.

Mr. SCOTT. They can in some instances, and others they do not.

Ms. HARSHBARGER. If Congress' goal is for seniors to benefit from drug manufacturer and pharmacy discounts negotiated by PBMs at the pharmacy counter, then would you agree that patient cost shares or deductibles should be based on the drug's net cost? After all, pharmacy discounts and drug manufacturer discounts are paid to PBMs and their affiliates.

Mr. SCOTT. I think we need to continue to provide choice and flexibility to employers when they are designing their benefit and making decisions about premium and out-of-pocket cost.

Ms. HARSHBARGER. OK. Ms. Reilly, while rebates have grown and net prices continue to fall, patient out-of-pocket costs are increasing. To illustrate this, despite a 62-percent decrease in the net price of a leading insulin since 2012, the average out-of-pocket cost for commercially insured and Medicare Part D patients taking this insulin increase by 60 percent over this period. And my question is, what impact do you think that requiring rebates to be passed on to patients would have on the pharmaceutical market?

Ms. REILLY. I think you would see many patients, insulin-dependent patients, but many others would find significant savings

at the pharmacy counter if rebates were actually being passed on to the patients.

Ms. HARSHBARGER. Yes. Would it start to address some of the distortions seen in the market today?

Ms. REILLY. Absolutely.

Ms. HARSHBARGER. Thank you. I will go back to you, Mr. Scott. According to a December 2021 study by the drug pricing research nonprofit, 46brooklyn Research, in October 2021, competition among new generic manufacturers brought the median list price of generic Tecfidera, a blockbuster MS drug, down to $900 per prescription. The average pharmacy acquisition cost at that time was $184 per prescription. Considering the brand version of that drug, it had a list price of more than $8,200 per prescription at that time. So, my question is, what do you say to the more than half the seniors who were stuck in Medicare Part D plans whose PBMs forced them to buy the more expensive brand version when they could have saved thousands of dollars by taking the generic?

Mr. SCOTT. So, without knowing the specifics on that drug, I would operate off an assumption that the brand was able to bring, not the price, but the cost of that drug down below the cost of the competitor, and so it made the cost for the Medicare plan less expensive.

Ms. HARSHBARGER. You know, I just left another hearing on Energy and Commerce with CMS, and we talked about these things, and there is a lot of work to be done. And the GAO just did a study that proves that there is a lot of work to be done, and I am going to suggest that the GAO study that they did complete goes to the FTC to do their inquiry, investigation, whatever you want, on PBMs. But there is a lot of disparity there, and I know as a pharmacist and as a compounding pharmacist what the cost of these drugs are. So, a lot of work to be done, and I appreciate you all being here today. And thank you, Mr. Chairman, for letting me waive on. Thank you, sir.

Chairman COMER. The Chair now recognizes Mr. Auchincloss from Massachusetts.

Mr. AUCHINCLOSS. Thank you, Chairman. I appreciate you allowing me to waive on. I wish that the gentleman from Missouri had stayed. We could have had a good colloquy because he brought up Netflix as an analogy, and it is a shame because it is actually a terrific analogy. And yet, he derived the exact wrong conclusion from that analogy, but it is a useful case study because we get drawn into all this jargon to help us think through what is really happening here.

Netflix is actually kind of exactly how we would hope that insurance companies and PBMs would work. You pay a subscription fee every month, $11 for Netflix. That is like your premium to an insurance company. They have a catalog of shows. Some of them cost a lot to make, some of them cost nothing at all to make, blockbusters or indie films, and yet because you pay that subscription fee, you get to watch the whole catalog, which is like their version of a formulary. And they even have, like, a specialty pharmacy kind of where you can get mail order DVDs if you really want something esoteric that they can not supply off of the streaming service. So, I wish insurance companies would look like Netflix. It

actually has a good competitive model, and they have got Disney Plus and Paramount, and they got a nice competitive marketplace there. It is keeping the premiums, as in the subscription fees, on a monthly basis low.

