THE ROLE OF PHARMACY BENEFITS MANAGERS IN PRESCRIPTION DRUG MARKETS PART III: TRANSPARENCY AND ACCOUNTABILITY

HEARING

BEFORE THE

COMMITTEE ON OVERSIGHT AND ACCOUNTABILITY U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED EIGHTEENTH CONGRESS

SECOND SESSION

JULY 23, 2024

Serial No. 118–123

Printed for the use of the Committee on Oversight and Accountability

Available on: *govinfo.gov*,
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U.S. GOVERNMENT PUBLISHING OFFICE
56–324 PDF WASHINGTON : 2024

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C O N T E N T S

WITNESSES

Opening statements and the prepared statements for the witnesses are available in the U.S. House of Representatives Repository at: docs.house.gov.

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THE ROLE OF PHARMACY BENEFITS MANAGERS IN PRESCRIPTION DRUG MARKETS PART III: TRANSPARENCY AND ACCOUNTABILITY

Tuesday, July 23, 2024

U.S. 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, Gosar, Foxx, Grothman, Palmer, Sessions, Biggs, Fallon, Donalds, Timmons, McClain, Fry, Langworthy, Burlison, Raskin, Norton, Lynch, Connolly, Krishnamoorthi, Khanna, Mfume, Porter, Brown, Stansbury, Frost, Lee, Casar, Tlaib, and Pressley.

Also present: Representatives Harshbarger, Miller-Meeks, Carter, Maloy, and Auchincloss.

Chairman COMER. This hearing of the Oversight and Accountability Committee will come to order. I want to welcome everyone here today.

Without objection, the Chair may declare a recess at any time, and I want to add that we will be recessing. We hope to get all the opening statements in. The House is unfortunately called to vote this morning, supposed to be somewhere around 10:30. But we will attempt to get mine and the Ranking Member's opening statements in as well as the opening statements of our witnesses, then we will hopefully take the recess, we will have votes, and then we will reconvene the hearing and begin with the questions.

I now recognize myself for the purpose of making an opening statement. But first, without objection, Representatives Buddy Carter of Georgia, Diana Harshbarger of Tennessee, Celeste Maloy of Utah, Mariannette Miller-Meeks of Iowa, and Jake Auchincloss of Massachusetts are waived on the Committee for the purpose of questioning today's witnesses.

Without objection, so ordered.

I want to welcome everyone to today's hearing on the role of pharmacy benefit managers in pharmaceutical markets. This is the third in a series of hearings discussing pharmacy benefit managers, or PBMs, and their role in the pharmaceutical market. At our first hearing, we heard from practitioners who interact with PBMs daily

and a transparent PBM executive. They shared how PBMs affect their ability to help patients and can negatively impact patients' health. Dr. Miriam Atkins, an oncologist in Georgia, discussed how PBMs dictate which drugs a patient can use and require the use of mail-order pharmacies. Kevin Duane, an independent pharmacist in Jacksonville, Florida, explained that he is no longer able to serve Tricare beneficiaries because Express Scripts forces Tricare beneficiaries to use specific pharmacies on military bases. As a result, hundreds of thousands of uniformed service members and their families have less access to prescription medications. Greg Baker, the CEO of a transparent PBM, discussed the importance of PBM reform in reducing the costs of prescription drugs.

At our second hearing, we heard from several stakeholders, including the National Community Pharmacists Association, the Pharmaceutical Research and Manufacturers of America, the Association for Accessible Medicine, and the Pharmaceutical Care Management Association. These witnesses provided testimony that the largest PBMs use spread pricing and abusive rebating practices, making it more difficult for generics, biosimilars, and other competitors to gain market share. We heard that the largest PBMs under reimburse competing pharmacies while overcharging payers and pocketing the difference. We learned that the largest PBMs steer patients to the pharmacies they own while often charging payers more and providing less care.

Now this Committee has the opportunity today to hear from the CEOs of the three largest PBMs: CVS Caremark, Express Scripts, and Optum Rx. In March of last year, I sent letters to CVS Caremark, Express Scripts, and Optum Rx requesting information about each business. Since then, we have received more than 140,000 pages of documents from the three largest PBMs, including details about their formularies, rebates, pharmacy networks, and contracts. In reviewing these documents, we have learned the three largest PBMs have used their position as middlemen and integration with health insurers, pharmacies, providers, and, recently, manufacturers, to enact anticompetitive policies and protect their bottom line. The largest PBMs share patient information and data across their many integrated companies for the specific and anticompetitive purpose of steering patients to PBM-owned pharmacies.

These PBMs frequently tout the savings they provide for payers and patients through negotiation, drug utilization programs, and spread pricing, but evidence indicates that these schemes increase costs for patients and payers. The largest PBMs force drug manufacturers to pay rebates in exchange for the manufacturers' drugs to be placed in a favorable tier on a PBM formulary, making it difficult for competing, lower-priced prescriptions, often generics or biosimilars, to get on formularies.

As many states and the Federal Government weigh and implement PBM reforms, the three largest PBMs have begun creating foreign corporate entities and moving certain operations abroad to avoid transparency and proposed reforms. The largest PBMs' use of tools, such as prior authorizations, fail first policies, and formulary manipulations hurts patients and result in poorer health

outcomes. The anticompetitive policies of the largest PBMs have cost taxpayers and reduced patient choice.

Today, the Committee is releasing a staff report outlining the results of our investigation into PBM policies. Simply put, the Committee's investigation has found that while PBMs' position as middlemen should have enabled them to reduce the costs of prescription drugs and improve Americans' health outcomes, they have not. Instead, the cost of prescription drugs has gone up every year for 15 years. Instead, patients have less choice and worse health outcomes.

I ask unanimous consent to enter the Committee staff report titled, "The Role of Pharmacy Benefit Managers in Prescription Drug Markets," into the record.

Without objection, so ordered. I encourage everyone to read this.

I am hopeful that today's hearing will provide transparency and accountability for how PBMs have impacted the market for prescription drugs. I now recognize Ranking Member for his opening statement.

Mr. RASKIN. OK. Thank you, Mr. Chairman. Welcome to the witnesses. It is the third Committee hearing this Congress on the subject, and we finally have the largest PBMs here at the table. Thank you for joining us. Patients say that some of your practices are making it more difficult and more expensive to access the medication that they need, and so we need to hear from you about what is going on. The three companies represented today account for 80 percent of the PBM market, which means that the three of you sitting here are responsible for the policies and practices that directly affect the lives and the health and the pocketbooks of 270 million people in America, most of whom are not even aware that your companies exist.

People do not choose their PBMs. People do choose a health insurance plan, which, in turn, has a PBM. Most people are offered a choice between a small number of health insurance plans, and then they wade through somewhat confusing language and murky distinctions to find the one that they think is best suited to the needs of their family. Nobody is thinking about the PBM that accompanies the health plan they use. In fact, most people do not even know that the health plan they are selecting is going to be working with a PBM. No one is considering the health insurance plan that they spend hours trying to select is closely affected not just by the insurance company, but also by another enormous business looking to profit.

Although PBMs operate way outside of public consciousness, your companies have immense power over patients. PBMs create the list of medications that determine what will and will not be covered by an insurance plan. They determine how much those medications will cost, and they determine which pharmacies a patient can or cannot use to access the medications. Your three companies are dictating these terms for four out of five people in our country, and I am glad you are here with us today to provide serious, robust insight into these decisions.

While we do not have a lot of visibility into the inner workings of PBMs, the work this Committee has done on PBMs this Congress has provided many examples of how your policies are not nec-

essarily always working for the people that are served. The New York Times recently reported that one of your companies was charging patients on Medicare more than $650 for a medication that would have cost less than $50 at an online pharmacy without any insurance at all. A different patient was reportedly charged $211 by one of your companies for a drug he could have acquired at Costco for $22. That is a 10-to–1 ratio between what people are paying through the PBMs versus what they could get in just an out-of-pocket purchase. Who do these policies benefit? Well, obviously not the patients. It seems they benefit the PBMs, which gets reimbursed by the health insurer for that higher price.

Even if this system works for some patients, it is clear that many served by your companies are falling through the cracks, whether they experience delays in getting the medicine they need or they are forced to overpay. In a for-profit healthcare system, we know companies are going to seek profits, but it is unacceptable for those profits to come at the expense of patients getting the basic medicine that they need to lead their full and healthy lives.

Democrats on the Committee have long worked to hold Big Pharma accountable for the ways in which they relentlessly manipulate the price of medications and make them unaffordable for tens of millions of Americans. Our 3-year investigation revealed that pharmaceuticals use anticompetitive tactics to stop generics from entering the market and to target the U.S. for high prices because our government simply did not have the power to directly negotiate with them the way that our pure countries do. But last Congress, Democrats passed the Inflation Reduction Act, and the wins from that landmark legislation are already being felt. Beginning next year, Medicare will negotiate drug pricing directly with the pharmaceuticals, and drug companies will now have to reimburse the government when they raise prices beyond the rate of inflation.

But we have a long way to go to place people over profits to put healthcare first. I hope that today's hearing can shed light on the way that PBMs are taking a page from Big Pharma's practices and exacerbating the drug affordability crisis. We need a healthcare system that is going to work for the people. Thank you, Mr. Chairman. I yield back.

Chairman COMER. The gentleman yields back. Today we are joined by David Joyner. He is the president of CVS Caremark and executive vice president of CVS Health. He has worked for more than 27 years in the healthcare and PBM industry. Dr. Adam Kautzner—did I pronounce that right? I usually do not—I apologize—is the president of Express Scripts and Evernorth Care Management. He earned his Pharm.D. from the St. Louis College of Pharmacy and is a nuclear pharmacist. Dr. Patrick Conway is the CEO of Optum Rx. He is a practicing pediatric hospitalist, who earned his medical degree from Baylor College of Medicine and a Master of Science in clinical epidemiology from the University of Pennsylvania. Thank you all for appearing here today. I am looking very forward to your testimony and questions.

Pursuant to Committee 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 that the witnesses answered in the affirmative. Thank you all. You may take a seat.

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

I now recognize Mr. Joyner for his opening statement.

STATEMENT OF DAVID JOYNER
EXECUTIVE VICE PRESIDENT
CVS HEALTH AND PRESIDENT OF CVS CAREMARK

Mr. JOYNER. Thank you, Chairman Comer, Ranking Member Raskin, and members of the Committee. I am David Joyner, President of CVS Caremark. I am here to provide you with the facts about what we do at Caremark: to bring down the cost of prescription drugs for millions of Americans.

We have successfully converted 90 percent of prescriptions to generics, driving costs to historic lows. That means our patients only pay $8 out of pocket, on average. We did the same for brand-name drugs. From 2017 to 2022, our proven tools and strategies drove down the net cost of brand-name drugs by 15 percent. Despite these successes, brand products with little to no competition remain the chief source of rising drug costs, spurred by their high list prices. Last year, a new-to-market drug carried a median annual price of $300,000, and Humira, Ozempic, and Stelara alone cost more than every generic drug we covered, combined.

Humira perfectly illustrates the challenge. Thanks to a strategy of patent manipulation, AbbVie blocked any competition, and it became the single most expensive drug for our customers and their members. The good news is that we were uniquely positioned to promote the adoption of biosimilars to deliver lowest costs at the pharmacy counter and to get these drugs to the people who need them. So, in April, we dropped Humira from our major formularies, covering only the biosimilars. Today, members are paying lower costs, in most cases zero dollar out of pocket, and employers, unions, and health plans have realized over half a billion dollars in savings. That is the impact we are having with just one drug. Now, across the more than 70,000 drugs we cover, we are leading the industry and our clients by prioritizing products with low list prices while maximizing savings for employers.

And let me be clear. We do not contribute to rising list prices, a fact confirmed by multiple, quantitative independent studies. Hampering our ability to negotiate lower drug costs only benefits the pharmaceutical manufacturers. These drug manufacturers who testified on Capitol Hill said they would not lower list prices if re-

bates were eliminated, it would only remove an essential tool in our ability to deliver lower cost medications, but there is always room for improvement. And I returned to CVS Caremark last year to evolve our PBM by increasing transparency and accountability. We have made major changes that benefit employers, labor unions, public health plans, Medicaid and Medicare, and the pharmacies that we work with. The way drugs are priced and reimbursed today is not transparent enough for patients, pharmacies, or plans.

That is why we built TrueCost, a transparent, cost-plus model, for every drug that we cover. We show our clients how much we pay and reimburse for every single drug, for every pharmacy in our network. For the more than 27,000 independent pharmacies in our network, they will be reimbursed in line with the price they pay to acquire each drug and to provide additional dispensing and administrative fees to cover their services for patients. Independent pharmacies representing 40 percent of our network are vital to our work. We reimburse them at a higher rate than we do CVS-owned pharmacies and as much as 25 percent higher for generics. We also have a network of 700 rural pharmacies with even higher reimbursements, 90 of which were added in the last year alone.

Despite our work, danger lies ahead for the American healthcare system: the price of GLP–1 drugs. Between skyrocketing demand and price hikes, the costs are overwhelming. Ozempic, Mounjaro, and Wegovy drove more than two-thirds of increased costs for CVS Caremark customers in 2023. If every adult with obesity received a GLP–1 prescription, costs would surpass $1.2 trillion annually. That is more than America spends annually on all drugs.

We will continue to do what is best: use the power of competition to make these medications available at lower cost to the people who need them. It is our job to provide affordable access to important, lifesaving medications that improve the quality of life for millions of Americans. We enable employers, unions, and state health plans to take care of their people, and when drug manufacturers want to charge them too much, we are there to rein them in. Thank you.

Chairman COMER. Thank you. I now recognize Dr. Kautzner for his opening statement.

STATEMENT OF ADAM KAUTZNER, PHARM.D.
PRESIDENT
EXPRESS SCRIPTS AND EVERNORTH CARE MANAGEMENT

Dr. KAUTZNER. Chairman Comer, Ranking Member Raskin, and members of the Committee, thank you for inviting me to testify today. My name is Adam Kautzner. I grew up in rural Missouri and began my career as a pharmacist for a regional hospital before joining Express Scripts more than 15 years ago. For decades, our mission has remained the same: helping employers, labor unions, government agencies, and health plans provide more affordable, higher-quality prescription benefits to their members. These sophisticated purchasers demand value and drive innovation from Express Scripts every single day. That mission is also very personal to me. In my early 30's, I was diagnosed with stage 3 melanoma, which then progressed to stage 4. I am here today because of pharmaceutical innovation, and it is why I work so hard to lower costs for more people to access the drugs they need.

In 2023, we helped keep average patient costs for a 30-day prescription to $15 for those with employer-sponsored plans. Alongside our clients, we shield patients from approximately 90 percent of drug costs in the healthcare system. In fact, patients spent less out-of-pocket in 2023 than in 2022, despite rising list prices set by manufacturers, because of our work to negotiate discounts across the supply chain. Our deep clinical expertise helps patients navigate complex care journeys, improve medication adherence, and prevent disease progression and comorbidities. From developing formularies that help guide patients to clinically sound medications to performing safety and quality checks on millions of prescriptions each day, we are the connective fiber fighting to ensure access to safe, effective, and affordable medications.

Many members of this Committee have expressed concerns regarding the viability of pharmacy access in rural and underserved America. As a pharmacist and someone who grew up in rural America myself, I understand this challenge and agree it must be addressed. Over the past year, we have worked to enhance reimbursement to pharmacies serving these areas, created new pharmacy revenue streams through clinical services, and we have regularly convened an advisory committee of independent pharmacists led by a former independent pharmacist. Over the past 5 years, the number of independent pharmacies in our network has increased by 20 percent.

I know there are questions regarding the transparency of pharmacy benefit services. Transparency is built into all of our pricing models, including our principal revenue sources, arrangements with manufacturers, and pharmacy claims data. Personalized information about the cost of prescription drugs is provided to millions of patients in real time to help them make more informed decisions with their doctors. I also know significant challenges remain. The median cost of a new medication in 2023 was $300,000, up from $180,000 in just 2 years. As newer and more sophisticated therapies continue to come to market with increasingly unsustainable prices, we need solutions to ensure people who need them can benefit from these innovations affordably.

Challenging our efforts to lower prescription drug costs are brand drug makers who exploit the patent system to maintain high prices for years beyond the date generics and biosimilars should become available to patients. For example, the primary patent for Humira, the best-selling drug in the world, expired in 2016. But biosimilar competition could not launch until 2023 because of the patent thicket constructed by the manufacturer. We applaud recent efforts to drive more competition and address patent abuses intended to maintain high drug prices. These efforts will lower prices for American patients and save billions for American businesses and taxpayers.

In closing, our mission and our business model, one, provide innovative solutions that enable access to medications at affordable costs and improved health outcomes; two, ensure clients have choices that enable them to deliver accessible, affordable pharmacy benefits; and three, share additional levels of transparency about the value we create. I appreciate this opportunity to answer your

questions about our role and how the value we create reaches patients. Thank you.

Chairman COMER. Thank you. Dr. Conway.

STATEMENT OF PATRICK CONWAY, M.D.
CHIEF EXECUTIVE OFFICER
OPTUM RX

Dr. CONWAY. Thank you, Chairman Comer, Ranking Member Raskin, and Members of the Committee. I am Dr. Patrick Conway, CEO of Optum Rx, a part of United Health Group. Optum Rx is a pharmacy services company that works to make healthcare more affordable and accessible and to improve health outcomes for our customers and patients. I am also a pediatrician, seeing patients on weekends at a Boston hospital, and I would like to share one experience from my earliest days as a physician that I will never forget and shapes my mission for patient care.

I sent a child home from the hospital with a prescription for a common antibiotic to treat a mild infection. In less than 24 hours, the child was back, readmitted, because when the mother took the prescription to the pharmacy, it cost $200 that she did not have. A scared kid and a terrified parent spent 7 days in a Boston hospital because they could not afford an antibiotic. This was a costly outcome for the system and, most importantly, an example of how we must do better for patients and families.

Experiences like that one, the realities that people face when it comes to paying for medicine and accessing care, drive our work at Optum Rx. They are what we have in mind when we deploy innovations like our Critical Drug Affordability Program that offers low or zero-dollar cost sharing on more than 290 brand and generic medicines including common antibiotics. Optum Rx exists to ensure patients have access to the safe and effective prescription drugs they need while managing their cost. My testimony focuses on how we do just that.

I would like to start with our critical role in prescription drug affordability and access. The high price of new drugs are challenging the healthcare system. In 2023, the median annual list price for a new medicine was $300,000, a 40-percent increase from 2021. The 5,000 plus customers who hired us, including employers, unions, health plans, and governments, rely on Optum Rx to be the counterweight to drug manufacturers' high and increasing list prices.

Our negotiated discounts and clinical tools deliver more than $2,000 per person in average annual drug savings, and a recent analysis found that PBM saved the broader healthcare system approximately $145 billion annually. Today we compete with more than 70 companies that offer a full range of pharmacy benefit services. We compete on the strength of our clinical capabilities, patient support programs, drug trend analytics, and our ability to lower drug costs for our customers.

Everything we do is rooted in a clinical foundation, starting with our independent Pharmacy and Therapeutics Committee, which, through clinical rigor, provides unbiased, evidence-based review of new and existing drugs and their place in therapy. We offer clinical programs and affordability tools to support each stage of a patient's healthcare journey. We also offer our customers a wide range of

formularies and pricing solutions to meet their affordability, predictability, and accessibility expectations. We negotiate with drug manufacturers to secure the lowest possible net cost for our customers. More than 90 percent of prescriptions are for low-cost generics, often without rebates, so negotiated discounts on the remaining 10 percent of expensive branded drugs are the only check on manufacturers' pricing power. Optum Rx passes through 98 percent of those discounts to our customers.

Our customers recognize the value of our work. In a recent survey, 97 percent of employers said they were satisfied with their PBM, and 93 percent said that it is essential to have the flexibility in how they offer prescription benefits to their employees. Our customers have diverse priorities, and preserving the options available to them is critically important. Optum Rx is committed to providing its customers with actionable transparency that helps them understand their options and how their pharmacy dollars are being spent. We are also committed to supporting our pharmacy partners by, for example, promoting their value as care providers in rural and underserved areas. We support legislation that will preserve and grow options for planned sponsors and how they offer coverage.

Congress should also take steps to rein in drug manufacturer patent abuses that have delayed generic and biosimilar launches, inhibiting the true market competition that leads to lower prices. We believe this holistic approach helps promote affordable and accessible prescription drugs. Several legislative proposals currently under consideration would work at cross-purposes with these goals. We believe these proposals would not lower manufacturer list prices, but would result in increased drug costs for employers, unions, health plans, and governments. We look forward to continuing our shared work addressing affordability and access to prescription medicines.

Thank you for your time today, and we welcome your questions.

Chairman COMER. Well, thank you all very much for your testimony. We will begin with questions. The House has called votes, but we have agreed I am going to get my questions in and Mr. Raskin will get his in, and then we will take a recess until 10 minutes after the final vote. So, I recognize myself for 5 minutes.

Mr. Joyner, are you familiar with CVS Caremark's lawsuit with New York Cancer and Blood Specialists regarding DIR fees?

Mr. JOYNER. I am.

Chairman COMER. Last week, the Southern District of New York ruled in favor of the practice and ordered CVS Caremark to pay over $20 million in back DIR fees, interest, and attorney's fees.

I ask unanimous consent to enter that ruling into the record.

Without objection, so ordered.

I understand that other oncology practices are in arbitration with CVS Caremark over the same issue and you are attempting to prevent those from becoming public. Given the Federal Court findings, do you intend to pay all practices back for a clear miscalculation of DIR fees, or do you intend to fight them all like you did the New York practice?

Mr. JOYNER. Thank you, Mr. Chairman. In specific response to these cases, we do actually comply with all Medicare Part D rules, and, in fact, part of this is actually creating network adequacy and

also making sure we are managing the network according to the terms and conditions. So, in this case, our goal is to apply these consistently across all 65,000 pharmacies and, most importantly, making sure we get the right drug to the right patient at the right cost.

Chairman COMER. So, are you going to fight the other rulings, or are you just going to pay, just out of curiosity, have you decided yet, the other lawsuit?

Mr. JOYNER. Yes. Consistent with what I had mentioned earlier, we do comply with the Medicare Part D rules, and we will make sure that we are consistent.

Chairman COMER. OK. This next question is to all the witnesses. During the Committee's investigation, we found evidence that each of your companies steer patients with long-term maintenance and other high-cost medications to the mail-order pharmacies you own, even though it often results in more difficulty for a patient to get their medication. Will you commit to stop steering patients to the pharmacies you own and instead let them choose the pharmacy that is best for them and pay the same price for the same prescription regardless of where they pick up the prescription? Dr. Conway?

Dr. CONWAY. We do provide patient options, including home delivery, and we will continue to provide those options to patients.

Chairman COMER. Dr. Kautzner?

Dr. KAUTZNER. Thank you for the question, Chairman. We focus on our clients—employers, labor unions, government entities—to make those decisions on their plan benefit designs, and so they make the decision on what types of pharmacies they want to provide.

Chairman COMER. So, are you denying that the PBMs steer patients from the independent pharmacies to your own mail-order pharmacies?

Dr. KAUTZNER. So, we carry out the benefit designs that our clients choose, and that is how we provide our services. For home delivery pharmacies today, the safety and efficacy for those patients——

Chairman COMER. Mr. Joyner, will you commit to——

Mr. JOYNER. Yes. Mr. Chairman, we will continue to offer home delivery at the request of our customers.

Chairman COMER. So, I am going to take that as an answer. You are going to continue to steer patients away from independent pharmacies to your own mail-order pharmacy. That is how I interpret those answers.

Next, during the Committee's investigation, we found 300 examples of PBMs placing higher-cost medications in more preferred positions on formularies. A report that just came out found that not only are you prioritizing higher-cost medications, you are setting dramatically different prices for some medications across the country. The report found that Suboxone, a critical treatment for opioid abuse, is being charged at 600 unique prices by just one of your companies, and another is charging 448 unique prices. Out of the top five PBMs, the lowest number of price points was over 200. Your companies have constantly claimed that drug companies set

market prices, but if that is the case, why are your companies charging different prices across the country? Mr. Joyner?

Mr. JOYNER. So, specifically, as it relates to creating competition with the manufacturers, we have done a remarkable job of lowering the cost of brand pharmaceuticals. In fact, if you look over the time period of 2017 to 2022, brand-name drugs have decreased by 15 percent. So, in keeping with our goal and our focus as a pharmacy benefit manager, it is to create the competition and lower the cost of pharmaceuticals for the customers which we serve.

Chairman COMER. Dr. Kautzner?

Dr. KAUTZNER. Last year alone, we saved our clients $64 billion, and we kept patient out-of-pocket costs on a per-prescription basis at just $15, despite brand manufacturers raising drug prices on 60 percent of those products. It is hard work to keep those costs down for patients and clients.

Chairman COMER. Dr. Conway?

Dr. CONWAY. As you said, manufacturers set the high list prices, but we are committed to providing the lowest net cost options to our clients so the drugs are more affordable to the people they serve.

Chairman COMER. So, your testimony today, it is not the PBMs, it is the drug manufacturers. That is the answer, because that is not what our report has concluded. That is not what we hear from doctors all across America. That is not what we hear from pharmacists all across America. We hear that you are the problem, and that is why we have had three hearings on this. This is why this is a huge issue. This is why just about every state now is taking up PBM reform.

There is a credibility issue with the PBMs, there is a transparency issue with the PBMs, and it does not appear that the PBMs are being consistent. We believe you have anticompetitive policies. I have more questions, but my time has expired. I will get some more time in a minute. I yield now to Ranking Member Raskin.

Mr. RASKIN. Thank you, Mr. Chairman. I wonder, do any of you guys have high school-aged children? You do, Dr. Conway. All right. So, do not set this at the elementary school level because I do not want it to be just you trying to help people. Do not set it at the Ph.D. level, but set it at the high school level. Explain to a high school student what the PBM does and what value you render in America's confusing healthcare system. Could you?

Dr. CONWAY. Yes. So, the way I would describe it to a high school student is the following. We provide lower-cost drugs to the people we serve—employers, unions, state governments, others—and we provide accessible, affordable options to people. It is based on clinical evidence on what medicines are most effective, and then we negotiate for the lowest net cost transparently and provide that information both to the customer and to the patients we serve.

Mr. RASKIN. OK.

[Chart]

Mr. RASKIN. The graphic behind me shows that when combined, the larger healthcare conglomerates, to which your three companies belong, control 20 percent of America's national healthcare expenditures, a figure that has been growing substantially. And the

three PMs represented today, independent of their parent companies, are so big that you would all fall within the top 40 businesses in America by revenue, and this size means that collectively you control nearly 80 percent of prescription drugs dispensed in the country. The next three largest PBMs account for 5 percent of the market, and the remaining 60 PBMs account for 6 percent of prescriptions managed and dispensed. OK.

So, Mr. Joyner, let us take you. Excluding the two large companies represented at the table along with you today, of the 60 PBMs that account for just 6 percent of the market, which does CVS Caremark consider to be, say, its top three competitors?

Mr. JOYNER. So, there are a variety of competitors, 70-plus PBMs in the marketplace all competing respectively for customers. This is a highly competitive marketplace, and we basically win and lose based off the value proposition that we present to our customers.

Mr. RASKIN. OK. So, who would be the top three outside of the mega corporations represented? Who would be your top three competitors for that 6 percent?

Mr. JOYNER. Yes. It will depend on the market segment. So, there are some Blue Cross Blue Shield solutions that compete effectively within that, so that would obviously be a competitor for that particular segment of the marketplace.

Mr. RASKIN. OK. Well, would you agree that the PBMs should be held accountable to the patients and not just the institutions you represent, or would you disagree with that? Dr. Kautzner, let me ask you.

Dr. KAUTZNER. We are absolutely, Ranking Member Raskin, accountable to our patients, and I think it is important to recognize that.

Mr. RASKIN. Can you explain how you are held accountable to your patients?

Dr. KAUTZNER. Sure. Every prescription that we process today undergoes 18,000 safety, quality, and benefit checks in less than 1 second. And with that work, we will prevent approximately 100 million potential medication errors this year, so that is how we positively affect patients. We also——

Mr. RASKIN. Right, but that is different from the question of accountability, so, I mean, the answer could be, no, that is not your function in the marketplace. But is there any accountability mechanism between you and the actual patients, or do you just deal with the institutions, the businesses, the unions, and so on that you represent?

Dr. KAUTZNER. So, our contracts are with employers, labor unions, government entities, but we absolutely are committed to patient care and health and care coordination. That is why we employ thousands of nurses and pharmacists within our organizations to provide that high-quality clinical care.

Mr. RASKIN. All right. Can you explain again and put it in clear terms because a lot of this stuff is hard for people to understand, OK? Why is it that there are so many cases that the Committee has found—the Chairman has cited them—where people are ending up being charged 10 times more within one of the plans than they would be if they were just to go and pay out of pocket for a drug? Why does that happen? Can you explain that?

Dr. KAUTZNER. So, today, for over 80 percent of patients in America, they spend less than $250 on all of their prescriptions in a given year. There are 1 percent of patients where challenges still exist, where that 1 percent may spend over $2,000 annually on prescription drugs. That is the group that we are providing patient savings programs for and working hard to provide improved patient benefit designs so that we can keep costs down in that area.

Mr. RASKIN. Again, I feel like the more I hear, the less I understand. I mean, I just have one simple question. If somebody is covered by one of the plans, how is it possible that they have got to pay 10 times more than they would pay if they were just to go and pay out of pocket for the drug? I mean, Mr. Joyner, can you explain why that would happen? And, I mean, I am willing to believe maybe that is not the majority of the cases. I think that is what you are saying, Dr. Kautzner. But can someone just tell us why that happens and it can help us understand the dynamics of this market?

Mr. JOYNER. Yes. As I said earlier, there are a variety of different pricing models in the marketplace today. What you are referring to is what, generally, is an average pricing that we have contracted with our clients. The good news is, and as I mentioned earlier about coming back into CVS Caremark, is I am trying to change and transform the marketplace, which is in large part why we introduced TrueCost, which is a price model that actually allows us to guarantee every drug at every pharmacy across 14,000 different medications. So, that would, in effect, get you to the consistency and actually eliminate many of the headlines that you are referencing.

Mr. RASKIN. All right. My time is up, Mr. Chairman. Thank you for your indulgence, and I look forward to questioning by our colleagues, including Representative Auchincloss, who is a real specialist in this. And I hope we will just get some illumination today about some of these strange things we found. Thank you.

Chairman COMER. Thank you. The Ranking Member yields back. Before we recess, I will make an announcement. Director Cheatle just resigned from the Secret Service.

Mr. RASKIN. Well done, Mr. Chairman. That was a great hearing.

Chairman COMER. Maybe you should sign more letters with me. No telling what we could do.

Mr. RASKIN. I mean, bipartisanship might be the wave of the future.

Chairman COMER. All right. Pursuant to the previous order, the Chair declares the Committee in recess, subject to the call of the Chair.

[Recess.]

Chairman COMER. The Committee will come back to order.

I now recognize the gentleman from Alabama, Mr. Palmer, for 5 minutes.

Mr. PALMER. Thank you, Mr. Chairman. I have got a number of concerns about how PBMs have operated and how it is impacting rural pharmacies. I grew up in rural Northwest Alabama and understand a lot of the pressures that are being placed on independent pharmacies, and I have just got some questions that I would like to run by.

There has been some significant confusion as to how much of the direct and indirect remuneration fees PBMs retain in the Medicare Part D program. So, I would like to try to clear that up. And if you could answer this, what percentage of DIR that your companies receive from competing pharmacies, in terms of what percentage are distributed to the U.S. Government—you might want to write this down—patients, insurer, or the plan are retained by the PBM? Mr. Joyner?

Mr. JOYNER. Congressman Palmer, the program you are referencing was discontinued in 2023.

Mr. PALMER. That program was discontinued?

Mr. JOYNER. Yes. Yes, sir.

Mr. PALMER. Can you tell me what percentage of the funds were retained in those categories up until then?

Mr. JOYNER. The program you are referring to was a performance-based network, and it was distributed to the high-performing pharmacies as a way of actually rewarding and recognizing or incentivizing high performance within the pharmacy network.

Mr. PALMER. You did not answer. You are not answering the question. So, what I would like to do is rather than go through this exercise of delay is just have each of you respond in writing to the Committee. Mr. Chairman, I would like to make sure that they do that.

Mr. PALMER. The three largest PBMs control over 80 percent of the market and wield enormous influence over America's access to prescription drugs and the prices that the people who need those drugs have to pay. And the PBMs tout themselves as companies that are reducing the cost of medications for all Americans. Yet the cost of prescription drugs and the spending on prescription medications have gone up every year for more than a decade. And so, it just raises the question, you know, how can you convince the American people that you are helping reduce the cost of prescription drugs when they have gone up so much? Dr. Kautzner?

Dr. KAUTZNER. Thank you for the question, Congressman. So, for patients that we serve, in 2023, patients spent less out of pocket on average for a 30-day prescription as they did in 2022, despite brand manufacturers raising prices on 60 percent of those drugs.

Mr. PALMER. What we saw is that some name-brand drugs were costing 35 times more, and that is the information that I have been given at PBM-owned mail-order pharmacies than independent pharmacies, and so I do not understand why there would be that much of a disparity. How could it be that on some of these drugs, and I am not saying all of them, but on the PBM-managed mail-order pharmacies, they would be 35 times higher? How do you explain that?

Dr. KAUTZNER. So, Congressman, I would be happy to look at those individual examples and be able to get back to you on those pieces.

Dr. KAUTZNER. What I can say is, on average, today, our employers make the decision on whether they want to have a home delivery pharmacy included in their network or not, so that is completely up to them.

Mr. PALMER. But do you think it is acceptable to charge a substantially higher price through a program that, say, an employee

has to be in than what a competitor would charge if they had access to the competitor's plan?

Dr. KAUTZNER. So, our employers hold us accountable to ensure that we are administering benefits at their direction that are providing lowest net cost for patients and for them. We help them build those benefit designs to do that.

Mr. PALMER. I mean, there is a New York Times article that exposed how PBMs operate in the marketplace, highlighting how they are driving independent pharmacies out of business, and they are not paying enough to cover costs. CVS Caremark overcharged an Oklahoma health plan for state employees $120,000 for just one cancer patient's medication. They also overcharged an Illinois cancer patient hundreds of dollars more than needed due to Caremark's formulary requiring her to use the more expensive version of the drug. Express Scripts forced a New Jersey retiree to pay $211 for his allergy medication when he could have gotten it for $22 at Costco.

So, each of you, I just want you to explain why you overcharge patients, employers, and the Government at some fairly exorbitant rates but often reimburse pharmacies less than it costs them to buy the drug in the first place. That does not make sense. You can respond to that. I know my time has expired. Each one of you can respond to that.

Mr. JOYNER. So, our experience proves that we actually pay CVS pharmacies less than we do other pharmacies in our network, and, in fact, when we do have people go into our pharmacies, they are paying, on average, 4.7 percent less.

Mr. PALMER. Mr. Joyner, you could pay a huge pharmacy like CVS less and still be overcharging, creating a massive disadvantage for the other pharmacies because their volume is so much lower. I will yield back, but let them respond, Mr. Chairman.

Chairman COMER. OK. The gentleman's time has expired, but please feel free to answer the question. Anybody?

Dr. KAUTZNER. Yes, happy to answer the question, Congressman. So, I grew up in rural America. I went to independent pharmacies growing up. I know that they are the major point for access to care for many underserved areas, both in urban and rural areas. Our focus as an organization has been to, one, help them evolve their business model to provide high-quality care in new and different ways, whether those are strep tests, biometric tests, behavioral screenings, those types of things. We also have convened an independent Rx initiative for independent pharmacists. So, we are convening on multiple times a year now 3 dozen independent pharmacist owners to help work with them so that we can become more productive together because we do agree that having independent pharmacies strong in our network is something that we feel passionate about. And actually, in the last year, 1,400 independent pharmacies have increased in our network in the last year. So, our work is paying off, and we are seeing more independent pharmacies continue to come into business and join our network.

Mr. PALMER. Mr. Chairman, I just want to make sure that people understand that when you have these huge pharmacy chains that do a massive volume, that they could actually make less on per transaction, but the cost of the volume still make a healthy profit

than a smaller independent that does not have that volume. I yield back.

Chairman COMER. The gentleman yields back. Mr. Krishnamoorthi, are you ready, or do you want to leave?

Mr. RASKIN. We will go to Dr. Foxx.

Chairman COMER. Or I can go to Dr. Foxx. You want to go?

Mr. KRISHNAMOORTHI. I can go.

Mr. RASKIN. Krishnamoorthi.

Chairman COMER. OK. The Chair recognizes an expert on PBMs, Mr. Krishnamoorthi from Illinois.

Mr. KRISHNAMOORTHI. Thank you, Mr. Comer, and thank you to the gentlemen and the witnesses. I understand that you are here today to advance what I understand to be your shared position, namely as the CEO of your trade association. PCMA recently stated, "Nothing can change the fact that PBMs have a proven track record of reducing prescription drug costs." Mr. Joyner, this is your collective position, correct?

Mr. JOYNER. That is correct.

Mr. KRISHNAMOORTHI. Well, I would like to just review some documents. First of all, in an interim staff report released this month, the FTC calls PBMs, "the powerful middlemen inflating drug costs and squeezing Main Street pharmacies." Mr. Joyner, that is what the FTC says, correct? It is right here.

Mr. JOYNER. That is correct.

Mr. KRISHNAMOORTHI. Now, let me just point to another headline, this time in the *New York Times*. The headline of this *New York Times* article is, "The Opaque Industry"—referring to PBMs—"Secretly Inflating Prices for Prescription Drugs." Dr. Conway, you do not deny that the *New York Times* headline says this, correct?

Dr. CONWAY. That is the headline.

Mr. KRISHNAMOORTHI. And further, at least eight different states have filed lawsuits alleging that PBMs are inflating drug prices and engaging in anticompetitive behavior. In fact, Ohio Attorney General Dave Yost states, "Express Scripts has used its dominance solely for its financial gain, creating a complex pay-to-play rebate system that perversely pushes manufacturers to increase drug prices in order to be placed on or receive preferred placement on PBM formularies." Now, Mr. Kautzner, you do not deny this is what Attorney General Yost said about your company, correct?

Dr. KAUTZNER. I do not recall seeing that exact quote, sir.

Mr. KRISHNAMOORTHI. Well, I will just show you. It is right here.

[Poster]

Mr. KRISHNAMOORTHI. This is on their website. Ohio Attorney General Dave Yost, it says exactly what I said. You do not deny that is what Dave Yost said, right?

Dr. KAUTZNER. It appears that is what the document you are showing says.

Mr. KRISHNAMOORTHI. So, on the one hand we have PBMs claiming to reduce prescription drug prices, and on the other hand we have the Federal Trade Commission, we have major media outlets like the New York Times, we have at least eight different attorneys general, Democratic and Republican, who all say that PBMs are inflating drug costs. I wonder whom the American people should believe.

I want to turn to another topic. That is the question of DIR fees, and I see some pharmacists in the audience. They probably understand what I am talking about here. DIR fees are the most insidious part of a class of fees known as post-sale adjustments or pharmacy price concessions. Essentially, DIR fees are clawbacks. They are clawbacks that PBMs get from pharmacies when the PBMs decide not to pay the originally agreed to reimbursements for the medicines that pharmacies have already dismissed in the past, in history.

So, let me look at the July FTC report and what they say about this. They note various public comments stating that DIR fees are unexplainable, create needless uncertainty for pharmacies, and are "a charade." The Centers for Medicare and Medicaid Services says that pharmacy price concessions, of which DIR fees are a part, exploded by 107,400 percent between 2010 and 2020, a rate of increase that literally staggers the imagination. I am not making this up. This number actually comes from CMS. This is not a typo. Mr. Joyner, this is what CMS says about pharmacy price concessions, correct?

Mr. JOYNER. Yes.

Mr. KRISHNAMOORTHI. The top five executives at each of the corporations that own the PBMs represented today have all had significant increases in their paid compensation over the past 3 years. Andrew Whittey, the CEO of UnitedHealthcare, earned between $18 million and $23.5 million, David Cordani saw his CEO composition go from $20 million to $21 million, Karen Lynch, the CEO of CVS, went from $20 million to $22 million, all in the span of 3 years. All at the same time we have these staggering DIR fees that have gone up by 107,000 percent over the last decade. At the same time, there have been 7,000 pharmacy closures during that time.

So, what is wrong with this picture? You have fees skyrocketing, you have pharmacy closures skyrocketing, you have drug costs increasing, and then you have CEO compensation at these different companies, that are called PBMs, also increasing. That is why Congress is scrutinizing this particular problem today. Thank you, and I yield back.

Chairman COMER. The gentleman yields back. The Chair now recognizes Dr. Foxx from North Carolina.

Ms. FOXX. Thank you very much, Mr. Chairman, and I want to associate myself with the comments of my colleague from Illinois. There is great concern, and the numbers that he put out have to be paid attention to. As you know, I Chair the Committee on Education and the Workforce, on which many Members of this Committee serve, and we have spent this Congress focused intently on improving transparency in healthcare and addressing the practices of pharmacy benefit managers, PBMs, in order to deliver lower healthcare costs to patients and plans. And, again, as you have heard from members, this is a concern all over Congress.

I am proud of the House's broad bipartisan support for the Lower Cost, More Transparency Act, legislation that will require PBMs to provide employers the information needed to make informed healthcare purchasing decisions on behalf of their employees, and I look forward to continuing to work with my Senate colleagues to enact it this year.

Today, we have CVS Caremark, Express Scripts, and Optum Rx or the "Big Three" represented, which own 80 percent of the U.S. PBM markets, and we need to know what impact this consolidation has on overall prescription drug prices, and I am going to ask you to give succinct answers. With an increase in consolidation, what incentives exist for PBMs to negotiate better rebates? Mr. Joyner? Quick answer.

Mr. JOYNER. Thank you, Congresswoman. The goal here and how I am measured by my customers is my ability to lower costs for themselves and for the members they serve. So, that is how I compete, and that is ultimately, you know, how they judge and value our performance.

Ms. FOXX. Dr. Kautzner?

Dr. KAUTZNER. Congresswoman, we operate in a highly competitive environment today. Every request for proposal that clients put out, you will see a half dozen or more PBMs that are competing aggressively for that business, and we have to continue to extract value out of pharmaceutical manufacturers to show that value to patients.

Ms. FOXX. Only a half dozen or more. That is a revealing number. Dr. Conway?

Dr. CONWAY. Thank you. We compete in a highly competitive market. We compete on clinical programs, transparency choice, and lowest net cost, and the Optum Rx retention of customers is 98-plus percent.

Ms. FOXX. The Federal Trade Commission's interim report on PBMs found that your three PBMs increasingly rely on group purchasing organizations, GPOs, which received roughly $7.6 billion in fees from drug manufacturers in 2022. Section 402 of the Lower Cost, More Transparency Act would require PBMs to disclose to plan sponsors fees received from manufacturers through the GPOs. For each of you, does your PBM pass on fees received from drug manufacturers and through GPOs back to plan sponsors in the form of rebates or otherwise? If so, what percentage of such fees do you pass on? Mr. Joyner?

Mr. JOYNER. Congresswoman, we pass over 99 percent of rebates in administrative fees across our book of business, and in Medicare, we pass 100 percent back to the government.

Ms. FOXX. Dr. Kautzner?

Dr. KAUTZNER. We do absolutely pass back rebates and fees to our clients. Many of our clients can receive 100 percent of those fees if that is the type of benefit design that they choose, and we charge a simple per claim fee for that type of service.

Ms. FOXX. Dr. Conway?

Dr. CONWAY. Similarly, the majority of our clients have 100 percent passthrough of rebates to our clients, and, on average, we are 98 plus rebate passthrough to clients as well, and it is their choice.

Ms. FOXX. This Committee has received testimony and documents that illustrate that transparent PBMs can achieve dramatically higher cost savings than your three companies. If that is truly the case, should not all PBMs be transparent? I just need a "yes" or "no" answer. Mr. Joyner?