Now, let us actually use the Netflix analogy to describe how PBMs actually work. Let us say you wanted to watch Real Housewives. They would instead say, oh, that actually costs a lot of money to make. Could you try Gilmore Girls first? We need you to watch that and see if you like it. That is called a step edit. That is what the PBMs do there, or they would say, you know what? We need a written permission from your wife to go watch Real Housewives because we will not let you watch it otherwise. That is called a prior authorization. Now, let us say that you wanted to watch Pirates of the Caribbean. And they said, well, wait a minute. That costs $250 million to make. We are going to need you to pay co-insurance on that. So, can you fork over $25,000 to help us cover the cost of that production?

Now, of course, consumers would say get lost, right? They would unsubscribe immediately. They would go to Disney. You do not have that kind of behavior. Why doesn't that happen in PBMs? Why don't we have that same kind of competition? Now, there are a lot of reasons. I do not want to overexert the analogy. There are legitimate differences, particularly with genericization, et cetera. But a big one is that wanting to watch Pirates of the Caribbean is different than having cancer. When you have cancer, you do not get to just say actually, I would rather not pay that co-insurance. What you have to say is, oh my goodness, my husband has to quit his job to take care of me, and I have to sell my car, and we are going to have to sell the house, and we are going to go into medical debt, which is one of the leading causes of bankruptcy in this country.

We have a system where the insurance companies, through formulary design, have put the onus of out-of-pocket costs squarely on the patients in this country in a way that is driving people to despair and debt. Now, PBMs like to claim over and over that drug manufacturers alone are responsible for high drug prices and for setting drug prices, but it is just not true. A 2022 report from 3 Axis Advisors' single plan analysis found a 51-percent increase in prices at the counter for generic medications in a 30-month period in Medicare Part D, despite the fact that NADAC saw 8.7 percent deflation for the same basket of generics, so the actual cost versus the billed cost.

Now, also in a newly released report by 3 Axis Advisors, their analysis found that one PBM reimbursed an independent pharmacy at five different prices for an antidepressant medication, duloxetine, dispensed by the pharmacy on the same day. Five different prices the same day, same pharmacy. The prices range from $9.30 to $96, a tenfold difference in price for the same drug at the same pharmacy on the same day. Mr. Chancy, would you agree that based on the foregoing, it is the PBMs that are driving drug prices up for American seniors?

Mr. CHANCY. Yes.

Mr. AUCHINCLOSS. And then, Mr. Scott, can you explain please how generic medications, where the market is supposed to work ef-

ficiently, can decrease by 9.1 percent, yet their costs for seniors increase by 51 percent?

Mr. SCOTT. I am sorry. Congressman, could you say that again? How generics——

Mr. AUCHINCLOSS. Can decrease by 9.1 percent as measured by NADAC. That is the actual cost, that we have to improve NADAC to get more transparent reporting, but even so it is still the best measure, yet the cost for seniors increase by 51 percent. This is an independent analysis.

Mr. SCOTT. Depending on the generics question, I think it gets back to the issue we have discussed for much of the hearing around whether the competitor drugs are coming in at a lower net cost and, therefore, getting favorable formulary replacement.

Mr. AUCHINCLOSS. Well, we are talking about generics here.

Mr. SCOTT. Right, and generics normally get that favorable formulary replacement the vast majority of the time, and that is why we have seen that 90 percent dispensing rate for generics.

Mr. AUCHINCLOSS. Well, the vast majority of time except, it seems, from this analysis. Would you agree that we need better NADAC reporting as a basis for pharmacy reimbursement for those claims?

Mr. SCOTT. We certainly would be open to talking about that.

Mr. AUCHINCLOSS. Would you be open to having out-of-pocket cost predicated on NADAC as opposed to on the list price?

Mr. SCOTT. I think you have to involve plan sponsors in the conversation about how they want to design benefit for the unique populations they represent.

Mr. AUCHINCLOSS. No, no, no, that is a circumlocution. Do you agree as a representative of the PBM that it would be more fair to predicate out-of-pocket cost for what the actual pharmacy paid for that drug?