Mr. JOYNER. Congresswoman, we are transparent.

Ms. FOXX. OK.

Mr. JOYNER. So, we compete in a transparent world.

Ms. FOXX. OK. Dr. Kautzner?

Dr. KAUTZNER. We are transparent as well and have transparent offerings that compete with other transparent PBMs.

Ms. FOXX. Dr. Conway?

Dr. CONWAY. Yes, we are transparent to customers and to the patients we serve.

Ms. FOXX. Mr. Chairman, I would like to ask one more question if you will indulge me.

Chairman COMER. Please.

Ms. FOXX. Thank you.

Chairman COMER. I have never told you no.

Ms. FOXX. Thank you.

Chairman COMER. I am afraid to tell you no.

Ms. FOXX. I would not tell you no either. 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? And, again, a quick answer so I do not abuse my privilege from the Chairman.

Mr. JOYNER. Today we are contracted with our customers to deliver on the contractual commitments they have given to us. So, in large part, it is making sure that we both deliver and execute against the guarantees and the contracts that they have negotiated with us.

Ms. FOXX. Thank you.

Dr. Kautzner?

Dr. KAUTZNER. Congresswoman, we focus on lowest net costs for our clients and for patients to deliver that value.

Ms. FOXX. Dr. Conway?

Dr. CONWAY. Yes, we provide transparency and choice to our customers, including plan employers, and compete on lowest net cost and best clinical programs.

Ms. FOXX. Thank you, Mr. Chairman. I appreciate the indulgence.

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

Mr. CONNOLLY. Thank you, Mr. Chairman. PBMs and Big Pharma play a blame game, do they not, Mr. Joyner? Big Pharma certainly sets drug prices in America and maximizes profit to its best ability. Would you agree with that?

Mr. JOYNER. I would.

Mr. CONNOLLY. Would you speak up in the mic, please?

Mr. JOYNER. Yes, sir. I agree.

Mr. CONNOLLY. OK. And this Committee has had hearings on drug pricing in the past, including, in some cases, really egregious examples of price gouging on generic drugs, on very old drugs like insulin, for example, which have not particularly been improved much over 100 years. How we deliver them, yes, but the basic insulin drug has not changed much. And as you know, that led to moves here in Congress to actually cap the price of insulin at $35 rather than have tens of millions of Americans suddenly not be able to afford a lifesaving drug. Any views on that particular example?

Mr. JOYNER. I think CVS Caremark has a particularly strong track record in this one category. These are branded medications. And if you look at our ability to lower the cost of insulin, both for our customers, which has actually seen a reduction for our plan sponsors that we serve, and, ultimately, the patients that are on these insulin therapies are paying less than $25 today. So, we have done a really nice job, I believe, of using competition to lower costs for the customers that we serve and, ultimately, to the benefit of the patients that are on these important therapies.

Mr. CONNOLLY. That is kind of a more recent development, is it not?

Mr. JOYNER. No, sir. We created the competition back in 2012, and from that point forward, you have seen the cost of insulin continue to decline. And so, the recent change where the manufacturer actually lowered the list price, which we applaud, came after we actually negotiated significant discounts to lower the cost for our customers.

Mr. CONNOLLY. Do you believe that the move to, for example, lower the price of insulin might have had anything to do with growing political pressure, including political pressure up here, to force the hand of both Big Pharma and you, otherwise—that is to say lower the price—or we will do it for you legislatively? Do you think that had any relationship at all to the decision?

Mr. JOYNER. Yes, it is plausible, plus there was a——

Mr. CONNOLLY. Plausible?

Mr. JOYNER. Yes, and there was a change in the way in which Medicaid priced this category. So, because they removed the cap, that actually would have penalized the drug manufacturer for the price increases that they have taken over the last decade.

Mr. CONNOLLY. So Big Pharma maximizes profits, but, of course, so do PBMs, right?

Mr. JOYNER. Our job is to continue to lower the cost for the customers which we serve.

Mr. CONNOLLY. Lower the cost?

Mr. JOYNER. Correct.

Mr. CONNOLLY. So, when we compare drug prices in the United States to Europe or Canada, in your efforts to lower costs, do we see American drugs actually lower in price for consumers than in Europe or Canada?

Mr. JOYNER. For the generic drugs, which is 9 out of every 10 prescriptions in this country are generic medications, and we believe we have done a remarkable job of lowering the cost of generics——

Mr. CONNOLLY. That is not my question.

Mr. JOYNER [continuing]. And the brands that actually represent the remaining 10 are more expensive than they are around the world.

Mr. CONNOLLY. Why?

Mr. JOYNER. Because the rest of the world negotiates for price in order to have access in their country.

Mr. CONNOLLY. So, we do not do that?

Mr. JOYNER. Beginning in January 2026, our government will start the first 10 drugs that will be negotiated on behalf of Medicare.

Mr. CONNOLLY. And do you expect prices to come down with that negotiation?

Mr. JOYNER. I believe the PBM industry, and specifically CVS Caremark, has done a really nice job of lowering the cost of those 10 medications that are there, and our hope is that there will be continued reduction in cost.

Mr. CONNOLLY. Yes, we all hope for that, but I was asking about the actual process and what the relationship is between that process and the expectation that there will in fact be lower drug prices. You just said our drug prices, in fact, are higher than most of the rest of the world. Same drug. And so, we all want to understand on behalf of our constituents and consumers, well, why would that be? Why would that be if it is the same drug? And I think you have answered by saying, well, they negotiate prices, we do not. We are going to start doing it. We have got a list of the first 10, and that would suggest that consumers have been paying a premium simply for want of negotiation on prices for many years. Would that be a fair conclusion to draw?

Mr. JOYNER. I can only speak to the role of the PBM and the fact that we have done what I believe is a good job of creating competition and lowering costs, and I will just look at the last 5 years. We have been able to reduce the brand of medications by 15 percent by using competition in a free market to be able to lower the cost for our plan sponsors.

Mr. CONNOLLY. Yes, and good for you, but when you talk about lowering costs, it is relative to the previous price in America. It is not relative to the cost of drugs in other advanced, civilized places like Europe and Canada, right?

Mr. JOYNER. Correct.

Mr. CONNOLLY. All right. So, when we say lowering the cost, you know, there is lowering the cost and then there is lowering the cost, and hopefully PBMs will help cooperate in that regard. You know, all of us believe that when a manufacturer invests R&D in a development of a new drug, that manufacturer takes risk and is entitled within reason to recoup costs. But when you take a 100-plus-year-old drug like insulin and you suddenly jack up the price just because you can—I am not saying you do it; we had hearings on that—that actually puts lives in jeopardy. And so, maximizing profits, nothing wrong with that, but not at the expense of people's lives, not at the expense of people's health. And I think PBMs, as well as Big Pharma, have an absolute obligation, and so do we up here, in protecting consumers, especially when the system does not work for them.

Thank you. I yield back, Mr. Chairman, and thank you for your indulgence.

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

Mr. TIMMONS. I appreciate my colleague across the aisle's remarks, but I think, with all due respect, you are missing the mark entirely. You are missing the mark entirely. Our country——

Mr. CONNOLLY. Well, not entirely.

Mr. TIMMONS. No, our country is sick. Our country is sick. Why is Europe and Canada paying less? Because they do not have an enormous obesity problem because half of them do not have diabe-

tes. I mean, all of these are preventable diseases. They are all preventable diseases. Mr. Joyner, what percent of the drugs that you sell treat trauma injuries, injuries of some kind, or genetic abnormalities? What percent? Ten, 15 percent of the drugs you sell?

Mr. JOYNER. I am not sure.

Mr. TIMMONS. I bet it is less than 20. We can all agree. So, everything else is purely preventable. I mean, so we have all of these problems with drug prices, but we have a demand issue. We have a demand issue. This country is sick. I have seen more people getting dialysis in the last 6 years. I go to these dialysis clinics at least once a year, and it is sad. There is more of them, and there is more of them, and 95 percent of people that have diabetes that need insulin can exercise and eat better and not have these problems. So, we are here to talk about who is making more money along the supply chain? Why do not we cut the supply chain off, cut the need off?

People need to be healthier. They need to take responsibility for their health. They need to exercise. They need to eat right. Our entire healthcare system delays death and treats sickness. We do nothing to facilitate health and wellness, and we talk about Europe. I mean, their diabetes rate is drastically less, so yes, insulin is less. There is less demand. And the cost of insulin goes up because millions and millions of Americans are increasing the demand on it. A hundred and twenty-nine million people in this country have at least one major chronic disease, at least one major chronic disease. Heart disease, cancer, diabetes, obesity, hypertension are the lead. All of those are very preventable unless you have a genetic abnormality. I will even use myself as an example.

I owned a CrossFit gym. I worked out every day, and I went to the doctor. I got some blood work done, and the blood work came back. She said, William, you have a cholesterol problem. I said, I am 10 percent body fat. I work out every day. What is up? And she said, well, what do you eat? At the time I was eating probably 16 ounces of steak a day. She was like, well, there is your problem, so I reluctantly changed my diet. I ate some fish, had some shrimp, ate some chicken. Go back, get my blood work done, not a problem. Could I, without any penalty, have continued eating 16 ounces of steak every day and gotten a pill, lived on that pill for the rest of my life and received no additional cost to me as a person? Yes, I could. That is our healthcare system. There is no accountability.

And you know what is crazy? That cholesterol pill that I take, after a couple years I am probably going to get a blood pressure issue. So, there is a pill for that. And, you know, let us just say I stop exercising, gain weight. There is a shot for that. I mean, this is not how our country needs to be operating. It is just outrageous. So, we are here talking about drug prices. The way to address our healthcare system is by accountability, personal responsibility. We have to incentivize health and wellness and not delay death and treat sickness. So, I realize I am on my soapbox here, but we have a major problem in this country. We have some of the worst outcomes of any developed country, and we spend four times more. Average spending, what, almost $5 trillion, and we have one of the least healthy developed population in the world?

So, I get it. We are fighting over drug prices, who along the supply chain is getting what and how they are doing that. We have to go to the root cause. We have to reduce the demand for all of these drugs. I mean, even the military is having a huge problem. We are having to constantly reduce our standards—reduce our standards

—because we cannot field a professional military. I mean, this is a national security threat. We have $35 trillion in debt. We are adding $1 trillion to our debt every hundred days, and we have workforce issues because people are unable to work because they are at the dialysis clinic or they are too sick. And, again, 90 percent of all of this is preventable with diet and exercise.

So, I understand that we are fighting over drug prices and who along the supply chain, but we have got to go to the root cause, and we have to get serious about incentivizing health and wellness and stop fighting over who gets what dollar as we delay death and treat sickness. And with that I yield back.

Mr. RASKIN. Would the gentleman yield for a question?

Mr. TIMMONS. Absolutely.

Mr. RASKIN. Well, I am very drawn by your analysis, but would you take it one step further and say that Congress and the Federal Government should not be investing in Big Sugar and Big Dairy and in unhealthy agriculture practices that end up producing diabetes and unhealthy outcomes?

Mr. TIMMONS. I do everything in my power to eat things that are from nature, and I will leave it at that.

Chairman COMER. All right. The Chair now recognizes Mr. Khanna from California.

Mr. KHANNA. Thank you, Mr. Chair. Dr. Conway, you are here as CEO of Optum Rx, but before that you were a doctor, actually a well-respected doctor, a pediatrician, as I understand it. And so, I want to ask you, when you were a doctor, if you had a 10-year-old, for example, who came in with arthritis and you recommended or prescribed Humira, do you believe that your judgment would be more valuable than some of your colleagues at Optum who may not have treated that patient?

Dr. CONWAY. Sir, I am still a practicing pediatrician.

Mr. KHANNA. Wonderful. So, can you answer the question?

Dr. CONWAY. So, in terms of clinical care, I believe clinical care should be based on evidence and the best medicine for the populations of patients.

Mr. KHANNA. But you would not privilege the doctor's opinion in that case? I mean, if you were treating a patient, 10-year-old with juvenile arthritis, you say, OK, I think she needs Humira, would you agree that your opinion should be given more weight than someone at Optum, who may not actually treat that patient?

Dr. CONWAY. So, I agree that prescriptions prescribed by physicians when consistent with the clinical evidence should be approved and given to the patient.

Mr. KHANNA. But that did not happen in the case of Cassidy, right? Are you familiar with this case where she was a 10-year-old girl? She had juvenile arthritis, and her doctor prescribed Humira, but for 6 months there was denial of that medicine, and then the

juvenile arthritis spread to her rib cage. Do you agree that that denial was wrong?

Dr. CONWAY. So, for any individual case, we are happy to look into it with you and get back to you. I would go——

Mr. KHANNA. Do you know why that was denied?

Dr. CONWAY. I would go back to our process, which was an independent Pharmacy and Therapeutics Committee——

Mr. KHANNA. Are you familiar with the process called utilization management?

Dr. CONWAY. We have an independent Pharmacy and Therapeutics Committee, which has pharmacists and clinicians.

Mr. KHANNA. And what happened in Cassidy's case because of utilization management is the Committee went back to Cassidy's doctor and said, no, do not give her Humira, even though the disease is spreading to her rib cage and she is in pain for 6 months because you need to try cheaper drugs first. Is that what utilization requires?

Dr. CONWAY. So, the vast majority of medications are approved when prescribed.

Mr. KHANNA. That is not my question, but is there a policy that you require people to try out cheaper alternatives first and that the doctor is overruled, as happened in Cassidy's case?

Dr. CONWAY. The vast majority of medicines are approved as prescribed. There are times when the independent P&T has recommended criteria that be followed, where at times one medicine is tried before another medicine.

Mr. KHANNA. And is cost part of the criteria?

Dr. CONWAY. The criteria start with the clinical standards and the evidence.

Mr. KHANNA. Is cost one of the factors?

Dr. CONWAY. No, the first criteria is the clinical evidence and criteria. If medicines are clinically equivalent, then the lower net cost can be considered.

Mr. KHANNA. So, cost is a factor, and there are times, as in Cassidy's case, that the doctor's clinical diagnosis is overruled because of cost. I mean, the doctor was begging for this to be approved for this girl for 6 months as arthritis spread from her knees and her ankles to her rib cage. And it was denied again and again because they were saying that the doctor needed to prescribe something cheaper. Do you believe that that was an outrageous decision to privilege costs over this girl's health?

Dr. CONWAY. As a practicing pediatrician, and I have taken care of many children with juvenile arthritis, it is critically important to follow the clinical evidence to prescribe appropriately.

Mr. KHANNA. But why would you not just say it is critically important to follow the doctor's recommendation? Can you commit to that today, that Optum Rx in the future will not have cases like Cassidy, and if a doctor is prescribing a medicine like Humira, will agree to fill that prescription?

Dr. CONWAY. For any individual case, for you or other Member of Congress, if you want us to look into that case, we will.

Mr. KHANNA. But can you make a commitment today that you will privilege the doctor's recommendation over the bureaucracy's recommendation? This is the heart of why people are so upset at

the PBMs. Can you just make that commitment that you will not override a doctor's? How about this? Can you commit that if a doctor recommends it twice, you will not override it?

Dr. CONWAY. As a physician, I hope you understand this, we value our partnership with physicians.

Mr. KHANNA. I am sure you value it, so then can you commit to taking their recommendation? Why would you not commit to taking their recommendation, or can you commit to not considering cost, taking cost out of your utilization?

Dr. CONWAY. We are committed to the independent P&T Committee that we have that is transparent, that includes independent——

Mr. KHANNA. It is like lawyers are writing your statements.

Dr. CONWAY. I am trying to answer your question, sir.

Mr. KHANNA. No, you are not, with due respect, sir. You are not committing to not having cost, and you are not committing to having a doctor's recommendation, even if they have it twice. If a doctor says, we need Humira, it is denied. Then the doctor says, we need Humira. You are not even committing to accepting that, and you are not committing today, and I will let you have the final word, and you are not committing to taking out cost as a consideration.

Dr. CONWAY. We are committed to effective clinical care for all the people that we serve.

Mr. KHANNA. Well, that does not answer my question. My time has expired.

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

Mr. GROTHMAN. OK. This is for any one of you. We are at the risk of a record number of pharmacy closures in 2024, which will only serve to make our pharmacy deserts worse. In fact, one-third of the independent pharmacies are currently at risk of going out of business. This is largely due to the PBMs which engage in patient steering and spread pricing, which charges employers more for medications than they reimburse pharmacies. With the role you play in prescription drug reimbursement, how can you sit here and say that PBMs are not a major cause of these closures, or do you agree it is a major cause of these closures?

Dr. KAUTZNER. Thank you for the question, Congressman. My 20 years of experience in this industry leads me to a different conclusion as with the data, which would show, today, we actually in the last 5 years have grown the number of independent pharmacies in our network from 18,000 to over 21,000. Fourteen hundred net new independent pharmacies are in our network in the last year.

Mr. GROTHMAN. Your network, is that nationwide or just your network?

Dr. KAUTZNER. Our total network is nationwide. It has over 64,000 pharmacies in it, of which over 21,000 of them are independent pharmacies. We also increased reimbursement to over 700 pharmacies across this country to address exactly what you just mentioned around underserved areas and rural and urban areas, so patients have access to care where they need it.

Mr. GROTHMAN. There is substantial evidence that PBMs often prioritize higher rebate medications over cheaper alternatives,

which directly drives up the cost of patients. How do you justify these practices that seem to place profits over affordability, and what specific actions will you take to stop exploiting patients with unnecessary high drug prices? Could you comment on that?

Dr. KAUTZNER. So, we fight every day to keep drug prices down. There are challenges with very high-cost branded products. There are new products that entered the market. Last year, unfortunately, had a median cost of $300,000 annually, so our focus is to bring down those costs. Some considerations that we are working through and we applaud Congress for doing is, one, reducing the patent thickets that 80 percent of the top 100 branded drugs put in place so they have monopolies on those drugs for much longer. That is a focus. Two is to make the biosimilar interchangeability pathway much easier so physicians do not have to get a new prescription for those drugs and you can enter biosimilar competition much sooner. As my example earlier this morning on Humira, the primary patent expired in 2016. They kept biosimilar competition from entering the market until 2023. When it did, the price and that cost came down 38 percent.

Mr. GROTHMAN. Amen, brother. Do you think the American system of researching drugs is, to a degree, broken, not enough emphasis on biosimilars, not enough emphasis, I guess I will say, on drugs that make the pharmaceuticals more money? Do you think that is true?

Dr. KAUTZNER. I think, as Representative Timmons mentioned, there is less of a focus now on some of the larger chronic disease states that so many Americans, unfortunately, have, and there is much more of a focus in drug manufacturers on very rare conditions. Some of those conditions they move to for ultra-rare, ultra-orphan type products because there is less competition, and they will have a monopoly on those drugs for much longer, which will increase their profits.

Mr. GROTHMAN. But in general, research overall, including university research, are they too focused on, I guess because the government pays for a lot of that research, are they too focused on or not focused enough on biosimilars, not focused enough on generics, not focused enough on things that may be cheaper and instead are spending the research dollars, including at the universities, on things that are going to result in higher costs?

Dr. KAUTZNER. From my view and my experience, there are times where there is not enough competition in certain cases, and competition is where we drive savings in this competitive market. So, whether it is biosimilars or generics and the lack of, those competitive products in those areas, yes, that becomes an issue in certain conditions.

Mr. GROTHMAN. Do you feel that some of that is the university's fault, or is it the government who is telling them where you have to put your research dollars?

Dr. KAUTZNER. That question is probably outside of my scope of expertise. We would have to get back to you on that piece.

Mr. GROTHMAN. OK.

Mr. GROTHMAN. I guess that takes up my time.

Chairman COMER. The gentleman yields back. The Chair now recognizes Mr. Mfume from Maryland.

Mr. MFUME. Thank you very much, Mr. Chairman. My thanks to both you and the Ranking Member for convening us for a third time to talk about PBMs and to allow us the opportunity, in this case, to have the three major players before us. I would like to, before I begin, recognize a group of retail pharmacists from my state of Maryland who are here and who have been very helpful with me and others in terms of helping us to understand their plight. They are seated in the audience here.

And I would ask, Mr. Chairman, unanimous consent to enter into the record their letter in support of continued bipartisan scrutiny of pharmacy benefit managers.

Chairman COMER. Without objection, so ordered.

Mr. MFUME. Mr. Chairman, I would also ask unanimous consent to enter into the record the American Federation of State, County, and Municipal Employees' letter advocating for increased transparency for PBMs.

Chairman COMER. Without objection, so ordered.

Mr. MFUME. Thank you, sir, and I will pass those down and we will get those right to you.

According to the Kaiser Family Foundation, last year, in 2023, 30 percent of Americans reported that they were unable to take their prescribed medication as needed due to exceedingly high costs. That is not me. That is 30 percent of the people in this country who were asked. In fact, my office has met with the Asthma and Allergy Network recently who conveyed that many parents in my district in Baltimore, as I am sure is the case in other districts around the Nation, are forced to forego their own medical needs to ensure that they themselves as parents are able to afford the ability to purchase medications like inhalers and EpiPens for their children who are in pain and who suffer and who need that sort of treatment and those sort of medications and other things. In addition, some of those families have multiple children, and in those instances those children who have the same ailments must share the same inhalers, EpiPens, or other things that are prescribed. Gentlemen, I do not know about my colleagues here, but I find this absolutely unacceptable, and I think, Mr. Chairman, that we have got to find some sort of bipartisan path to bring about regulation. Otherwise, we will be faced with the possibility of having a fourth hearing.

Hubert Humphrey said something that bears repeating. He said that the moral test of government is how that government treats those who are in the dawn of life, how they treat those who are in the twilight of life, and how that government treats those, like the elderly and others, who are in the shadows of life. We are not doing a good job when it comes to prescribed medications because what we are doing is to push them further into those shadows. Now, I know that I could be a band of one on this, but I am never going to stop banging this drum because people are hurting.

And I just do not understand, to the three of you who are here, how is it that you are right and the Federal Trade Commission is wrong. Help me to understand how you are right, and the attorney generals of eight states, and it could be nine as of today, are wrong. Please tell me how the analysis done by major media outlets, like the New York Times and others, underscore this problem, but they

are wrong, and please tell me how pharmacists and doctors say that you are the problem and you say they are not. So, I think this begs for an approach that is bipartisan and one that finds a way to correct this issue. Quite frankly, I am tired of running around and playing Ring Around the Rosie.

Now, I am not saying you should not have any sort of profit margin, but I think those margins are exorbitant. I have yet to see the formulas. Even though you say you are transparent, I do not know what formulas you use to come up with the pricing. You know, is it sleight of hand? Is it now you see me, now you do not? This is crazy. This is absolutely crazy, and I would go so far to say it is anti-American. And for my colleague who said earlier that 90 percent of all of this can be corrected, that it is preventable, there are cases of obesity that are genetic. There are cases of cancer that go back to genetic disposition. I could name a ton of other diseases that you cannot prevent that are not a part of this so-called 90, and these people need help. They need to be able to purchase the medications they need without a lot of sleight of hand. So, I have yet to see the transparency, with all due respect.

My time is concluding, but, Mr. Chairman, I would welcome any opportunity that you and the Ranking Member put together that we might be able to find a way to address this problem once and for all for Americans all over the United States. I yield back.

Chairman COMER. The gentleman yields back, and I agree. Mr. Mfume, I look forward to working with you. I will remind, we passed a PBM piece of legislation that impacted the Federal Employee Health Plan that came through this Committee. That was our sole jurisdiction on it, but we are going to continue to work together, and I pledge to work with you in that endeavor in a bipartisan way. The Chair now recognizes Mr. Burlison from Missouri.

Mr. BURLISON. Good afternoon. I guess I am part of a dying breed. I am still a free-market, believe-in-capitalism Republican, which is apparently rare in this town. I happen to agree wholeheartedly with my associate, Mr. Timmons, that we have dramatically removed all costs in any kind of, you know, decisionmaking from patients all through the regulatory schemes that originated here in Congress. And so, we further continue to try to remove any kind of negotiating power, and then we wonder why healthcare costs just continue to skyrocket year after year, and yet we have this one example where healthcare costs are not. Yet it seems, just from hearing this, you know, what I have heard today, you guys are forcing yourselves on your customers. Do you literally put a gun to the head of the businesses that hire you, that pay you, Mr. Joyner?

Mr. JOYNER. Not at all. In fact, they hire us to do a very specific job and, as we said earlier, very high satisfaction rates.

Mr. BURLISON. And if they are not happy, they do not have to continue to pay you, right?

Mr. JOYNER. Exactly. They have choices and options.

Mr. BURLISON. So, if they are not happy, if the price is too high, just like in the normal market, they can choose someone else. There are apparently 70 different options, and yet we are here wanting to dig deep into your pricing structure, get involved in your profits. That is what is remarkable to me.

Now, look, I do have concerns about my independent retail pharmacies, and I was pleased to hear that you guys are engaging with them. I am going to get to that question next. Let me ask this, and I think this will be telling. Big Pharma, pharmaceutical companies, they obviously do not like you, right? You guys negotiate down pricing, but do they utilize you, Mr. Kautzner? Pharmaceutical companies have employees, and this will be very telling. Do they use pharmacy benefit managers to manage the insurance costs of their own employees?

Dr. KAUTZNER. Congressman, yes, we do have clients who are pharmaceutical manufacturers.

Mr. BURLISON. Why in the world would they choose? Obviously, you are forcing yourself on them. You are forcing yourself for them to purchase your services, right? The services that they say are so egregious, and yet they choose to purchase, to hire one of you to manage their own employees' costs. I think that that is evidence enough, but I want to get to what can we actually do to reduce the costs of pharmaceuticals for patients, and I am trying to be creative. What this place does is just add more regulations, try to get into the lives and the businesses as much as possible. What regulations could we look at that would actually empower independent pharmacists and hopefully provide better access to patients? And I would like to hear from each of you.

Mr. JOYNER. So, Congressman, I think our track record speaks for itself, which you mentioned earlier. The PBM industry, specifically CVS Caremark, has been very successful in creating competition to lower costs for our customers, and if you look at the generic medication adoption rate, it is 9 out of every 10 prescriptions is a low-cost generic. The remaining 10 that are brands, we use competition to effectively lower the overall cost. So, between 2017 and 2022, we were successful in lowering the brand medications by 15 percent. So, I do think that the PBM model does work in terms of creating competition and lowering cost.

I will add on that I think what the concern here is the out-of-pocket cost for the members. In large part, that is what we have delivered and introduced a new pricing model called TrueCost because the idea now is to make sure that the member gets exposed to the lowest net cost. In fact, what the pricing model is inherently designed to do is make sure that it gets closer to the acquisition cost, making it simple and easy for the patient to access the medication.

Dr. KAUTZNER. So, Congressman, in regard to independent pharmacies, you are from Missouri. I live in Missouri. There are, unfortunately, 20 percent of Americans living in rural America today and only 10 percent of America's physicians live there. That creates an access-to-care challenge. Independent pharmacies can help fill that challenge by allowing them to work at the top of their license, expanding scope of practice opportunity——

Mr. BURLISON. I a hundred percent agree.

Dr. KAUTZNER [continuing]. So that they have those opportunities and they can get to the patients that need them most. When I was a kid, I used to go to an independent pharmacy because it was hard to get into a doctor at the time. It is that type of work

that we need to work together on and partner to be able to do, and that will have a real effect in communities.

Chairman COMER. Oh, I am sorry. Go ahead and answer the question.

Dr. CONWAY. I will be very brief, given the time. We agree with your points that transparency, choice, and a competitive market serve our customers. They value that choice, as we described, and we continue to drive both affordability initiatives to consumers and support for independent pharmacies.

Mr. BURLISON. I really appreciate your comments, and I wholeheartedly agree. I am going to be pursuing an effort to try to reevaluate what pharmacists are allowed to do to try to increase their scope because at the end of the day, we need more healthcare providers, we need better access to healthcare, and we need to improve their ability to get reimbursed, and I think this may be a win-win. Thank you.

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

Ms. NORTON. Thank you, Mr. Chairman. Today we are here for yet another hearing on a very important topic that Democrats have long worked to address: high drug prices. The high cost of healthcare is a burden on individuals and families in the United States. Prescription drugs are too expensive across the board. A 2023 polling by the Kaiser Family Foundation found that 3 out of 10 Americans have not taken their medicine as prescribed because of high costs. A 2023 report from Patients for Affordable Drugs found that for certain cancer medications, some patients spend up to $16,500 out of pocket. I would like to ask each of our witnesses today, Dr. Kautzner, yes or no, do you agree that we need to do more to lower the price of medicines for people across the country? Yes or no.

Dr. KAUTZNER. Congresswoman, there is always more that we can do to lower patient out-of-pocket costs, and we would certainly be happy to offer some recommendations on how we and Congress can do that.

Ms. NORTON. Mr. Joyner, do you agree that we need to do more to lower the price of medicine for people across the country?

Mr. JOYNER. Congresswoman, I agree, and that is the role of the PBM, is to continue to create competition to lower costs for the customers on which we serve.

Ms. NORTON. Thank you. Mr. Conway, do you agree that we need to do more to lower the price of medicine for people across the country?

Dr. CONWAY. Yes. We need to do more to make medicine more affordable for the people across the country, and that is what we work on each and every day.

Ms. NORTON. I appreciate that because it seems pharmacy benefit managers are a factor in these unacceptable high costs. An interim report published by the Federal Trade Commission this month and a *New York Times* article in June found that pharmacy benefit managers contribute to rising out-of-pocket drug costs, including by steering patients away from cheaper medications like generics. The bottom line is that high costs are harming Americans.

Fortunately, the Democratic-led Inflation Reduction Act that President Biden signed into law in 2022 is already addressing these high costs. The Inflation Reduction Act caps the amount someone on Medicare has to pay out-of-pocket for insulin at $35 per month. This is estimated to save $500 per person per year. Capping the cost of insulin so everyone who keeps it can afford it will save lives. Nearly 7 million Americans rely on daily insulin, about 4 million of whom will directly benefit from the $35 Medicare limit set by the Inflation Reduction Act. The Biden-Harris Administration is working to expand the $35 insulin cap to all Americans. Already several insulin manufacturers, including the largest manufacturer, Eli Lilly, have committed to lowering the cost of insulin by 70 percent and capping out-of-pocket costs at $35 per patient, not just those on Medicare.

The Inflation Reduction Act also limits out-of-pocket costs for patients covered by Medicaid Part D to $2,000 per person beginning in 2025. Patients for Affordable Drugs has found that 99 percent of cancer patients who use brand medications will benefit from the Inflation Reduction Act's $2,000 cap on out-of-pocket costs. This is estimated to create annual savings at $7,590 for those patients. Overall, the Inflation Reduction Act will improve lives for over 1.4 million Americans covered by Medicare. It will also lead to an estimated $7.4 million in savings in annual out-of-pocket costs for enrollees. The Inflation Reduction Act has and will continue to benefit Americans who face burdensome high-cost prescription drugs.

I hope the pharmacy benefit managers here today will commit to actions that similarly benefit American families by reducing the cost of medications and increasing patient choice and access to medication. Thank you, Mr. Chairman, and I yield back.

Chairman COMER. The gentlelady yields back. The Chair now recognizes Mr. Fallon from Texas.

Mr. FALLON. Thank you, Mr. Chairman. We all know that the cost of healthcare has steadily increased, and it is in an environment of already record-breaking inflation. More and more Americans are forgoing healthcare coverage because they simply cannot afford it. PBMs state that they exist to save people money, yet the PBMs are seeing, quite frankly right now, sky-high profits and healthcare costs are becoming prohibitively expensive for the average American. According to the Federal Trade Commission, three PBMs now control 80 percent of the market. They have vertically integrated with suppliers of goods and services, retail, mail-order, especially pharmacies and large health insurers. As a result of vertical integration, there are pharmacies owned by the same company as the PBM that are linked to, "affiliated pharmacies", as well as local and independent pharmacies, which are known as unaffiliated pharmacies.

Each one of you here today represents a group that is integrated, insurer, PBM, pharmacies and provider services together. So, for the witnesses here, Mr. Conway, Joyner, and Kautzner, what is your relationship with your respective companies with independent and unaffiliated pharmacies? Would you describe it as positive or negative? Mr. Joyner, is it positive or negative because, I apologize, we have limited time.

Mr. JOYNER. No, I am just saying, Congressman, I think independent pharmacies are a critical part of our network.

Mr. FALLON. So, you would say you would describe your relationship with them as positive?

Mr. JOYNER. I would, and we also reimburse them more money, so I think that is one of the benefits of a relationship.

Mr. FALLON. And Dr. Kautzner?

Dr. KAUTZNER. Congressman, we have worked hard very recently to make it a positive interaction with independent pharmacists.

Mr. FALLON. And Dr. Conway?

Dr. CONWAY. The goal is also positive and support independent pharmacies and pharmacists.

Mr. FALLON. OK. And the same thing I would like to start with, Mr. Joyner, do your companies steer patients to affiliated pharmacies? Yes or no.

Mr. JOYNER. We actually establish a variety of different network options.

Mr. FALLON. And again, at limited time, yes or no?

Mr. JOYNER. So, the answer is no.

Mr. FALLON. OK. Dr. Kautzner?

Dr. KAUTZNER. No, sir. Our clients make the decision on what pharmacy networks they want to use for their patients.

Mr. FALLON. Dr. Conway?

Dr. CONWAY. No.

Mr. FALLON. Well, it is interesting because there is a 71-page report here from the FDC, a study found that from internal documents and public comments, that not only do PBMs reimburse their affiliate pharmacies at significantly higher costs than affiliated, but it also shows that PBMs use a number of tools to steer patients to their affiliated pharmacies, even when the cost is higher to the patient. And when discussing that matter, documents also show that they are more concerned about the optics of a patient paying thousands of dollars more than the actual patient paying thousands of dollars more. You have an independent pharmacists coming into our office, in Congress, repeatedly, and they say they feel they are forced into using PBMs. So, I am assuming that you all know what a passive contract is. Mr. Joyner, do you know what a passive contract is?

Mr. JOYNER. It would be helpful if you could describe it.

Mr. FALLON. OK. A passive contract is when a PBM sends a proposed contract to a pharmacy, for example, by fax, with a clause in it that says the pharmacy is in unless they opt out, and then they are automatically signed into the contract with the PBM. There may not even be confirmation that the proposed contract was received. Now, I find that to be unethical, but the FTC study showed that passive contracts make up a large percentage of the contracts sent out by the PBMs. So, that is what I would say a passive contract is.

Mr. JOYNER. Yes.

Mr. FALLON. OK. Dr. Kautzner?

Dr. KAUTZNER. Sir, you are asking am I aware of what a passive contract is, just to confirm?

Mr. FALLON. Yes.

Dr. KAUTZNER. Yes. Yes.

Mr. FALLON. So, you are aware. Dr. Conway?

Dr. CONWAY. Yes, I am aware of that term.

Mr. FALLON. OK. Dr. Conway, have you all done this, where you are sending out unsolicited communications to pharmacies and saying if you do not respond, you are opted in, unless you opt out?

Dr. CONWAY. We do not participate in that type of contracting, and our independent pharmacy network has grown over the last several years. And we pay them more than retail pharmacies and actually pay non-affiliated pharmacies, on average, comparable or more than our affiliated pharmacies.

Mr. FALLON. So, would you say whether a pharmacy is owned by the same company as the PBM, is that a factor in determining reimbursement rates?

Dr. CONWAY. No. We pay affiliated and non-affiliated pharmacies comparable rates. Often our own affiliated pharmacies are actually the lowest cost options in the market, and at the end of the day, as described, the clients, employers, and others select the network that they want to provide to their employees.

Mr. FALLON. I wish I had more time. Mr. Chairman, I yield back.

Chairman COMER. Thank you. The gentleman yields back, and before I yield to Ms. Brown, just want to remind the witnesses, you are under oath. And the statement about having a good relationship with pharmacists, with independent pharmacists, that is a bit of a stretch according to dozens of pharmacists that have texted my phone when you all said that. So, just want to remind everyone, you are in the crowd, obviously. Just remind you, you are under oath, and the witness that testified yesterday, things did not turn out well for her over the past 24 hours. This is a serious issue. There is clearly a problem with the independent pharmacies and the PBM, and to characterize it that you have a great relationship, I believe, is a stretch. That is my opinion, but the Chair recognizes Ms. Brown from Ohio.

Ms. BROWN. Thank you, Mr. Chairman, and thank you for reminding our witnesses they are under oath.

Our three witnesses, the executives of top three pharmacy benefit managers, control 80 percent of the market share in the industry. Eighty percent. Over 270 million Americans have their drug prices in some way controlled or affected by these three companies sitting before us today. And yet, these companies have failed to communicate as to how they are working to lower the cost of prescription drugs, pass along savings to patients, and protect local and independent pharmacies. Members of Congress from both parties have expressed concerns about PBMs dictating requirements to local, independent, and small pharmacies, compelling them into your networks, and to accept the terms or be excluded from this crucial market. Unfortunately, many pharmacies cite untenable contract terms from PBMs as part of the reason they must close.

Experts project nearly one-third of all independent pharmacies will be forced to close by the end of this calendar year. And approximately 2,200 retail pharmacies closed their doors in the last 4 years, many of which are in low-income or rural parts of the country where access is already a major issue. So, I just want to get some clarity. If you do not agree that consolidation among the pharmaceutical industry is a key factor toward these closures, then

in your opinion, what is the cause? Any of you can feel free to jump in.

Dr. KAUTZNER. So, Congresswoman, the data that I have shows a bit different of a picture around independent pharmacies and independent pharmacists. And our data would show that in the last 5 years, within our own network—I cannot speak to others—that we have actually seen a net increase of about 20 percent of independent pharmacies open, net increase, and in the last year, 1,400 net increase.

Ms. BROWN. Anyone else care to dispute this accusation claim with alternative facts, perhaps?

[No response.]

Ms. BROWN. Well, thank you. Would you share the same insight as it relates to local pharmacies rather than independent pharmacies?

Dr. KAUTZNER. So, I would characterize independent and local as being similar. So, we only track independent pharmacies, of which they make up one-third of our pharmacy network and account for over 21,000 pharmacies across the country.

Ms. BROWN. Similar but not the same. Reclaiming my time. Thank you. Many people, especially in vulnerable populations, rely on local and independent pharmacies, similar but not the same, for their medications and important health services. However, PBMs are forcing more and more people to specialty pharmacies or mail-order pharmacies, which are owned by the same parent company as PBMs. As one example, PBMs can tell patients they can only receive an extended supply of their medication if they go to a specific pharmacy owned by the same parent company as the PBM, generating even greater profit for these giant pharma corporations. So, I am just going to dovetail into what my colleague talked about on the other side of the aisle. How do you respond to the accusations that you are steering patients to pharmacies owned by your parent companies? Hello?

Dr. CONWAY. So, we have over 26,000 independent local pharmacies in our network. The reimbursement rate, the volume of prescriptions has gone up over time, the number of pharmacies have gone up over time, and agree with you on the importance of these pharmacies.

Ms. BROWN. Anyone else with an actual answer?

Dr. KAUTZNER. So, one, we do not steer. Our clients make the decision on which pharmacies they decide to put into their network, and our data would show that in the last year, mass retailers saw a 6 percent increase in pharmacy prescriptions. In the last 5 years, grocers saw an increase of 23 percent, while in the last year, our home delivery pharmacy had a relatively flat volume.

Ms. BROWN. Thank you. I would again reiterate what our Chairman talked about at the top of my remarks, is how critical this issue is and how important it is for you to be truthful, because Americans deserve an affordable and accessible healthcare. When a local pharmacy closes its doors, residents lose access to the pharmacy they know well. And when the only pharmacy in a community closes, patients are forced to travel further to get medications they need, potentially delaying their treatment and care. It is unacceptable to me that PBM practices would harm communities in this

way. And with that, Mr. Chairman, I yield back. Thank you for indulging me.

Chairman COMER. The gentlelady yields back. The Chair now recognize Mr. Fry from South Carolina.

Mr. FRY. Thank you, Mr. Chairman. I think Oversight is turning over a new leaf in two hearings in 2 days and wide bipartisan support. What do you think about that, Mr. Raskin? I think it is good.

You know, it is interesting. For years, PBMs have quietly assumed control of a major facet of America's pharmaceutical industry through vertical integration and consolidation and methods like spread pricing. Major PBMs have been able to take control of prescription drug access, leaving little room for transparency in an industry where the sole mission should be to provide essential and lifesaving pharmaceuticals to patients. This sort of control has caused an almost irreversible strain on America's independent pharmacies. One is in my district, one is in the Ranking Member's district, one is in the Chairman's district, and all across this country.

An illustration of that fact, the National Community Pharmacists Association, which represents over 19,000 pharmacies, cites that we can expect one pharmacy closure each day in the United States. I have heard from pharmacies within my district that it is cost-prohibitive to obtain the drugs and dispense them, and so they just choose not to. That they make their money or their profit on other things that they sell, like milkshakes or T-shirts or whatever it is, in their particular pharmacy is kind of alarming.

So, for me, I think we start at the beginning. To what extent, you each that are here today, you each have lawyers on your team that review contracts—is that correct—and draft contract language. Is that correct? Yes or no.

Mr. JOYNER. Correct.

Dr. CONWAY. Yes.

Dr. KAUTZNER. Yes.

Mr. FRY. How much opportunity exists for a small mom-and-pop pharmacy in a rural area to negotiate their own contract? Is it a boilerplate contract? Do they have any negotiating room at all? Say I own my own pharmacy.

Dr. KAUTZNER. We are always open, Congressman, to negotiating with pharmacies.

Mr. FRY. How does that look?

Dr. KAUTZNER. Pharmacies can always redline a contract back to us and negotiate.

Mr. FRY. Do they? Do they?

Dr. KAUTZNER. They do.

Mr. FRY. How often?

Dr. KAUTZNER. I do not know——

Mr. FRY. How often do you actually negotiate with them?

Dr. KAUTZNER. As I said, I do not know an exact percentage. We have over 64,000 pharmacies in our network today, so it is a broad number, and there is a lot of volume that goes through.

Mr. FRY. OK. I mean, just to guess, would you say it is 20 percent of the time?

Dr. KAUTZNER. I would not want to speculate, sir. We could get back to you.

Mr. FRY. I actually do not believe you, and I am curious. If you have information on that, I would love to see it. I do not think that they actually have any negotiating power whatsoever. That is what we have heard. There is a wide gulf right now between what you are saying and what I have heard privately, so what is the disparity there?

Dr. KAUTZNER. Congressman, we are happy to engage and do engage with independent pharmacies. We have, through the new initiative that we kicked off last year, it engages with over three dozen independent pharmacy owners that we convene. We meet with them on how we can work better together. We have had productive discussions in those meetings and are finding paths forward. It is around improving patient access to care and around providing additional services in those underserved communities in urban and rural areas. That is what we are focused on right now and then improving reimbursement in some areas where access to care is really important. And we have done that for over 700 independent pharmacies across this country.

Mr. FRY. What exactly is the goal with community pharmacy contracts that contain rates and terms that you know are below acquisition costs of the pharmacies? And these, in my opinion, unacceptable contracts, are they intended to force out competition? What is the goal of that? We have heard that a lot from independent pharmacies.

Dr. KAUTZNER. Sir, we are not focused on putting pharmacies out of business at all, and as I have said, our data actually is very different. We have had a net increase of 1,400 independent pharmacies in our network in the last year alone. So, we are continuing to work hard with them to find those paths forward for patients to have broad access to care, whether it is an independent pharmacy, a grocer, or some other type of mass retailer.

Mr. FRY. What about the other two on this panel that have been pretty quiet? What do you have to say about that, that pharmacists are at a competitive disadvantage and that often receive the rates and terms or below what the acquisition cost is?