Mr. SCOTT. The PBM is there to work on behalf of the employer or the plan sponsor who is going to make the determination about those questions on out-of-pocket cost.

Mr. AUCHINCLOSS. OK. I am here to work on behalf of the patient, OK? And what is good for the patient is that they are not paying co-payment rates that are predicated on the list price that nobody pays. It is a made-up price, it is literally fiction, and the only person who is exposed to it are my constituents. Why shouldn't they have an out-of-pocket cost that is based on what the actual transaction and payment is for goods delivered?

Mr. SCOTT. To the extent that we are deploying the savings delivered by the PBM, if you put all of that toward out-of-pocket cost, then you risk the potential of having an impact on the affordability of the benefit. It is a tradeoff. As long as the cost or price is high——

Mr. AUCHINCLOSS. Over and over again you point to the premiums going up. There is just no evidence to support that. It is not true that the premiums have to go up, and, indeed, what we have seen is out-of-pocket cost going down, improving medication adherence, and it will lead to an overall healthier risk population.

Mr. SCOTT. And I know——

Mr. AUCHINCLOSS. It is a false assertion.

Mr. SCOTT. And I know when you and I last visited, we talked about the static versus dynamic scoring issues that have come around some of the estimates. But prior estimates, for example, around the Trump Administration's rebate rule demonstrated a fairly dramatic effect on premiums, so it is something I think we have to be sensitive to.

Mr. AUCHINCLOSS. I am over my time. Chairman, thank you.

Chairman COMER. The gentleman's time has expired. A very good analogy there. I enjoyed that. Now, our questions have concluded. And prior to adjournment, the Ranking Member and I are going to give brief closing statements. I now yield to the Ranking Member for his closing statement.

Mr. RASKIN. Mr. Chairman, first of all, thank you for calling us together for this important hearing. Thanks to the witnesses. I want to thank my friend, Mr. Auchincloss, for the great insight he brings to this problem.

I appreciate the insights of all the witnesses and the ways that different players in the healthcare system, from the pharmaceuticals to the PBMs, may be placing barriers in the way of people just getting affordable medication. And it is troubling to me that three companies dominate the PBM market, giving them outsized influence in the healthcare system that is replete with actors, who, if we are being honest, are all incentivized to put their profits over the needs and the interests of the patients, our constituents. I do not want to lose sight of the role that Big Pharma plays in this complex and multifaceted pharmaceutical supply chain. Mr. Scott makes some fine points about that. Drug companies have spent years making billions off of patients, and PBMs are now just one piece of the puzzle. They have gotten in on the action.

The Inflation Reduction Act has already begun to create savings for seniors because we made sure that the market works by giving Medicare the power to negotiate with Big Pharma for lower drug prices, and President Biden is now working to expand these wins for people covered in the commercial markets as well. We have got to figure out a way to make sure that the patients are not paying exorbitant, bloated, inflated prices so different actors within the medical system can get rich off of them. We got to put the patients first.

I am glad for this hearing, and I am glad to continue our work of investigating ways that we can be prioritizing the needs of the American people first. Mr. Chairman, I look forward to working with you on legislation to that effect. I yield back to you.

Chairman COMER. Thank you. You want to ask questions, Ms. Porter? Is that OK? Ms. Porter, go ahead. She has been an advocate on this issue. I will make an exception. You have 5 minutes.

Ms. PORTER. Thank you very much, Mr. Comer. I am sorry. I was coming from a hearing that was not run as well as you do here in Oversight. Ms. Reilly, we can both agree that pharmacy benefit managers, PBMs, are not working for patients, but I really want to illustrate the problem for the American people. What are pharmacy benefit managers supposed to do?

Ms. REILLY. The goal of a pharmacy benefit manager is to negotiate on behalf of employers and plan sponsors to lower the net cost of drugs, and I actually think they do that very effectively. I think

the challenge is those rebates and discounts, which often exceed 50 percent of the list price, do not make their way back to the patient to lower the price that they ultimately pay.

Ms. PORTER. Are PBMs transparent about how much savings they negotiate and where those savings are realized?