Mr. JOYNER. Yes. Congressman, we have more than 27,000 pharmacies. That effectively equals 40 percent of our network are independent pharmacies today. As we have said earlier in the testimony, we do reimburse these pharmacies at a much higher rate. In fact, upwards of 25 percent more for generics. If you were to apply that just across our commercial book, we have effectively paid independent pharmacies $340 million more than the equivalent chain pharmacies.

Mr. FRY. Mr. Conway?

Dr. CONWAY. We also have a similar number of independent local pharmacies, and, also, the volume of prescriptions and pharmacies in the network has continued to go up over time. We also have programs where we will pay them for particular services as options.

Mr. FRY. I am going to wrap up here, Mr. Chairman, just for 1 second. In our first hearing, we heard about TRICARE, reimbursement of a medical facility or a pharmacy right outside of a base, and that it was cost prohibitive for them to care for our Nation's men and women in uniform. And so, part of this was because the cost did not justify keeping or continuing to serve that population.

So, I would invite you, that you are all here—you have heard the bipartisan support here—that you all need to do more to work with these independent pharmacies because they are closing at a rapid rate, and they are getting sucker-punched every single day because of competitive disadvantages that you all place in the marketplace. Thank you.

Chairman COMER. The gentleman's time has expired. The Chair recognizes Ms. Stansbury from New Mexico.

Ms. STANSBURY. Thank you, Mr. Chairman. Gentlemen, thank you so much for being here today. I know you have taken a beating already for many hours this morning. I am not a healthcare policy specialist. I am not a prescription drug specialist. I am just a New Mexican. What I know is our healthcare system is terribly broken. In New Mexico, we have families that still do not have access to healthcare, people who are waiting in waiting rooms at hospitals who cannot get emergency care. We have people who still do not have health insurance in spite of the expansions that we have had through the Inflation Reduction Act and, of course, the Affordable Care Act. And we still have people who are dying of unnecessary diseases because they cannot afford lifesaving care and prescription drugs.

So, for me, this is really about the humanity of our health policy, and that is why I believe healthcare is a human right. And that is why I believe and support holistic and systemic reforms to our healthcare system because we should not have to have hearings like the hearing we are having here today. It should not be so complicated that, you know, one of our grandparents cannot afford to get the lifesaving medication that will keep them alive and healthy for the coming years. And it should not have to come to the reality that we have private for-profit companies who have figured out how to game the system so that they can generate profits while providing some sort of service for their clients at the expense of our communities.

So, you know, Dr. Conway, we had the opportunity to meet yesterday in my office, and I really did appreciate you stopping by. And one of the comments that you made in the conversation that we had is that, well, the prescription drug companies need to lower their costs. You know, the middlemen are just sort of taking advantage of the system as it exists. You did not say that. I said that. But I think what this hearing really points to is a bigger problem, a sickness in our healthcare system, and the fact that private for-profit companies are able to profit at the expense of our communities, even if you are providing a service within that ecosystem.

And a lot of my colleagues today have alluded to the Inflation Reduction Act, and I just want to emphasize that part of why it was so significant is it was one of the first times that we passed Federal legislation that enabled our Federal healthcare provider networks to negotiate prescription drug costs, just like you do as middlemen for your clients, so that our seniors could actually access affordable prescription drugs. And we know it is going to save people money, we know it is going to save lives, but there are still millions of Americans who cannot afford medication. And I understand that these PBMs provide rebates. My mother was in the hospital a year ago, and when she was being discharged, she was told

that the medication she needed for her heart condition was going to cost $400 a day. She was given a rebate.

I think in these kind of policy discussions, the humanity gets lost, and, you know, these companies are taking advantage of a system that is not set up for our communities. So, I think the one question that I would ask of each of you is just a very simple question, which is, do you believe that our system needs systemic reform? Do you believe that drug prices should be reduced, and would you support that, and would your company support that, even if it meant that you could not benefit and profit off of it? And why do we not start with Mr. Joyner?

Mr. JOYNER. Congresswoman, thanks for your comments, and I completely agree with you. I retired at the end of 2019, and I came back a year and a half ago for the very specific reason that you mentioned, which is I want to be a part of changing the healthcare system in this country. In large part, we have been successful in doing, at least within the last year, we introduced a biosimilar into the market with a low list price——

Ms. STANSBURY. Thank you——

Mr. JOYNER [continuing]. Delivered savings to the members at zero out of pocket and 50-percent cost reductions for our employers. So, I think we are making headway, and especially with the new price model, to solve exactly what you are referencing.

Ms. STANSBURY. Thank you. Dr. Kautzner?

Dr. KAUTZNER. Congresswoman, there is always more that we can do, and you do point out some challenges that our healthcare system certainly has. We believe within the commercial market, we can move swiftly to be able to make lower-cost products available to patients. Certainly, there is always more that can be done.

Ms. STANSBURY. Thank you, Dr. Kautzner. Dr. Conway?

Dr. CONWAY. First, I appreciated the meeting yesterday. We at UnitedHealth Group do think the health system needs to perform better for everyone. And as I said yesterday, we believe list prices of pharmaceuticals as set by manufacturers should come down in the United States.

Ms. STANSBURY. Thank you. And I did not mean to interject, gentlemen, but this is not a hearing for advertising your companies. This is really about addressing the healthcare crisis that our communities are facing, and I appreciate the role that you are playing, but we have got to reform the system because there are people dying in this country who should not be because they cannot access medicine. And with that, I yield back.

Chairman COMER. The Chair now recognizes Mr. Langworthy from New York.

Mr. LANGWORTHY. Thank you very much, Mr. Chairman. I really appreciate you bringing this hearing forward, and I thank you all for being here today to discuss this important topic for Americans of all ages and across all communities.

Employers, unions, and even state governments that sponsor self-insured health plans for their workers are considered fiduciaries under Federal law. They must make decisions that keep health plan cost low and that are in the best interests of patients. Now, currently, PBMs are not held to the same standard that applies to plan sponsors, despite essentially standing in the shoes of

the plan sponsor when performing pharmacy benefit plan design and management services on their behalf. As a result, PBMs continue to charge unreasonable and excessive fees, steer plan participants to higher-costing prescription drugs, and pocket rebates and discounts that should belong to the plan. These actions are not in the best interest of participants, and are not what the plan sponsors would do, much less could do, given their fiduciary duty to the plan.

Mr. Joyner, can you tell me why you think PBMs should not be a fiduciary?

Mr. JOYNER. Congressman, the role of the PBM is to serve the customer or the clients that are managing the pharmacy benefits, so we do not have control over the benefit design that actually passes through to the member.

Mr. LANGWORTHY. So, it sounds like PBMs do not want to help. They do not want to be plan fiduciaries because there are certain things that they do or want to do which fiduciaries would not be permitted to do. Can you give me some examples in ways in which PBMs' hands might be tied if they were a plan fiduciary?

Mr. JOYNER. A good example, and I will use the new price model that we are rolling out. Today, we pass through 99-plus percent of the rebates to our customers. And our customers then determine how best to use those discounts in terms of reducing either the premiums and/or reducing the other costs of the drugs. In TrueCost, we are looking to incorporate those discounts so that it passes through to the actual member in getting the client alignment so that it actually aligns both the client and the employee experience.

Mr. LANGWORTHY. Do you think that PBMs are making decisions that help keep plan costs low, or are they helping plan sponsors be good stewards of benefits?

Mr. JOYNER. Our first goal is to reduce and manage the overall cost of pharmacy, and then, ultimately, that allows our customers to become good stewards of their benefits.

Mr. JOYNER. What about when Johnson & Johnson's PBM charged patients over $10,000 for a $28 drug?

Mr. JOYNER. I am not familiar with that.

Mr. LANGWORTHY. How about when PBMs refuse to give patients access to much cheaper alternatives to expensive drugs like Humira?

Mr. JOYNER. So, Congressman, using the Humira example, we actually took Humira off of our formulary in April of this year. We converted 97 percent of the medications into a lower-cost biosimilar. Our clients' plan sponsors saved $500 million as a result of that change, 50 percent reduction off of what they were spending in 2022, and, importantly, the employees, for the most part, paid zero dollars out of pocket for that biosimilar.

Mr. LANGWORTHY. So, it sounds like PBMs believe that they are currently doing their best to keep costs low and act in the interest of the patient. If that is the case, you are already complying with fiduciary standards. So, why are PBMs so dead set against being fiduciaries?

Mr. JOYNER. Again, as I mentioned, we do not have control over the benefit design. The clients, the employers, which is an employer-funded healthcare system, they determine how they are

going to ask members to participate from a premium or contribution and ultimately designing the out-of-pocket cost for their employees. We facilitate that, but we do not make the decisions on behalf of our customer.

Mr. LANGWORTHY. Will your company commit to supporting fiduciary standards for PBMs?

Mr. JOYNER. We certainly support complying with the contracts that we have with our customers, and, again, our contract is to make sure that we are delivering the lowest net cost and managing the overall pharmacy cost for our customers.

Mr. LANGWORTHY. I think there is a reason PBMs do not want to be fiduciaries. In my remaining time, I would like to pivot and discuss a recent court ruling that CVS Caremark was involved in. Last year, an arbitration panel required CVS Caremark to pay over $20 million to just one oncology practice, New York Cancer and Blood Specialists, for miscalculating these fees. In essence, the company charged higher fees when an oncologist did the right thing by stopping an oral cancer drug that was not working and had side effects. CVS Caremark clearly stood in the way of properly treating cancer patients. Mr. Joyner, CVS Caremark fought to hide this award and not pay it vigorously, suing the oncology practice. However, last week, the New York Southern District Federal Court ruled in favor of the practice and ordered CVS Caremark to pay over $20 million in back DIR fees, interest and attorney fees.

I enter that ruling into the record with unanimous consent, Mr. Chairman.

Chairman COMER. Without objection, so ordered.

Mr. LANGWORTHY. I understand that other oncology practices are in arbitration right now with CVS Caremark over the same issue. Given the Federal Court's findings, do you intend to pay all practices back for a clear miscalculation of DIR fees, or do you intend to fight them like you did the New York practice?

Mr. JOYNER. Congressman, as I answered the question earlier today, we comply with all the Medicare Part D rules regarding network adequacy as it relates to also the DIR. So, we have consistent and standard terms and conditions, and we fully expect to administer and support those for our customers.

Mr. LANGWORTHY. Thank you very much. I yield back, Mr. Chairman.

Chairman COMER. The Chair now recognizes Mr. Casar from Texas.

Mr. CASAR. Thank you, Chairman, and I would like to commend the Ranking Member and yourself on having this bipartisan hearing. I would like to see more of this and appreciate it.

Today we are discussing pharmacy benefit managers, or PBMs, which, as we have talked about today, are pretty opaque organizations that most Americans do not know very much about. But the three leaders of these PBMs today touch or interact with about 80 percent of the prescription drugs accessed by Americans. And the goal of PBMs is to negotiate down the prices of the medicine that we need, but this comes at a time when Americans, indeed, are paying more for prescription drugs. The 25 drugs with the highest Medicare spending have tripled in cost since entering the market. Between 2022 and 2023, 4,200 drugs have seen price increases, and

our country still has the highest per capita prescription drug spending among developed nations.

And so, the goal that we have set for PBMs in this system, in my view, we are far from hitting that target. In fact, we are headed in the wrong direction. The three companies represented before us, though, are some of the most profitable companies in America. These three companies made a combined $400 billion in revenue and some $18 billion in profit in 2022. And so, to me, I think one of the core questions we are trying to ask today is, if there is this much profit in this industry, where are the savings for everyday Americans?

We have discussed and I have heard from colleagues about how PBMs are connected to the same parent company as health insurance, which can limit patient choice. We have heard about how rebates, which are the savings negotiated by PBMs, could be raising the cost of drugs, and we have also heard how PBMs can shut out local pharmacies and drive profits toward pharmacies under their umbrellas. But I want to focus on a different issue, which is the question of group purchasing organizations, or GPOs.

The three major PBMs have a GPO under their umbrella. If I am right, I think CVS' is Zinc, Express Scripts' is called Ascent, and Optum Rx's is called Emisar Pharma Services. The goal, supposedly, is to leverage purchasing power to negotiate greater savings from pharmaceutical manufacturers, but these are relatively new practices. From each of the witnesses, a quick yes or no, each of your GPOs was founded in or after 2019. Is that correct, Mr. Joyner?

Mr. JOYNER. Correct.

Mr. CASAR. Doctor?

Dr. KAUTZNER. Yes, that is correct.

Mr. CASAR. Thank you.

Dr. CONWAY. Yes.

Mr. CASAR. And my understanding is that before those GPOs were founded relatively recently, PBMs were negotiating without the separate company doing it on their behalf. And so, the obvious question is, why do the PBMs need these new GPOs? According to New York Times reporting, a former Optum Rx executive said, "The intention of the GPO is to create a fee structure that can be retained and not passed on to a client." And that is a big deal if the value is getting discounts and prescriptions, but now we have these totally new companies supposedly to create fees that then could not be passed along. In 2018, before any of the GPOs were founded, drug manufacturers paid $3.8 billion per year in fees to PBMs. By 2022, they were paying $7.6 billion in fees to PBMs and to their GPOs.

So, again, just here for my last minute, the point is that PBMs are supposed to be reducing drug prices, supposed to be reducing healthcare costs, but a 2022 study found that the average premium for individual health insurance has gone up $225. Two in 5 adults on employer-sponsored insurance are having difficulty affording their medical care. So, if people are paying more money, if the number of fees has nearly doubled here to $7.6 billion, then why are prices not coming down?

I guess my question to you, Dr. Conway, for example, would be, if these GPOs are generating this much more in fees, where is the value to the American people? Why is it that annual premiums continue to go up? Why is it that thousands of drugs have seen price increases while billions of dollars in new fees and profits are going to PBMs and to their GPOs? Dr. Conway, you can take it.

Dr. CONWAY. The purpose of the GPO is to negotiate rebates, larger discounts on our clients' behalf. As I said, many clients choose 100 percent of those rebates to pass through to them, and so we will continue to work to make medicines more affordable and healthcare more affordable for the American people we serve.

Mr. CASAR. Since you created these GPOs in 2019, we have gone from $3.8 billion in fees to $7.6 billion in fees, but we continue to see the price of drugs go up. How does that add up?

Dr. CONWAY. So, the net prices of drugs we continue to negotiate down. The list prices of drugs have gone up exponentially in the U.S., and those list prices are set by manufacturers.

Mr. CASAR. Mr. Chairman, right before I yield back, I just think through all of the acronyms and all of the opaqueness we have been dealing within this hearing, we continue to see the American people pay more and more. And once you take away all of the sort of shell games, people are paying more, there is more profit going both to Big Pharma and to the PBMs, and it is ultimately our constituents that are left paying the price. Thank you. I yield back.

Chairman COMER. The gentleman yields back. The Chair recognizes Mr. Gosar from Arizona.

Mr. GOSAR. Mr. Chairman, I yield my time to you.

Chairman COMER. Thank you, Mr. Gosar. I appreciate it. In the past 5 years, the states and the Federal Government have begun enacting PBM reforms. Each of your companies or your parent companies created corporate entities in foreign countries, well known for their lack of financial transparency and low tax rates. Each of your companies has since begun shifting PBM duties, including negotiations with manufacturers to those foreign countries. In fact, Mr. Kautzner, Cigna Express Scripts created Ascent Health Solutions, based in Switzerland, to serve as a group purchasing organization, negotiating rebates with manufacturers. Cigna Express Scripts also created Quallent Pharmaceuticals, based in the Cayman Islands, to buy cheap pharmaceuticals and sell them at a higher rate in the United States. Mr. Conway, UnitedHealth Group's Optum Rx created Emisar Pharma Services, based in Ireland, to serve as a group purchasing organization negotiating rebates with manufacturers. Mr. Joyner, CVS Caremark created Cordavis, based in Ireland, to commercialize biosimilar products and resell them in the U.S. for higher prices.

Your companies have created entities in foreign countries that appear to be for the specific purpose of avoiding U.S. regulation and avoiding U.S. taxes. This is simply not acceptable, but I will give you each the opportunity to explain why those three countries, Ireland, Switzerland and the Cayman Islands, were better locations for these companies than the United States. Mr. Joyner?

Mr. JOYNER. Mr. Chairman, Cordavis, which is located in Ireland, is in Europe, close to where the drug is being manufactured today. So, the whole premise of building an operation in Europe is

to be close to where the drug is manufactured so it helps with the logistics, and the ability for us to bring the product into the U.S. And good news is, the biosimilar that we brought to market was a lower list price product. It was 82 percent below the price of Humira. As of April 1st, by removing Humira from our formulary, we actually pulled 97 percent of all the biosimilars through for our customers, yielding $500 million worth of savings for our clients. And the employees and/or the members of these firms actually paid zero dollars out of pocket for the medication. So, it is actually a win-win for us all.

Chairman COMER. Dr. Kautzner?

Dr. KAUTZNER. So, Mr. Chairman, the creation of Ascent Health Services in Switzerland as a group purchasing organization is delivering more value because of the aggregation of additional entities that are also participants within Ascent Health Services, more than what Express Scripts could do on their own. GPOs have been used within healthcare for decades and have been shown to lower costs for clients and for patients ultimately.

Chairman COMER. Dr. Conway?

Dr. CONWAY. Emisar is incorporated in the United States. It does have employees both in the United States and Ireland. And as stated by others, the purpose is to negotiate rebates and discounts on behalf of our clients, and we adhere to all laws and regulations and do that transparently.

Chairman COMER. Mr. Joyner, in your written testimony to the Committee, you referenced a new transparency program called TrueCost. When did that program start?

Mr. JOYNER. Congressman, we announced it last year.

Chairman COMER. Have you piloted the program to determine if it actually enhances transparency?

Mr. JOYNER. We have. In fact, we have now rolled it out to our own employees, effective June 1st, and have a number of customers lined up as we entered the——

Chairman COMER. So, when will it be fully implemented?

Mr. JOYNER. So, our expectation is that it will be staged, but right now, our hope is that we will have a good portion of our business moved into 2025 and ultimately into 2026.

Chairman COMER. Dr. Kautzner, in your testimony, you referenced the Independent Rx initiative that Express Scripts launched in spring 2023. What tangible benefits to independent rural pharmacies has this program produced?

Dr. KAUTZNER. Mr. Chairman, we increased reimbursement to over 700 independent pharmacies out of our own pocket as part of this initiative. In addition, we convened an Independent Rx Committee that we have met several times already with, in-person, 38 pharmacists, I believe, that are independent pharmacy owners, to work on advancing the practice of pharmacies so that pharmacist can practice at the top of their license.

Chairman COMER. Has Independent Rx increased reimbursement rates to independent rural pharmacies?

Dr. KAUTZNER. It has to over 700 that have accepted the increased reimbursement that we are paying out of our own pocket.

Chairman COMER. Last question. You also referenced that the number of independent pharmacies in Express Scripts' commercial

network increased by 20 percent from 2019 to 2024. Does this include the 15,000 pharmacies dropped from the TRICARE retail pharmacy network in late 2022?

Dr. KAUTZNER. So, our broadest network had 18,000 pharmacies roughly in 2019, which expanded to over 21,000 by 2024. That is the 20 percent increase. The TRICARE network, over two-thirds of the independent pharmacies in our network do participate in TRICARE, but it is less than the total.

Chairman COMER. The Chair now recognizes Ms. Pressley from Massachusetts. I want to thank the gentleman from Arizona for yielding his time. The Chair now recognizes Ms. Pressley from Massachusetts.

Ms. PRESSLEY. Thank you. The discussion today speaks to an injustice, an injustice that many of my constituents in the Massachusetts 7th experience daily: the high cost of lifesaving prescription medication. Pharmacy benefit managers, or PBMs, play an outsized role in determining coverage and cost of medication by designing lists of drugs that a health insurance plan will never cover for a patient, known as formularies. For some medications, PBM formularies require additional approval before you, a patient, can pick them up at the pharmacy. For example, prior authorization is a PBM power where a doctor must ask the insurance company if they can prescribe the specific medication and their so-called step therapy. That requires you to try different medication and have a negative reaction before being prescribed the medication that your doctor recommends.

These policies are hurting people across our Nation, including in my district. One of my constituents, a mother, shared her story of how she was forced to go through a step therapy to treat her neurological condition and saw her condition worsen as a result, to the point where she spent a year relearning how to walk, and her story is no anomaly. Step therapy is not just ruining people's lives, it is killing them. Families have been robbed of their loved ones due to the delays, the greed, and harmful policies of PBMs.

Mr. Joyner, CVS Caremark is one of the largest PBMs operating within my district. What do you say to my constituents who have been harmed by denying them the medical care that they need and deserve?

Mr. JOYNER. Congresswoman, I do not have the specific details of what you are referencing, but I certainly do understand and look specifically at ways in which we can improve the prior authorization process.

Ms. PRESSLEY. Are you sorry?

Mr. JOYNER. No. I think it is an important part of the healthcare system is to make sure that our customers hold us accountable and look to make sure we have oversight for both patient safety. They are also focusing on ways in which we can improve adherence to the therapy, because if they are not staying on therapy, obviously, then there is——

Ms. PRESSLEY. OK. Reclaiming my time. I wish you were sorry. You should be. I have not heard from a single doctor who can justify the public health benefits of the health insurance policies.

According to the Federal Trade Commission, the committees responsible for determining access to medication do not just consider

clinical recommendations. PBEs also "take into account business considerations and make formulary determinations to maximize profits." I will remind the witnesses that you are all under oath. My next questions will be "yes" or "no". Mr. Kautzner, does Express Scripts factor in business considerations or potential profits when deciding access to prescribed medication? Yes or no, and, again, you are under oath.

Dr. KAUTZNER. Thank you for the question, Congresswoman. We do a clinical-first approach, so all clinical evaluation is done first——

Ms. PRESSLEY [continuing]. Yes or no?

Dr. KAUTZNER [continuing]. Then a financial evaluation is done after that.

Ms. PRESSLEY. Yes? Yes or no, for the record.

Dr. KAUTZNER. Financial evaluation is included after the clinical.

Ms. PRESSLEY. Mr. Joyner, does CVS Caremark factor in business considerations or potential profits when deciding access to prescribed medication? Yes or no.

Mr. JOYNER. Congresswoman, we have a Pharmacy and Therapeutics Committee that assesses the clinical value of the medication.

Ms. PRESSLEY. You all are very smart. Can you just answer the question? Yes or no.

Mr. JOYNER. Like I said, we have a P&T Committee that assesses the clinical——

Ms. PRESSLEY. Reclaiming my time. Reclaiming my time. Dr. Conway, does Optum Prescription factor in business considerations or potential profits when deciding access to prescribed medications? Let us see if three will be the charm. Yes or no.

Dr. CONWAY. Clinical consideration and lowest net cost to the customer, including a formulary exception process.

Ms. PRESSLEY. Reclaiming my time. Well, my office has met with patients, families, providers, and community pharmacists throughout my district from East Boston to Cambridge to Roxbury, and they all point to one conclusion: you are putting profits over people. Your corporations are denying people access to necessary medications, preventing them from going elsewhere by forcing independent pharmacies to close their doors. And that is why I am glad we are having today's hearing to shine a bright light on your unethical practices, and I look forward to working to Congress to rein in PBMs. Thank you, and I yield back.

Chairman COMER. The gentlelady yields back. The Chair now recognizes Mr. Biggs from Arizona.

Mr. BIGGS. Thank you, Mr. Chairman. I associate myself with many of the comments of Representative Casar from Texas, and nobody will be more surprised than he, but it is true. I thought he did a nice job. Mr. Kautzner, I want to focus on active service members who are insured through TRICARE. The Department of Defense just renewed their exclusive contract with Express Scripts. Is that correct?

Dr. KAUTZNER. That is correct.

Mr. BIGGS. It is my understanding that as part of this renewal, in October 2022, 15,000 independent pharmacies were removed from the TRICARE network. Were these pharmacies priced out, or

did Cigna negotiate the removal from the network as a condition of renewal of the contract?

Dr. KAUTZNER. So, Congressman, all independent pharmacies had the opportunity to continue to participate in the network, and they made a decision not to. We have subsequently opened back up their opportunity to participate should they want to.

Mr. BIGGS. How many came back?

Dr. KAUTZNER. So, right now, two-thirds of the independent pharmacies in our total broadest network participate in the TRICARE network, and in total——

Mr. BIGGS. I am sorry. I do not want to be pushy, but when you say two-thirds of this or that, it does not do any good. I want to know how many. What is the actual number?

Dr. KAUTZNER. So, roughly, if we have a network that has over 21,000 pharmacies in total, independent pharmacies in our network, two-thirds of those, roughly, are participating in the TRICARE network.

Mr. BIGGS. So, 14,000. Is that what you are telling me? Two-thirds of 21,000 is 14,000, right?

Dr. KAUTZNER. It is an approximation, but it is in that area.

Mr. BIGGS. Did these pharmacies return in 2023 after the renegotiations?

Dr. KAUTZNER. We continue to keep that open, so any pharmacies that want to choose to participate have the ability to.

Mr. BIGGS. How many of those came back after the renegotiation in 2023? Look, I am not playing "gotcha." I just really want to know, OK?

Mr. KAUTZNER. I do not have that information in front of me today, sir. We could certainly provide it, though.

Mr. BIGGS. Yes. Mr. Chairman, I want to introduce two unanimous consent. I always have articles, as you know——

Chairman COMER. Yes.

Mr. BIGGS [continuing]. Article one, "Prescription Drug Middleman Potentially Profiting Off Veterans" and "TRICARE Removed 15,000 Independent Pharmacies from Network" into the record.

Chairman COMER. Without objection, so ordered.

Mr. BIGGS. Thank you. I have serious concerns about how the situation looks. What is the justification for limiting choice and access to medication for service members, Dr. Kautzner?

Dr. KAUTZNER. So, Congressman, we continue to exceed the access standards that are set by TRICARE, which, ultimately, are set by Congress for patients. Ninety-eight percent of patients that are TRICARE beneficiaries live within 15 minutes of a pharmacy that is in their network today.

Mr. BIGGS. It is my understanding that you are a vertically integrated corporation. Is that right?

Dr. KAUTZNER. The Cigna Group has multiple different companies, if that is what you are referring to from vertical integration.

Mr. BIGGS. Yes. I think you know what vertical integration is. Do you ever steer patients, including service members, to your own pharmacies or to use mail order? In other words, do you ever steer consumers to your preference as opposed to necessarily their preference?

Dr. KAUTZNER. Congressman, we carry out the benefit as directed by TRICARE, and TRICARE makes the decision on which pharmacies they want to have in their network and prefer.

Mr. BIGGS. So, I am going to ask that question again because you seem like a nice guy, you seem bright, so I think you can answer this question. Do you guys ever engage in steering patients to your preferred service provider?

Dr. KAUTZNER. Congressman, if we are specifically speaking of TRICARE——

Mr. BIGGS. Yes.

Dr. KAUTZNER [continuing]. TRICARE makes the decision on whether they want to prefer a pharmacy or not. So, in this instance, TRICARE does have our home delivery pharmacy as an option as a preferred pharmacy.

Mr. BIGGS. Thank you. Mr. Chairman, I am going to run out of time, so I am going to just give you some more of these as well. So, I think we did that one and that one. Here we go.

"Mail-Order Medications are Often Exposed to Unsafe Temperature;" Study Says 90-day Prescription is not for everyone." "How Chaos at Chain Pharmacies is Putting Patients at Risk;" "Independent Pharmacies Continue to Face Financial Hardships as the Clock Ticks on PBM Reform;" "America's Pharmacy Deserts"——

Chairman COMER. Without objection, all those articles will be entered into the record.

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

Chairman COMER. The Chair recognizes Ms. Tlaib from Michigan.

Ms. TLAIB. Thank you, Chairman Comer. Chairman, I do want to help support all the text messages you got. I actually got letters of independent pharmacists to say they do not have great relationships with their PBM. One is from independent pharmacies in Flint, Michigan, another who owns a number of independent pharmacies in the Upper Peninsula in Michigan.

Chairman COMER. Without objection, so ordered.

Ms. TLAIB. Each of you have said that you have business plans or processes and methods in place to help lower cost for our residents, yet has been well documented there has been a huge reduction of pharmacies in many vulnerable areas. I do have really just a question, and it is really a yes or no, and I promise, like, you should know this. But did you all make more money, I mean, like, in 2023 than you did in 2022, like profit? Did you make more money, Joyner? Did you guys make more money? Are your profit is going up? Yes or no. Is it——

Mr. JOYNER. In 2024, my profits are going down from 2023.

Ms. TLAIB. It is going down right now?

Mr. JOYNER. Yes.

Ms. TLAIB. You are not making any money?

Mr. JOYNER. No, we are making money. I am just saying——

Ms. TLAIB. But it is down from 2023?

Mr. JOYNER. Yes.

Ms. TLAIB. Interesting. How about you, Kautzner? Kautzner, is that how you say——

Dr. KAUTZNER. Yes. So, the Cigna Group's profits, as we report, did increase from 2022 into 2023 and for the first quarter of 2024.

Ms. TLAIB. So, you are doing good. OK. How about you?

Dr. CONWAY. Yes, Optum Rx earnings increased from 2022 to 2023.

Ms. TLAIB. By a lot. Is it, like, doing really well? I do not understand how you are making money and making profit if you are trying lower cost on our residents. I am just confused how you can do both. I know my colleagues are not going to get into it, but you got to be making money from somewhere if it continues to increase. So, one of the things that I know are, of course, the DIR fees and reimbursement, but one of the things in the report, and I know you all saw it, but in there it talks about the post-sale adjustments. Get this, and Chairwoman McClain and I come from the same state, but check this out. Post-sale adjustments can require a pharmacy to often blindly make payments of hundreds of thousands of dollars back to PBMs months after the relevant prescriptions are sold.

So, this is, like, one of my residents going in, and they buy $5 worth, I do not know, dairy products or something like that. Like, I think I used the example of a gallon of milk. Goes in, buys a gallon of milk, later sees a charge of $5 extra, like, after they left the grocery store. So, quoted in the report, it says we are often talking about PBMs charging hundreds of thousands of dollars. These are not small fees, though.

So, the FTC report noted that one of the metrics PBMs often use is—it is really interesting—deciding whether or not to charge pharmacies retroactive fees. These are, again, they left, they paid for it, you all came back and charged them more. It is crazy. I kid you not, Chairwoman, but there are many reasons. So, they say that, basically, the post-sale adjustment is based on whether or not, like they are punishing them because a patient is unable to afford their medication, or when the patient cannot pick up the medication on time, that they have an unpredictable work schedule or something, whatever it is. It is some weird little factor you guys are putting in, reasons that might all of a sudden say, well, we got a post-sale adjustment. How many of you use post-sale adjustments? Caremark, you guys use post-sale adjustments?

Mr. JOYNER. No. That program discontinued in 2023.

Ms. TLAIB. How about you, Kautzner?

Dr. KAUTZNER. Congresswoman, we do not engage in clawbacks.

Ms. TLAIB. Yes. How about you?

Dr. CONWAY. Optum Rx does not do clawbacks or charge DIR fees.

Ms. TLAIB. So, what is this thing about you all doing the thing about using to determine whether or not to charge pharmacies, removing, like, the patient adherence? How many of you use that factor, that the patient adheres? How many of you? Kautzner, you look like you are interested in this question.

Dr. KAUTZNER. So, Congresswoman——

Ms. TLAIB. You guys got away——

Dr. KAUTZNER [continuing]. The DIR program expired last year, so that is not——

Ms. TLAIB. But do you at all determine post-sale adjustments or anything? You do not do any of that anymore?

Dr. KAUTZNER. We do not engage in clawbacks.

Ms. TLAIB. OK. You call it clawbacks. Is that what you guys call, clawbacks, post-sale? So, if any of your independent pharmacies, they walk out, you guys do not go back and say, oops, you owe another $10? None of you do that?

Dr. KAUTZNER. That is not a practice that we are engaged in.

Ms. TLAIB. OK. What is this about a factor using a patient adherence from factors being used to determine whether or not? Like, what is that about? Like, the patient is using it. I am being serious, you guys. This is something in the FTC report, so I am just curious. Did you guys stop it because they caught you, or what is going on here? You guys changed the name of it?

Dr. KAUTZNER. The DIR program was actually removed. It was a government decision. It was not a decision that——

Ms. TLAIB. We forced you guys to do it?

Dr. KAUTZNER. It was enacted by the government.

Ms. TLAIB. Yes, yes. We forced you to do it? What else should we be forcing you guys to do, because it is still—I am being serious. You know that you are in the practice. If you are making profits continually, it is not reducing the cost on our residents. Something is wrong. I mean, you hear this. I had one in my district, Chairwoman, last thing, he paid like $100 or something right out of pocket. He never got reimbursed for it, ever. Again, whatever you all are doing, it is putting them out of business, and guess what? That means less access to our residents that really depend on independent pharmacies. But again, it sounds like we need to do some forcing them to act in good faith.

If we stop those programs, what else do we need to stop so they can treat everybody fairly and not monopolize as well? I know you guys do that and you do not offer everybody the same service, and that is ridiculous. With that, I yield.

Mrs. MCCLAIN. [Presiding.] Thank you, and I now recognize myself for 5 minutes.

I think part of one of the biggest issues we have is the pharmacists think there is a problem. The patients who use the services think there is a problem. I am curious to see, do you all think there is a problem with the PBMs? Mr. Joyner?

Mr. JOYNER. Congresswoman, as I mentioned in my opening statement, I do believe that there is an opportunity to improve.

Mrs. MCCLAIN. So, is that a yes? The reason why I ask is because we cannot fix a problem that we do not think exists. Yes, there is an opportunity to improve. I am asking you, do you think there is an issue, do you think there is a problem, because perception is 90 percent of reality and the user thinks there is a problem, the pharmacist thinks there is a problem. I am wondering if you think there is a problem.

Mr. JOYNER. I absolutely believe that there is an opportunity to solve that problem through——

Mrs. MCCLAIN. So, is that a yes?

Mr. JOYNER [continuing]. TrueCost.

Mrs. MCCLAIN. Is that a yes?

Mr. JOYNER. So,——

Mrs. MCCLAIN. OK. Never mind. How about you, Dr. Kautzner? Do you think there is a problem that we have an opportunity to fix?

Dr. KAUTZNER. Congresswoman, healthcare is hard. So, agree that there are challenges and continued issues that we can all do better on, and we certainly can be part of that solution.

Mrs. MCCLAIN. OK. I want to ask it one more time before my patience gets—do you think there is a problem?

Dr. KAUTZNER. Congresswoman, there are always challenges within healthcare.

Mrs. MCCLAIN. OK.

Mr. KAUTZNER. And so, we all——

Mrs. MCCLAIN. I reclaim my time. Dr. Conway?

Dr. CONWAY. Yes, as a practicing physician, medicines need to be of——

Mrs. MCCLAIN. Hallelujah. Do you gentlemen see how he answered that question? Yes, there is a problem. We might be able to get to some solutions, and I think therein lies the problem. You all are the middlemen. You all want to make a profit which, OK, that is good, but if you are not delivering an outcome to the people who use it, how long do you all think you are going to have a job? There is a problem, we got to fix it, right? And part of the issue is prescription drug prices have increased every single year for the past 15 years, and the so-called middlemen in the drug market, the PBMs, clearly have the ability to impact that cost. And I remind everybody the reason why we put this program together was to help reduce costs. Am I inaccurate on that?

[No response.]

Mrs. MCCLAIN. It seems to have done the opposite, yet the most concerning thing to me is I continue to ask you all when you come into my office because you seem to think that there is not an issue—except for you, Dr. Conway, and I appreciate that—is show me the data that supports your position, right? Just show me the data because the other side that thinks there is a problem, the end user, has the data, right?

My colleague from Michigan has testimony from our constituents telling us that there is a problem. They have this little thing called data. When I ask you all for data, ad nauseam, I might say, you send me a really pretty PowerPoint, which I would like to enter into the record, which is a sales piece.

Mrs. MCCLAIN. I spent 35 years in sales. This is not data.

So, I am going to ask, before we go on, do you have and if you do not, that is OK. Perhaps that is where you should start. Do you have specific data, not a pitch book, but do you have specific data that you could share with me and the Members of this Committee that shows you actually are doing what the PBMs are supposed to do and that is save costs for the patient? Do you have specific data that you will actually send to me, Mr. Joyner?

Mr. JOYNER. Absolutely. We will send you——

Mrs. MCCLAIN. And when could I expect that?

Mr. JOYNER. I will work with my staff and get it to you ASAP.

Mrs. MCCLAIN. ASAP as in Monday perhaps?

Mr. JOYNER. I will work with my staff.

Mrs. MCCLAIN. That is great. ASAP as in 2 months from now? ASAP as in 2 years from now of which I have been asking?

Mr. JOYNER. Yes.

Mrs. MCCLAIN. ASAP just as like ASAP.

Mr. JOYNER. No, we do——

Mrs. MCCLAIN. OK. I will pay you as soon as I can pay you, too. Do not you worry. I will get you your profits ASAP, yes? I cannot define "ASAP" but, you know, like ASAP.

Mrs. MCCLAIN. How about you, Mr. Kautzner? When can I expect this data, not the pitch book?

Dr. KAUTZNER. Congresswoman, I refer you to review the written testimony that we submitted. It is a lengthy testimony, and it is full of data and stats of the good work that we do and would be happy to followup on any additional stats that——

Mrs. MCCLAIN. Good. Let us book a meeting with you and I. I would be more than happy, OK? I would enjoy that because therein lies your problem is you all do not think you have a problem, and I have been asking ad nauseam for data and you shuck and jive. "Oh, look over here. "Oh, it is not really happening." "Oh, it is two-thirds." Well, I am not really sure how much two-thirds is. I mean, people are having problems. You want zero transparency. I can see why. It is like we are trying to help you. One side is saying they are hurting, the American people who pay costs are hurting, yet you do not have any data to show us. It is very, very frustrating, and I will just share with you where this is going to end. This is going to end that the PBMs being out of business and the only people you have to blame for that is yourself.

And with that I am over. I will yield back. The Chair now recognizes Mr. Frost for 5 minutes.

Mr. FROST. Thank you so much, Madam Chair. Patients are paying hundreds of dollars for extra drugs, thanks to Big Pharma and PBMs. PBMs are claiming that they are lowering medication costs, but for many drugs they are not. PBMs, you all are doing dirty deals, conspiring with Big Pharma to drive up drug prices. Big Pharma says to PBMs, agree to recommend expensive brand-name drugs to healthcare plans and we will give you better rebates, like a recent FTC investigation brought up. For example, Mr. Kautzner, your PBM only suggests brand-name drugs that treat hepatitis C, even though cheaper generic alternatives exist, according to a recent New York Times article. Mr. Kautzner, has Express Scripts, your company, ever entered into a rebate agreement that requires Express Scripts to cover a brand name medication instead of a generic one?

Dr. KAUTZNER. So, Congressman, in terms of first hepatitis C, we led the charge on that a decade ago and saved our clients a billion dollars and saved American healthcare $4 billion.

Mr. FROST. But is it "yes" or "no" on the question I asked? Has your company entered into rebate agreements that require your company to cover brand medication instead of generic ones? Yes or no.

Dr. KAUTZNER. There are times when we will prefer a brand product over a generic——

Mr. FROST. Why?

Dr. KAUTZNER [continuing]. When there is limited generic competition, and the lowest net cost is the brand is actually cheaper, and we actually are able to put in our system so the patient pays the generic copayment or the generic coinsurance. So, the patient is not harmed in those situations and our clients actually save. The

reason they save is because brand manufacturers contract and prevent generics from entering the market, and when you have limited competition, sometimes a brand actually can be cheaper.

Mr. FROST. Reclaiming my time. So, the answer is, yes, you have entered into rebate agreements with these companies to push a brand medication instead of generic. You are saying that there is cost savings, but patients still have to pay more since the copays are usually higher for the brand-name drugs versus the generics.

When PBMs are not doing dirty deals and they do suggest generic drugs to healthcare plans, they have been known to charge massive markups. One example, Mr. Joyner, your PBM charge some healthcare plans $138,000 a year for a generic cancer drug that actually has a wholesale cost of just $14,000 a year, according to a recent New York Times article. That is an 885-percent increase in price. Mr. Joyner, the cost of that greed is passed directly on to ordinary people. Will you commit right now to lowering the cost of generic medications like this one on your formularies?

Mr. JOYNER. So, Mr. Congressman, we have committed and I have mentioned in my opening testimony that we are introducing a new price model by the name of TrueCost, and we are committed to lowering the cost of both brands and generics for members.

Mr. FROST. That is good. That is good. So, can you commit right now that the current increase on that is 885 percent? Can you at least commit to not going higher than 885 percent of a markup on your generic medication?

Mr. JOYNER. So, if you look at TrueCost——

Mr. FROST. Is it "yes" or "no?" Would you be able to do it? Would TrueCost make sure that——

Mr. JOYNER. Absolutely. TrueCost, which is our new innovation, and what we believe is changing the marketplace.

Mr. FROST. That is good. So, because of TrueCost, we can confirm today that at least the medication will be marked up 885 percent?

Mr. JOYNER. No, that is not——

Mr. FROST. No? So, it could go over 885 percent?

Mr. JOYNER. So, TrueCost allows us to get to the acquisition cost of the product, which is——

Mr. FROST. Mr. Joyner, I am sorry. Just a "yes" or "no." Sir, are you saying, no, it cannot?

Mr. JOYNER [continuing]. Passed on to the member.

Mr. FROST. It could be 885 percent of the markup on the generic medication?

Mr. JOYNER. No, the way in which——

Mr. FROST. No? Now, it is no?

Mr. JOYNER. The way in which the TrueCost price model will work is that we will take 14,000——

Mr. FROST. OK. I am going to move on because I have limited time, but it was a simple "yes" or "no." I thought it was a "yes," and you went back to "no." It seems like, no, you cannot say that you will not be having an 885 percent markup on generic medications. PBMs and Pharma are both to blame for these high drug prices. You guys love to point fingers at each other, but this will not work. We are holding both of you accountable.

I know you like to talk about this 6-percent number. Your PBMs will talk about how they take home just 6 percent of the cost plans

and patients pay for prescription drugs while pharma takes 64 percent. But that just tells part of the story because that 6 percent number, that statistic comes from the cost of drugs you cannot even negotiate for. PBM's real cut of the profit is much higher when you look at the drugs that you touch.

I am just curious, Dr. Conway, what was your salary this last year?

Dr. CONWAY. My salary last year was a little north of $4 million.

Mr. FROST. Dr. Kautzner?

Dr. KAUTZNER. Sir, I would be happy to provide that offline.

Mr. FROST. Do you like to provide it now? I just got it from Dr. Conway.

Mr. KAUTZNER. Our company does publish——

Mr. FROST. OK. I am moving on. You do not want to say it. Mr. Joyner?

Mr. JOYNER. I just came back to the company, so I am now in my first year.

Mr. FROST. What are you supposed to get this year?

Mr. JOYNER. I will followup with you offline.

Mr. FROST. Followup offline. I know I am over time, but it does not matter if you are Democrat or Republican, this is a crisis in this country. People are dying because they cannot afford their medication, and you all are part of the problem. I yield back.

Chairman COMER. [Presiding.] The Chair now recognizes Mrs. Miller-Meeks from Iowa.

Mrs. MILLER-MEEKS. Thank you very much, Mr. Chairman, for allowing me to waive on to this critically important hearing, and thank you for moving my cost saving PBM reform legislation, The Drug Act, favorably through your Committee earlier this year. Let me also just add on to what my colleague just said in who is responsible for high prices in prescription drugs, and I am going to add that government is also responsible for that in some of the legislation that we put forward.

It is no secret that PBM middlemen artificially inflate the cost of and limit access to prescription drugs. My first attempt at PBM reform was as a state senator when I passed a bill in 2019, trying to get at transparency of this marketplace. This occurs at the expense of patients who receive health insurance in public and private markets and impacts patients of all ages. The PBM market has become highly consolidated with the three largest PBMs controlling roughly 80 percent of prescriptions. The top six PBMs account for 97 percent and in Medicare Part D, four PBMs managed benefits for a combined 90 percent of beneficiaries.