Ms. REILLY. Typically, not. I think that is one of the big challenges in the system today, is that it is hard for employers and plan sponsors to understand where the money goes. Increasingly, employers are demanding passthrough of almost all the rebates, but as a response, PBMs have shape-shifted and they have started transferring and getting more revenue off of fees they create, which are often opaque. They get them not just from pharmaceutical manufacturers, but from pharmacies as well.

Ms. PORTER. So as a patient, do patients have a way to know——

Ms. REILLY. No.

Ms. PORTER [continuing]. Whether they are getting cheaper prices because their insurance plan uses a PBM?

Ms. REILLY. No.

Ms. PORTER. OK. So, if PBMs were more transparent, it is possible that patients would know, and employers would know. We would have this data, and we would be able to figure out whether patients are really benefiting from PBMs and which PBMs. I have seen your ads, by the way, that you run about PBMs, and your ads say that transparency is key. And many of your members, large pharmaceutical companies, advertise their medications on TV. Even though only doctors can prescribe these medications, these companies advertise directly to consumers. What is the purpose of those ads?

Ms. REILLY. The purpose of those ads is to raise awareness for patients about medicines that may be available to treat conditions that they either know they have or know that they do not have yet. They raise symptom awareness to prompt a conversation between a doctor and the patient. But ultimately, the decision about what medicine gets prescribed is up to the doctor and oftentimes the PBM or an insurer depending on whether that medicine is actually on the formulary or not.

Ms. PORTER. So, there are lots of disclosures, though, that are made in these ads. We have all seen——

Ms. REILLY. Yes.

Ms. PORTER [continuing]. That virtually every drug is going to give you a headache and constipation and who knows what else. Those disclosures do not include in these direct to patient ads any disclosure about price? There is no price transparency in those ads, correct?

Ms. REILLY. Well, that is in part because the price paid depending on the consumer can vary. A patient on Medicaid may pay a different price than a patient with commercial insurance, so no, they do not, but those ads do direct patients back to those companies' websites to find out more information about pricing and what prices might be applicable for them.

Ms. PORTER. Are the companies' websites required to disclose the pricing?

Ms. REILLY. They are not, but our companies have voluntarily agreed to do that.

Ms. PORTER. The list price?

Ms. REILLY. Yes.

Ms. PORTER. OK. So, can you commit today to change in policy that your organization will disclose pricing? I realize there are multiple prices, but we could come up with a rule that says you have to disclose a range, you have to disclose the median price, the average price. Will you commit to that?

Ms. REILLY. I believe our companies are already and have committed to doing that. They direct patients back to their website, where patients can find more information about the prices of the medicines. It is important as a patient, first of all, to not be scared off. They may go to the website and say, well, that is the list price. That is what I am going to have to pay, which may not be the case.

Ms. PORTER. I am reclaiming my time. I mean, they may be scared off by the headaches and constipation, too. I mean, the idea here is to give people information. You said transparency was key. I think it would be key for people to have a sense of the possible range of cost. Not everyone is going to get the side effects either. Let me make you list those, and so the idea here is you would give some information about price to give some idea. I mean, I think the problem here is that you are arguing for transparency in the case of PBMs on price, but then your company is not willing to—your organization, excuse me—is not willing to commit for transparency in your own advertisements. Now, as you know, the Trump Administration——

Ms. REILLY. I would disagree that we have not been willing to advocate for transparency. We supported the Trump rebate rule, which would have provided transparency across every single medicine sold in the Part D program. The only entities that opposed that were the pharmacy benefit managers, who did not want transparency into those prices.

Ms. PORTER. OK. I want to make sure we are talking about the same thing because I do not want to talk past to. The Trump Administration rule that would have required drug manufacturers to disclose list prices in TV ads, your organization and its members supported that? Yes or no.

Ms. REILLY. Our organization did not support that, no.

Ms. PORTER. So, you spent time and money and your organization spent time and money opposing transparency for pricing when you advertise, but you want to hold PBMs to make those disclosures?