PBMs claim that they reduce drug prices by holding pharmaceutical companies accountable. This is done by requiring rebates on drugs, which are then passed on to the beneficiary, but is that beneficiary the patient? While PBMs often do not negotiate discounts from manufacturers, patients are not the ones who benefit from them. In Medicare Part D, for example, patient cost sharing is based off the list price of drugs which are artificially inflated by the PBMs to extract a higher rebate.

As a result of these practices, for 79 of the 100 most rebated drugs in Medicare Part D, beneficiaries pay more for the drug than their insurer, again, demonstrating that beneficiaries—in this case,

seniors—are not benefiting from rebates. This is why I led the bipartisan Share the Savings with Seniors Act, which would require full rebate pass through for chronic care drugs covered under Medicare Part D plans. Another way PBMs cut cost at the patients' expense is by limiting the number of treatments available on formularies despite claims by PBMS that they promote access. In 2022, 1,156 medications were excluded from at least one of the three PBMs—CVS Caremark, Optum Rx, and Express Scripts—from their formularies which represented a 961-percent increase and excluded products from 2014.

This is not a partisan issue. Every American who utilizes prescription medications experiences the impact that PBMs and vertical integration have on our healthcare system. And let me also say that my mother had Express Scripts, and for me, there are some benefits that PBMs actually help to provide. However, this is why that the Federal Trade Commission, because of this vertical integration which currently comprises our Federal Trade Commission, more Democrats and Republicans are investigating the harmful impacts of middlemen and the vertical integration.

Chair Khan of the FTC stated in recent interim report that dominant pharmacy benefit managers can hike the cost of drugs, including overcharging patients for cancer drugs, and that PBMs can squeeze independent pharmacies of many Americans, especially those in rural communities that depend on essential care. In Iowa, for example, 25 independent pharmacies have already closed this year, and I met with Hy-Vee, which is a grocery retailer, that also has pharmacies. They are in seven states. They are closing two pharmacies. And so, if you have a multistate company or national companies that cannot keep pharmacies open because of the cost and reimbursement or reimbursing lower than what it cost a pharmacy to acquire the drug, these independent community pharmacies will close and are closing.

When the FTC testified in front of the Energy and Commerce Committee earlier this month, the witnesses confirmed that your companies have not been complying with document requests, and that was true of my first bill in Iowa. We were supposed to have data within a year. It took 3 years to get data that was already in the possession of the PBMs. If your companies are so convinced that they can lower drug cost and increase access to innovative treatments for patients, you should be eager to demonstrate and not withhold information. Patients in my district are getting squeezed at the pharmacy counter and are seeing access to lifesaving medications restricted. This is why I am actually proud to lead these multiple bills to reform the drug pricing landscape to ensure PBMs and insurers are actually helping patients.

Questions to any of you three. Many experts recognize that misaligned incentives in the current payment system have led to PBMs to favor medicines with high list prices and larger rebates or discounts. However, when your companies faced exposure over this rebating practice, PBMs have shifted their compensation models to focus on administrative or other fees, which have typically remained tied to list prices. So, even in the cases where PBMs are passing most of the rebates back to health plans, PBMs still have an incentive to favor high list prices and doing so the current PBM

compensation model is causing patients to face a higher financial burden for their prescription drugs. In my view, PBMs should not tie their compensation to the price of a medication, especially a percentage of the medication. That seems counter to your stated mission of lower drug costs. Do you not agree? Mr. Joyner, agree or disagree?

Mr. JOYNER. So, we have actually introduced a biosimilar at a low list price. So, we do believe that introducing products at a low list price is actually beneficial for our customers and the patients and the PBM.

Mrs. MILLER-MEEKS. Thank you. Dr. Kautzner?

Dr. KAUTZNER. Congresswoman, we have been on the record for years of employing drug manufacturers to lower their list prices and continue to do so.

Mrs. MILLER-MEEKS. And Dr. Conway?

Dr. CONWAY. We want manufacturers to lower their list prices.

Mrs. MILLER-MEEKS. I would like PBMs to have a reduction in the amount of a drug that they are putting into the billions of dollars that are in this marketplace and will continue on the PBM reform that I have started on. Thank you so much, Mr. Chair. I yield back my time.

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

Ms. LEE. Thank you, Mr. Chair. In Southwestern Pennsylvania, we are deeply familiar with the consequences of concentrated corporate power in our healthcare systems. Whether it is the hospital system, a health insurance conglomerate, or both combined, the consequences of healthcare monopoly are always the same, higher costs, reduced access, and worsened health outcomes. And with health insurance companies like United Health, Cigna, and Aetna, it is evident that through their monopoly power, they have been able to rig our healthcare system to prioritize profits over patient health, capitalizing on each level of the drug supply chain to boost shareholder returns.

Last year, the parent companies for all three PBMs testifying here today were incredibly successful as evidenced by their windfall profits. And I know that some of my colleagues before me have gotten at this, but I am still curious. Mr. Joyner, how much total revenue did CVS Health report in 2023?

Mr. JOYNER. Just shy of $180 billion, I believe.

Ms. LEE. And how much of total amount was attributable to Caremark?

Mr. JOYNER. The question was CVS Health?

Ms. LEE. Yes, but then how much of that was attributable to Caremark?

Mr. JOYNER. The Caremark revenues were just shy of $180 billion.

Ms. LEE. Thank you. Mr. Kautzner, how much total revenue did Evernorth Health Services report in 2023?

Dr. KAUTZNER. Congresswoman, I do not know the exact amount, but it is certainly within the filings that we provide. What I can say is——

Ms. LEE. Yes. I believe its $153.5 billion. How much of that total was attributable to Express Scripts?

Dr. KAUTZNER. So, we do not report the Express Scripts' segment on its own, so I could not provide that information.

Ms. LEE. Thank you. Dr. Conway, how much total revenue did United Health Group report in 2023? I am sorry, can——

Dr. CONWAY. I am sorry. I believe it was in the high $360 billion in terms of revenue for the whole group.

Ms. LEE. How much of that amount was attributable to Optum Rx?

Dr. CONWAY. A hundred 16 billion dollars was the revenue of Optum Rx last year.

Ms. LEE. So, while your three companies earn billions, Americans continue to pay some of the highest cost for medications in the world. Last March, the Kaiser Family Foundation released data showing more than a quarter of adults said it was either somewhat or very difficult to afford prescription drugs. For people of color, 60 percent of black respondents and 65 percent of Hispanic respondents reported difficulty affording healthcare, and this is despite your claims of negotiating significant rebates from drug manufacturers to lower drug prices.

So, to any of you, it appears that this system of rebates actually benefits the PBMs rather than the patients as we have been talking about. How do you explain this discrepancy? Anyone? Dr. Conway?

Dr. CONWAY. So, we compete in a market that is competing on lowest net cost to the customer, clinical programs, transparency, and choice. It is a highly competitive market. I have been in this role for about a year. Retention rates are 98-plus percent in Optum Rx, and within that market, we work each and every day to make drugs more affordable. To your point——

Ms. LEE. But they are not more affordable.

Dr. CONWAY. So, as I mentioned earlier, we have got over 290 drugs now in a program we rolled up that is zero-dollar or $5 copays, so less than $35, typically zero dollars and $5. I agree with you that we need to continue to work along with stakeholders' processes——

Ms. LEE. Thank you. Yes, thank you, thank you for that.

Dr. CONWAY [continuing]. Make more affordable.

Ms. LEE. Thank you. Just stick in there. Last year, Optum Rx's former CEO testified before the Senate Committee on Health, Labor, Education, and Pensions. She explained that some of your customers, "Choose to compensate us for the savings we generate and the services we provide by opting for us to retain a small fraction of discounts we negotiate with pharmaceutical manufacturers." For companies that choose this compensation model, what percentage of the discount you negotiate with drug companies does Optum Rx retain on average?

Dr. CONWAY. The majority of customers choose 100 percent rebate passthrough. On average, across the entire book, it is 98 percent of rebates that are passed through to our customers.

Ms. LEE. Your former CEO stated that "Other customers prefer that we pass along 100 percent of the savings we negotiate." So, on average, how do clients who choose this model pay Optum Rx as an administrative fee?

Dr. CONWAY. They have a set of choices in how they pay us. Some of them choose administrative fees. There is a set of options that we provide to them transparently that they select on how they reimburse us for our services.

Ms. LEE. It is clear that the savings you are claiming to be providing the patients are either woefully inadequate or not reaching them at all. I look forward to working with my colleagues to reign in PBM monopoly power and lower drug costs for all patients, and I thank you all for your time. I yield back.

Chairman COMER. The Chair now recognizes Mr. Sessions from Texas.

Mr. SESSIONS. Mr. Chairman, thank you very much. Thank you to the panel that has spent a good bit of time here. I am a strong proponent of the free enterprise system and of capitalism, but along with that comes something which you find yourself embroiled in today and it is not new to you, and that is the view that a few PBMs control more than 80 percent of the market, and part of the free enterprise system, or at least capitalism, is opening markets up.

You and I both understand, and that is fine because I use some of them back home, larger pharmacy chains that then have some bit of influence about where the market goes, who, where the drugs are given out. But as I read about what was called spread pricing, it then disturbs me, and that is really why we are here today, I think why the Chairman is here, why the Ranking Member is here, why all these members are coming forth because we think that. And it is best said here, due to PBM's role as middlemen and their responsibility to reimburse pharmacies for dispensing drugs, PBMs can reimburse pharmacies that they own more than they give to competing pharmacies such as community and independent pharmacies. But it really is a little bit more than that as an example, and that is maybe others are not even included in options that are available at the time they order their drugs.

One example may be Blink that I am aware of. Blink has a number of employees in the district that I represent, and they are, once again, just like you are part of the free market, part of doing things, but they are part of the free enterprise system, part of the effort to provide competition which is a basis of how we as Republicans think. Tell me about the ability that companies have, perhaps their pharmacies, perhaps their insurance company, perhaps they are you, about blocking competitors rather than allowing what might be an opportunity for customers to more fully get the carrier or the provider that they want? Anyone? Mr. Joyce?

Mr. JOYNER. Yes, Mr. Joyner. Thank you, Congressman.

Mr. SESSIONS. Joyner.

Mr. JOYNER. Yes. So, the networks work differently by market type. So, in Medicaid as an example, as in any willing provider, which essentially means that anybody can participate assuming that they are agreeing to the terms and conditions of the contract. As you move to the commercial where you actually deal with employers, employers have different needs and many of them are looking to either open up a network because they want to make sure it is open access, but they are also, as a result, generally paying more money.

There are others that are looking to save money and they want to restrict and do not narrow the network. And so, what we do is facilitate the options to help them actually make the decisions that are best for them, ultimately trying to cater to the employer choice and making sure that we actually show them options to be able to create savings and/or a better experience for the employees they serve.

Mr. SESSIONS. So, preferred customer. This is not unusual.

Mr. JOYNER. Correct.

Mr. SESSIONS. What you are describing is a part of the system, and that is what you are saying that you and working with the people who contract with you make the decision. At what point then would—either, any of you three—would a person without an employer, without, you know, where probably a vast number of Americans are, who is looking out for them?

Mr. JOYNER. So, the employer and/or those that are providing the benefits for them are looking out. Most employers that you talk to want to make sure that they are offering a benefit that is attractive and is seen as a benefit because they are spending a lot of money on healthcare for their employees. So, they are looking out for the wellbeing and they are expecting us to deliver best-in-class service and also making sure that we deliver the savings to be able to provide an affordable benefit.

Mr. SESSIONS. So, they would come to you and you would say to them, by coming to us here is a benefit that we give to you, and by a larger amount of dollars that you would spend with us or numbers of customers, we would give you a preference. OK. Mr. Chairman, I ask for just 30 more seconds.

Chairman COMER. Go ahead.

Mr. SESSIONS. So, what this group of people here are about, Members of Congress, we do not see where that is necessarily open to better competition, better prices, and to people who may be left out of those equations. They may not have an employer-provided benefit. They may not have a preferred company that would advocate on behalf of them. And I think if we were being realistic, we would say, and say to you, too, that is why we are here today. We would like there to be the same advantage for a larger number of people than is available today and I think you can accept that and not argue with it.

Look, I spent 16 years with AT&T. Not everybody came to AT&T. There was a more robust market. There needs to be a robust market for people that do not have advantage. I appreciate each of you being here today. Mr. Chairman, I yield back my time.

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

Ms. PORTER. Mr. Joyner, before the COVID vaccine, what was the highest grossing drug of all time?

Mr. JOYNER. I am sorry. Before the what?

Ms. PORTER. Mr. Joyner, before the COVID vaccine, what was the highest grossing drug of all time?

Mr. JOYNER. Humira.

Ms. PORTER. Humira? That is because for 20 years, Humira was the only option for rheumatoid arthritis patients. People did not have cheaper alternatives, and they literally ended up paying the

price, and that price without insurance was a whopping $7,000 per month. And before you decide to put all the blame on to AbbVie, the manufacturer of Humira, I will remind you that I had some choice words for AbbVie's CEO, so we already know they are a big part of the problem here. But good news, in 2023 Humira's patents finally ended and cheaper biosimilar drugs came on the market. So, Mr. Joyner, by the end of 2023, how much of the market did Humira's competitors control?

Mr. JOYNER. Less than 1 percent.

Ms. PORTER. Wait. You are telling me that patients have the option to get a much cheaper drug and almost everyone wanted to pay more money to get Humira? Make it make sense, Mr. Joyner. Were the biosimilars not as clinically effective?

Mr. JOYNER. No, it is a great question, Congresswoman, and generally speaking, the products that came to market initially were priced more like brands. So, we were working with another manufacturer, bringing a product to market that was actually 82 percent less than the list price of Humira. And in April of this year, we actually removed Humira, the most successful product in the country, from our formulary. We converted 97 percent of that volume. In fact, in just 3 weeks' time, we built more market share than all was dispensed in 2023.

Ms. PORTER. Mr. Joyner, that is remarkable. Why did it take a year and a half?

Mr. JOYNER. We believe because——

Ms. PORTER. Was it because you were waiting until you could manufacture your own version of Humira called, I believe it is Hyrimoz?

Mr. JOYNER. So, we actually brought a product to market in April because that is when we believe that there was enough manufacturing capacity——

Ms. PORTER. April 2024?

Mr. JOYNER. Correct. And we saved 50 percent off of the 2022, spent $500 million worth of savings for our customers, and the patients basically paid zero dollars out of pocket. So, it was a really great success story today.

Ms. PORTER. Well, there is no doubt that Humira having competition has been a good thing, but you waited over a year from when the Humira biosimilars became available, to put them on your drug list. Yes or no.

Mr. JOYNER. So, not a year from when the Hyrimoz product was introduced, but——

Ms. PORTER. No, let me repeat the question. Let's try to get an answer. Did CVS—yes or no—Caremark wait a year to add Humira biosimilars to their drug list?

Mr. JOYNER. No, we added biosimilars to our drug list in 2023. We did not remove Humira until April of——

Ms. PORTER. So, a patient would have paid the same for Humira and the biosimilars at that time?

Mr. JOYNER. It would have also had copay support, so they could have gotten the benefit of a zero-dollar out-of-pocket cost.

Ms. PORTER. How much did CVS receive in rebates from Humira's manufacturer, AbbVie, in 2023?

Mr. JOYNER. I am not certain.

Ms. PORTER. Mr. Chairman, I ask unanimous consent to enter into the record a Kaiser Family Foundation health news article titled, "Save Billions or Stick with Humira: Drug Brokers"—that would be you all—"Steer Americans to the Costly Choice."

Chairman COMER. Without objection, so ordered.

Ms. PORTER. So, that article says that Humira's rebates were at least 40 to 60 percent of the drug's list price in 2023. Does that sound right to you?

Mr. JOYNER. It is in the ballpark.

Ms. PORTER. OK. So, let us use the low figure of 40 percent being the rebate of the list price that you negotiated. This is your value in the marketplace, correct, negotiating this rebate? How much did Humira generate in sales in 2023? Do you know?

Mr. JOYNER. I do not know.

Ms. PORTER. Fourteen-point-four billion. What is 40 percent of 14.4 billion?

Mr. JOYNER. So, 52?

Ms. PORTER. Pretty good. Pretty good math. Five-point-six billion dollars. Did all that money that you got as a rebate, did it go to patients?

Mr. JOYNER. The rebates were passed through to our customers, the employers, the organizations that fund healthcare in this country, and then they use those dollars, in some cases to actually pass it on to the members.

Ms. PORTER. You did not retain any of that rebate?

Mr. JOYNER. As we have mentioned in my opening statement, CVS Caremark passes through 99-plus percent of all the rebates that we negotiate with the manufacturers.

Ms. PORTER. Look, I think here is the problem. Pharmacy benefit managers today are the worst kind of middlemen. You stop competition, you prevent transparency, you manipulate markets, and you make our healthcare system more complicated. Dr. Kautzner, you said healthcare is hard. No, the practice of medicine is hard. Healthcare is just a profit center in this country. I yield back.

Chairman COMER. The gentlelady yields back. The Chair now recognizes Mr. Buddy Carter from Georgia.

Mr. CARTER. Thank you, Mr. Chairman, and thank you for you allowing me to waive on, and, gentlemen, thank you for being here. I want to congratulate you. You have done something that very few people have been able to do and that is to bring bipartisanship to Congress. I am so impressed with the testimony and the questions that have been given here today. They are spot on because at the end of the day, we all want the same thing. Whether you are a Republican, whether you are a Democrat, whether you are an Independent, you want accessible, affordable, quality healthcare. All of us want that. This is why we are here today.

I want to bring it to a more personal note. And the reason I want to do that is because, as you know, I am a pharmacist, and I practiced pharmacy for over 40 years. And patients come to me. In fact, last week, in my office, I had a phone call with the mother of Matty. Matty is a 15-year-old from Georgia. Matty has a rare genetic disorder called spinal variant neurofibromatosis type 1. Tumors grow on every single level of his spine and his chest wall.

[Photo.]

Mr. CARTER. This is a picture of Mattie behind me. The family asked that I share this with you. Mr. Joyner, CVS Caremark denied Matty's access to a lifesaving drug, Pulmozyme, that he had been on for 2 years, and he almost died as a result. In fact, he ended up in the hospital. He is still in the hospital. He is back in the hospital for the foreseeable future, and the rest of his life could be impacted because of it. All of a sudden, he had been getting this drug for 2 years, and CVS Caremark came in and said you do not have a diagnosis for it.

What would you say to Matty's family, Mr. Joyner? As a pharmacist, what am I supposed to say to Matty's family about this?

Mr. JOYNER. Obviously, this is a terrible situation, and I certainly feel sorry for the way in which this case has proceeded.

Mr. CARTER. Do you feel like CVS Caremark is providing quality care to Matty?

Mr. JOYNER. I do not know the specifics of this case. I will say that we do follow evidence-based guidelines, and so the goal is to make sure that we are looking at each individual case as it relates to the——

Mr. CARTER. I just want to make sure, Dr. Kautzner and Dr. Conway, that you all understand, that we are talking about real people here. We are not talking about just a business model. Yes, I was a business owner for 32 years. I owned three pharmacies, institutional pharmacy, a number of businesses, but we are talking about real people. After all, for 40 years, I was the one who had to go to the counter and tell the patient how much the medicine was. I was the one who watched a senior citizen make a decision between buying groceries and buying medicine. I was the one who watched a mother in tears as she tried to figure out how she was going to pay for the antibiotic. That is why, when I got up here 9 1/2 years ago, the first thing I did was go to the FTC, will you please look at the vertical integration that exist in the drug pricing chain. Finally, 2 years ago, they started doing that.

All of you are familiar with the 6(b) study and familiar with the interim report that came out? Mr. Joyner, are you familiar with it? Did you have a chance to read it?

Mr. JOYNER. I am familiar, and, yes, I have read it.

Mr. CARTER. Dr. Kautzner?

Dr. KAUTZNER. Congressman, we——

Mr. CARTER. Are you familiar with the report, and have you read it?

Dr. KAUTZNER. I am familiar with it, and we strongly disagree with it.

Mr. CARTER. Have you read it?

Mr. KAUTZNER. I have read it.

Mr. CARTER. OK. Dr. Conway?

Dr. CONWAY. Yes.

Mr. CARTER. You have read it and you are familiar with it?

Dr. CONWAY. Yes.

Mr. CARTER. Mr. Joyner, does CVS Caremark, in any way, steer patients toward their own pharmacy? Yes or no.

Mr. JOYNER. So, as we mentioned earlier——

Mr. CARTER. Yes or no. Do they steer patients toward their own pharmacy?

Mr. JOYNER. We do not steer patients. We provide options to our customers.

Mr. CARTER. OK. Dr. Kautzner?

Dr. KAUTZNER. Our clients make their benefit design decision, and they——

Mr. CARTER. No. Yes or no? No. I am going to take that as a no. Dr. Conway?

Dr. CONWAY. No.

Mr. CARTER. No. Are you familiar with the report saying that there is evidence that the FTC has that the three major PBMs in this country—your three companies—are steering patients toward their own pharmacy? Are you familiar with that being in the interim report in a 6(b) study? Mr. Joyner?

Mr. JOYNER. I certainly read that, but I do not agree with the findings.

Mr. CARTER. OK. Dr. Kautzner?

Dr. KAUTZNER. Congressman, the interim report is full of prejudgments. It lacks any economic, empirical, or data analysis.

Mr. CARTER. Are you familiar with what they say and steering?

Dr. KAUTZNER. I am familiar with what they said.

Mr. CARTER. Yes.

Dr. KAUTZNER. And we have provided over 3.3 million pages of documents and would implore the FTC to do what they committed to do, which is a wholesome review of all the data.

Mr. CARTER. And let me assure you, they are doing it. Dr. Conway, are you familiar with it?

Dr. CONWAY. Yes, and we provide——

Mr. CARTER. And you still deny it?

Dr. CONWAY. And we provide choice to our clients in their pharmacy network design.