Ms. REILLY. In part because the list price is not a price that nearly any one pays. Patients should know the price that they are going to pay when they go to the pharmacy counter, not the list price of a medicine. It is important for patients to have transparency in terms of their insurance design and how much they are going to be asked to be paid when they go to the pharmacy counter. And our companies' websites provide much more detailed information because it is not as simple as one number to be disclosed.

Ms. PORTER. I would just argue that, and I appreciate your indulgence, Mr. Chair. I would just argue that, you know, none of the disclosures that we are making when we are advertising directly to patients about something as complicated as prescription medicine,

which they are not even authorized to prescribe to themselves, I think we could come up with a disclosure amount.

What I want you to think about and what I really appreciate your good faith engagement with me on is that I feel a little bit like the pharma industry is pointing a finger at PBMs saying they are not disclosing enough about price, but you are not leading the way on price disclosures either. And I respectfully say that when people are watching a TV ad and they are in the middle of "O-O-Ozempic", they are not running to their website and looking up the price. Like, you put the important information for a market in an ad, and I think that with a lot more transparent drug pricing, we should have more transparency across the board. I yield back.

Chairman COMER. OK. The gentlelady yields back, and I will conclude by saying I think this was a very substantive hearing, a very bipartisan hearing, a lot of different ideas and opinions. And the role that this Committee is going to play is we are going to continue to shine a light on this. We are going to continue to investigate. We are going to continue to brainstorm.

We are watching our friends in Energy and Commerce very closely on this issue. We expect something to be done. There is support for something to be done, something meaningful. We want to increase transparency, and I think we all have the goal of lowering the cost of prescription drugs for consumers, and that is what PBMs were supposed to do, but we do not believe that that is happening. And when you have Republicans complaining about excessive profits, that is pretty bad because most Republicans are for the free market, and Republicans want to see companies succeed and we want to reward risk takers and innovation in research and development.

But that is not what the PBMs are supposed to do. The PBMs are supposed to lower the price of prescription drugs, and I do not think when PBMs were created anyone ever envisioned the PBMs to become such massive vertically integrated companies. And that is a problem, and that is a problem that I think there is overwhelming bipartisan support to solve.

You know what I was thinking? Congress passes lots of bills, and every bill that is passed is well intended, but oftentimes what happen are unintended consequences. And I was thinking about a couple of issues and bills that I have a pretty good amount of knowledge on in banking: Dodd-Frank. You know, Dodd-Frank was passed after the banks failed. The goal was to hold the banks accountable and to not have any more banks that are too big to fail, and what has happened since Dodd-Frank, there have been no new banks created. All the small banks are consolidating or being taken over by big banks, so we have less choice out there, and it has not reduced the price of banking. I would argue it has increased the price of banking, more fees because there is less competition.

The Farm Bill. I am a farmer by trade. I am going to support the Farm Bill, but the Farm Bill has a lot of policy in there in my opinion, and I have argued and argued, that gives the large farmer a competitive advantage over the smaller farmer. It is almost impossible for a small farmer to get started in agriculture today, but the big farmers keep getting bigger every day.

Then you look at healthcare. We have legislation that is passed and written in the legislation. There are higher reimbursements to larger medical providers with respect to Medicare and Medicaid reimbursements. And what has happened is it has almost forced every small family physician to join a larger network, and you have less choice out there, and it has not reduced the cost of healthcare. It has reduced competition. It has reduced choice and options for people, especially in rural America. And then PBMs. As I said earlier, no one ever envisioned PBMs to get to where they are today and be such massive vertically integrated companies.

So, we need to have robust debate about this, we need to continue to have dialog, we need to start exploring options, and we need to get something done because healthcare is one of the biggest, if not the biggest, problems we have in America. And a very few times in Congress is there bipartisan agreement to fix something in healthcare, so I welcome the opportunity to continue to work with my Democrat colleagues to try to come up with a solution to fix this problem, to add transparency, and to lower the cost of prescription drugs for every American.

With that, I want to again thank our panelists once again for their important and insightful testimony today.

With that and without objection, all Members will have 5 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 1:08 p.m., the Committee was adjourned.]