Mr. CARTER. Look, guys, you are not talking to somebody who does not know what is going on. I signed those contracts with the PBMs as the owner of Carter's Pharmacy. I know what they say. I know how I am limited. The first bill I got passed up here was the right for the pharmacist to tell the patient if they paid cash, that it would be cheaper than their insurance because you had a gag clause in there that said that the pharmacist could not tell the patient that it would be cheaper if they paid cash for it. I was able to get legislation passed that changed that. There is only one word I know to describe this, and it is "despicable." Mr. Chairman, I yield back.

Chairman COMER. The gentleman yields back. The Chair now recognizes Mr. Lynch from Massachusetts.

Mr. LYNCH. Thank you, Mr. Chairman. First of all, I want to thank the Chairman and the Ranking Member for putting this hearing together, and I want to echo, associate myself with the remarks of Mr. Carter about the refreshing opportunity to work across the aisle with him and others on this problem.

I am the former Chairman of the Subcommittee on Federal Workforce on this Committee. And I can go back to the year 2005 when we looked at what was happening with pharmacy benefit managers in prescription drug pricing under the Federal Employees Health Benefit Program. Now, this is the gold standard among affordable health insurance programs—it covers 8 million Federal

employees and retirees and family members, so this is one of the biggest and best funded because you have got 8 million people paying into it. Our investigation revealed that the Federal Employee Health Benefit Plan was regularly paying up to 45 percent more for its prescription drugs than other Federal programs, including those administered by the Department of Veterans Affairs and the Department of Defense.

The single primary reason for the inflated cost of prescription drugs was that, contrary to other Federal programs, the Federal Employee Health Benefit Plan did not negotiate or regulate drug prices for employees and enrollees. Instead, the programs relied on pharmacy benefit managers, PBMs, to negotiate prescription drug benefits and maintain affordable prices. So, here is how bad it was. At the time we were doing this, CVS had a program where any person off the street could come in, and for $10, they could gain access to the CVS Caremark Program. So, someone off the street could walk in and pay $10 and get their drugs at a fixed price. In contrast, any of the 8 million people who were paying into the Federal Employee Health Benefit Program was paying 45 percent more—45 percent more—than the person with no insurance.

So, think about this. If I am one of the 8 million employees or enrollees that are paying into their insurance program, they would be better off putting their union card in their shoe, walking in off the street without insurance, they would get a better deal than the PBM was getting them for their plan. So, in other words, the person with insurance under the Federal Employee Plan was paying $200 more for the drug than the person walking in off the street. That is just absolutely ridiculous. The PBMs were harming the very people they were meant to protect, the people that they actually had a contract to provide affordable drugs for. This has to stop. This has to stop.

Back when we tried this before, PBMs were spending their money all around the Hill, and unfortunately, spinning a story that was not factual, and that won over some of my colleagues, and we were not able to get that bill to move. I just hope that, Mr. Chairman, with your leadership and the Ranking Member's leadership and my brothers and sisters across the aisle, let us work together on behalf of America today. Let us put all the other stuff aside and fix this problem. It is far too long in coming. Thank you, and I yield back.

Chairman COMER. The gentleman yields back, and I agree and will make that pledge. The Chair now recognizes Mrs. Harshbarger from Tennessee.

Mrs. HARSHBARGER. Thank you, Mr. Chairman, and I thank the gentlemen for being here today.

First of all, I want you to know, I have been a pharmacist for 37 years, and I know firsthand how pharmacy benefit managers maneuver, honestly, to put financial screws to independent pharmacists and community pharmacies, and I have worked in every area of pharmacy except nuclear. So, that includes hospital, that includes retail, home health, hospice, the whole nine yards, and I have lived that experience, being an independent pharmacy owner. You know, what happens is, when you have PBMs to do these things, it leads to increased drug prices by steering prescription

drug coverage to whatever pads your bottom line, and the case in point is the FTC interim report that just came out.

But before I get into that, I want to ask you a question. This is really just a "yes" or "no" question. The Centers for Medicare and Medicaid Services issued an FAQ during the COVID public health emergency stating it was a Medicare Stark violation if a medical practice delivered a drug to a patient, and that during the public health emergency, there were Stark waivers in place which have now expired with the end of the public health emergency. For the record, I ask each one of you if you have had any communications with CMS that prompted this FAQ or related to it in any way? And if so, what was the communication? Starting with you, Mr. Joyner.

Mr. JOYNER. Yes. I am not familiar with what you asked.

Mrs. HARSHBARGER. OK.

Dr. KAUTZNER. Congresswoman, I am not aware of what you just asked.

Mrs. HARSHBARGER. OK.

Dr. CONWAY. Not that I am aware of.

Mrs. HARSHBARGER. Thank you. Now, Mr. Kautzner, we have had the findings of numerous independent studies and the findings of the July 9 FTC interim report, and it is well documented many times over that certain medicines get marked up by thousands of dollars per prescription when they tend to flow through pharmacies owned by the same parent company as the PBM setting the prices. And per the FTC interim report, it states PBMs are paying their affiliated pharmacies up to 40 times average acquisition costs or more.

And there is an internal document, if you have read the FTC interim report, that says, an executive of one PBM stated in internal documents, "You can get imatinib at a non-preferred pharmacy like Costco for $97, at Walgreens, which is a preferred pharmacy, for $9,000, and at preferred home delivery for $19,200." And it goes on to say, "We have created planned designs to aggressively steer customers to home delivery where the drug cost is 200 times higher." The optics are not good.

So, my question to you is, how can the American public trust PBMs when they have done nothing to help with the pricing behaviors, and then you interfere with the clinical decisionmaking process as well with physicians, with prior approvals and things like that, how can American public ever trust what the pharmacy benefit managers are doing?

Dr. KAUTZNER. I appreciate the question, Congresswoman. So, each and every day, we process millions of prescriptions. On every one of those prescriptions, we perform 18,000 safety, quality——

Mrs. HARSHBARGER. Well, I know that. Believe me, I have read the report.

Dr. KAUTZNER. And within 1 second, we are able to do determination. We are going to prevent 100 million potential medication errors just this year alone.

Mrs. HARSHBARGER. OK. I am going to the next question. We are going to talk about 340Bs. I would like to ask each of the witnesses a yes or no. Does your company profit off of its involvement in the 340B drug discount program? Yes or no. Mr. Joyner?

Mr. JOYNER. The 340B marketplace today is an issue with our customers because the manufacturers are only paying——

Mrs. HARSHBARGER. Well, do you profit or not? It is a "yes" or "no."

Mr. JOYNER. We do participate in the 340B program, yes.

Mrs. HARSHBARGER. So, I would assume you do, Mr. Kautzner?

Dr. KAUTZNER. So, the Cigna Group does have pharmacies that will participate in a 340B program, as do many pharmacies across this country.

Dr. CONWAY. We also have areas and customers where we participate in 340B.

Mrs. HARSHBARGER. Well, this is what I would like for you to do is report back to the Committee, give me a rough estimate of how much money your company collects due to its involvement in the 340B program, and we would appreciate you following up with Chairman Comer with that information. And I or one of my colleagues can submit a written question for the record.

Mrs. HARSHBARGER. Mr. Joyner, we have seen disclosures from your company, the fourth-largest for-profit company in the country, warning investors that any reduction in 340B contract pharmacy arrangements could materially and adversely affect the company. And I find this confusing and alarming because the 340B discount program is intended to support safety net clinics and low-income patients, the underinsured or the uninsured. So, can you please explain exactly how this Federal safety net program became such a large part of your company's bottom line that you felt the need to inform investors that your profit would be negatively impacted by changes to the 340B program?

Mr. JOYNER. So, Congresswoman, as you know, the 340B program has changed over the last several years. We actively participate with health systems to help support their 340B programs. We do have pharmacies that participate within, as a contract pharmacy, with those——

Mrs. HARSHBARGER. Well, why would an independent pharmacy get a contract and it says this is your reimbursement rate if the 340B stays in place, and this is your reimbursement rate if it does not, if we negate it in Congress?

Mr. JOYNER. No. I think if you look at the change in the 340B laws, the amount of or the activity of contract pharmacies shrunk or contracted based off the interpretation of a recent court ruling. So, as a result, the narrowing of the 340B——

Mrs. HARSHBARGER. Well, they found a way to rake the system is what it amounts to, and it is not just the pharmacies. It is some of the hospitals as well, and I think you need to relook at the 340B program and how you are abusing that program. And I know that my time is up, Mr. Chairman, but let me say this. Celeste Maloy, Representative Maloy from Utah, was here and she waited over an hour and she has a 2 p.m. hearing. And I just want you to know that we will be working with her in finding solutions for this. So, with that, I yield back, sir.

Chairman COMER. The gentlelady yields back. The Chair recognizes Mr. Auchincloss from Massachusetts.

Mr. AUCHINCLOSS. Thank you, Chairman. Long day, gentlemen, almost over. All three of your companies are part of the Pharma-

ceutical Care Management Association. Is that correct? Yes? And I see the PCMA is here today as well. The PCMA responded to the FTC's interim report with a statement that said, amongst other things, that the report is based on anecdotes and comments from anonymous sources and self-interested parties. The PCMA said the report was supported only by two cherry-picked cases. PCMA said the report completely overlooks the volumes of data that demonstrate the value that PBMs provide. Do any of you three want to disassociate yourself from those comments about the FTC report or do you stand by those?

Mr. JOYNER. We stand behind them.

Mr. AUCHINCLOSS. We stand behind them. I found the FTC report compelling. I found it also to be supported by excellent investigative reporting by the *New York Times*, by the *Wall Street Journal*, by a recent report from 3 Axis Advisors examining Washington state employer data, by a June 2023 MedPAC report that found that payments were likely to be highest to pharmacies that are affiliated with the PBM prescription drug plan, while non-vertically integrated pharmacies were most likely to receive the lowest payments. I thought that the evidence fact pattern was quite strong.

But given the claims of PCMA, and, in particular, Mr. Joyner, the claims that CVS has made about TrueCost, I decided to do my own investigation in Massachusetts. I got access to a Fortune 500 employer's data in Massachusetts and looked at their benefits, which are administered by CVS, and this data here is not anecdotal. This is CVS' own data for an employer based in Massachusetts. I am going to throw out two prices for each drug name, and I want you to guess, Mr. Joyner, which drug is the price CVS charges the employer and which drug is the NADAC price. And I wish that one of the pharmacists in the audience here could help me with these drug names, but we have got teriflunomide, which is used to treat multiple sclerosis. It is priced at $6,229 or $16. Which one do you think is the CVS TrueCost, and which one is NADAC?

Mr. JOYNER. If it were the TrueCost price, it would be the lower.

Mr. AUCHINCLOSS. Well, that is interesting because the answer is the CVS price is $6,229 and NADAC is $16. That is a 38,000-percent markup. Abiraterone acetate is used to treat cancer, and is priced out at $91 or $5,800. Which one is the CVS price, do you think?

Mr. JOYNER. If that client has adopted the TrueCost pricing model, it would be the lower.

Mr. AUCHINCLOSS. We have the CVS price of $5,800, NADAC at $91. That is a $6,300-percent markup. I can keep going. We have got prostate cancer 6,000 percent above NADAC. We have got leukemia, 13,000 percent above NADAC; chronic kidney disease, 5,000 percent above NADAC; HIV, 4,000 percent above NADAC; heart failure, a modest 161 percent markup above NADAC. These are not aberrations, Mr. Joyner. These are not anecdotal. This is your data in my home state. And while specialty drugs may be used by less than two percent of the U.S. population, they account for over 50 percent of the drug spent.

So, if there is any cherry-picking going on, it is not by the FTC, regardless of what PCMA says. It is by the Big PBMs. You are

cherry-picking drugs to apply them to specialty rates at specialty formularies. There is a clear pattern of marking up drugs used to treat the sickest patients, and you are marking these drugs up and filling them disproportionately at your pharmacies through steering. These kinds of markups are anticompetitive. They should be illegal. And that is why, along with my colleague from Tennessee, Mrs. Harshbarger, we introduced today the Pharmacists Fight Back Act, which will stop these markups, patient steering, the patient exploitation in Federal healthcare plans and impose criminal violations for such behavior. No more exploiting the sick. No more drugs being priced thousands of percentage points above NADAC, as I just listed here, and steered to your affiliated pharmacies. No more underwater reimbursing independent pharmacies or imposing point-of-sale and retroactive fees. These practices must stop. Transparent pricing and patient choice should be our north star.

Dr. Kautzner, in my remaining time, I do want to pivot and ask you about Ascent, the GPO that you have domiciled in Delaware but operating in Switzerland. Switzerland is an interesting place to be operating. You do not have any plan sponsors there. The Ohio attorney general thinks that you are doing that because you are trying to engage in anticompetitive behavior. Can you attest here under oath that every action being undertaken in Switzerland would be legal under U.S. competition law?

Dr. KAUTZNER. Congressman, Ascent Health Services is a healthcare group purchasing organization around commercial rebates. We have multiple owners within that organization.

Mr. AUCHINCLOSS. But can you attest that everything that is happening in terms of sharing information about rebates, sharing information about negotiations, everything that is happening in Switzerland, would all of that be legal under U.S. law?

Dr. KAUTZNER. Congressman, I am neither an attorney nor an expert on Ascent Health Services, so that is not a question I could answer.

Mr. AUCHINCLOSS. Will you commit to following up with my office to determine whether or not every action that is taking place in Switzerland would be legal, or whether Attorney General Yost is correct that it is, in fact, a way to sidestep U.S. antitrust law?

Dr. KAUTZNER. Congressman, we can certainly take that back and review your question and get back to you. Thank you.

Mr. AUCHINCLOSS. I will now yield my time to Ranking Member Raskin.

Mr. RASKIN. Thank you, Congressman Auchincloss, and thank you for your leadership on this. I am definitely getting on your bill with Congressman Carter, and I appreciate your joining us today. I had to leave the room before when Congressman Frost was discussing the matter of compensation, as Congressman Auchincloss just pointed out. There is huge profits being raked in on this business, and we want to know where the money is going. Dr. Conway, what was your compensation? I am sorry, I was not in the room when this happened. Did you state what your compensation is?

Dr. CONWAY. I was the only one to answer the question. My base salary is $950,000. I believe the question was total compensation.

Mr. RASKIN. Total compensation is how much?

Dr. CONWAY. Total last year was a little north of $4 million.

Mr. RASKIN. Four million. OK. And Dr. Kautzner, how about you?

Dr. KAUTZNER. So, Ranking Member Raskin, the Cigna Group reports our top five highest-paid executives in our annual report. I am not one of them. I would be happy to followup with you offline.

Mr. RASKIN. That is too bad, but what was your compensation last year? Not the top five.

Dr. KAUTZNER. As I said, I would be happy to followup with you offline.

Mr. RASKIN. Well, all right. Chairman Comer, what was your compensation last year as the United States Congressman?

Chairman COMER. Same as yours, $174,000.

Mr. RASKIN. A hundred seventy-four thousand dollars. Congressman Sessions, how much did you make as a Congressman for the U.S. House of Representatives last year?

Mr. SESSIONS. I am half paid. I retired and came back. So, half is about a pension of 22 years, and then half is the remaining. So, I am trying to be honest about that.

Mr. RASKIN. Yes. I was not aware of that particular mechanism.

Mr. SESSIONS. Yes. They net you. I can make no more than $174,000, but half of it was pension from serving 22 years.

Mr. RASKIN. I got you, but your take-home would be $174,000.

Mr. SESSIONS. I am not allowed a penny more.

Mr. RASKIN. Well, thank you for laying that all there out in public.

Mr. SESSIONS. Well, you asked.

Mr. RASKIN. Dr. Kautzner did not want to do that. Mr. Joyner, how much was your compensation last year?

Mr. JOYNER. So, CVS Health published the top five, and I am not part of the top five compensated employees.

Mr. RASKIN. All right. What was the bottom five of the top five at your company?

Mr. JOYNER. I am not aware.

Mr. RASKIN. What was the top one of the top five?

Mr. JOYNER. I think as reported earlier, I think it was $20-plus million for our CEO.

Mr. RASKIN. Twenty million dollars was the highest paid person?

Mr. JOYNER. That was what was reported earlier.

Mr. RASKIN. OK.

Mr. JOYNER. I can certainly confirm that.

Mr. RASKIN. All right. Well, there is a lot of money being made out there, and a lot of pain and a lot of hardship. And your companies are taking a huge chunk of money out of an already staggeringly expensive and inefficient system, a system so convoluted that most people do not even know that your companies exist. And so, a lot of people are profiting from the opaqueness, the complexity, the convolution of this healthcare system, and we really have got to clean it up. And I wish that you guys would be part of the solution to help people understand instead of part of the problem.

The FTC interim report said that not all the companies had complied fully with their request for information and documents. Mr. Joyner, has CVS Caremark produced all of the responsive documents to the FTC? And you are under oath.

Mr. JOYNER. We believe we are in full compliance. Multiterabytes of data and millions of pages of documents that we believe were in compliance and on time with the FTC request.

Mr. RASKIN. So, you have produced all responsive documents? Everything they have asked for, you have produced?

Mr. JOYNER. We believe we have produced what has been asked and requested.

Mr. RASKIN. OK. Mr. Kautzner, how about Express Scripts?

Dr. KAUTZNER. So, we have supplied, from what I am told, 11 billion data points, 768 million rows of data, over 3.3 million pages.

Mr. RASKIN. OK. I got you. Yes, those are all big numbers.

Dr. KAUTZNER. We would implore the FTC, implore them to actually review all of that data, and we believe that——

Mr. RASKIN. That is up to them, Dr. Kautzner. I have such a simple question. Have you produced all responsive documents? Have you turned over what they have asked for?

Dr. KAUTZNER. As I said, I know we have supplied 3.3 million pages of documents. I am not aware——

Mr. RASKIN. Let us say it is 87 zillion. That is not my question.

Dr. KAUTZNER. I am not aware——

Mr. RASKIN. My question is, have you produced everything that has been requested?

Dr. KAUTZNER. I am not aware of every request and was not involved in the turning over, though, so that is a question we would have to get back with you on.

Mr. RASKIN. So, you do not know. Your answer is you do not know. OK. And Dr. Conway, has Optum Rx produced all responsive documents to the FTC's request?

Dr. CONWAY. Yes, I believe we have been fully compliant with the FTC request.

Mr. RASKIN. OK. I am over my time. Thank you, Mr. Chairman. I will go back to you.

Chairman COMER. The gentleman yields back. I just would like to ask unanimous consent to enter the following documents into the record: The Committee's report of PBMs dated December 10, 2021; the Federal Trade Commission's interim staff report on PBMs; a letter from the National Association of Chain Drug Stores and the National Community Pharmacists Association; a letter from the Association of Accessible Medicines, a letter from the 60 Plus Association; a letter from the PBM Accountability Project; a letter from a coalition of pharmacy and pharmacist organizations; a statement from Patients Rising; report by American Pharmacy Cooperative, Inc., a letter from the National Association of Manufacturers; and a statement from the National Association of Chain Drug Stores President and CEO.

Without objection, so ordered.

I want to thank our witnesses for being here today. I know it was a long hearing. I apologize we had to take a brief recess for House floor votes.

Ranking Member, is there anything else you wanted to add before the end?

Mr. RASKIN. Yes, just one or two things. First of all, I want to thank you, Mr. Chairman, for two excellent hearings in a row, Monday and Tuesday. We have had a great week so far in terms

of our ability to try to penetrate governmental or corporate bureaucracies that seem to be indifferent to a clear public interest. And I learned a lot from this hearing, I have got to say, and it is disappointing to me to learn about so many abuses taking place inside this system, and so we should act on this, Mr. Chairman. Again, we had clear bipartisan consensus here, that this kind of profit taking at the expense of patients, which is what the healthcare system should be all about, is really unsustainable, and we hear about it from our constituents all of the time.

I understand that is not the principal concern of our witnesses today, despite the protestations that their goal is to save cost. No. Their goal is to make money as corporations. That is the way the system is really operating, and that is fine. That is what they are doing, but we have got to protect the American people, and I hope we can act together to really try to reduce costs and make sure that everybody in America can get the prescription drugs that they need at an affordable price. I will yield back to you, Mr. Chairman.

Chairman COMER. The gentleman yields back, and I agree and look forward to working with you on that. I have also been in communication with Brett Guthrie, who I believe has a good chance at being moving up in the Energy and Commerce Committee in the future. And this is something that we are going to have to work closely with the Energy and Commerce Committee on because they have primary jurisdiction over a lot of what needs to be done. We had two Members from Energy and Commerce here today, Mrs. Harshbarger and Mr. Carter. They are both experts on the issue, and I am sure there are some members on your side of the aisle that are on Energy and Commerce as well.

In closing, I am a little disappointed in some of the witness testimony today, especially the fact that you all claim to be transparent. Instead, you have created group purchasing organizations or rebate aggregators in foreign countries, like Ireland and Switzerland, which I can assure you is the hardest country on the planet. That is not a third-world country to get any type of financial information, and pharmaceutical companies in Ireland and the Cayman Islands to evade taxes and congressional regulatory efforts. You refused to answer questions posed by members on both sides of the aisle. The book is still open about your testimony with respect to your relationship with independent pharmacies. That one was hard to believe. You pointed the finger at manufacturers, even though PBMs are the center of the problem. You have taken no ownership of your action to roll in the rise of prescription drug cost.

We get elected by our constituents. In my district, I have 740,000. How many do you have in your district, Mr. Raskin?

Mr. RASKIN. Seven-hundred-and-ninety-four-thousand.

Chairman COMER. Yes, 794,000. So, we all represent probably between 700,000 and 900,000 people, and one of the biggest issues is the rising cost of prescription drugs, and that is a bipartisan issue. And there are not many things that are bipartisan in this town, unfortunately, especially on this Committee, but this Committee is in agreement that PBMs need to be reformed.

Now, we have passed bills in Congress and state legislatures are passing bills increasing transparency. But as we mentioned throughout the hearing, there are things that you do to evade

transparency, much like going to foreign countries. We believe that some of these transparency bills are a lot like a resolution. You pass a resolution, and when you go back and say we did something to keep people off, but as resolution really does not do anything.

We need real reform. I disagree with some of the things that were stated by people across the aisle. I am a free market guy. I am all about making a profit. I think that risk takers should be rewarded for making a profit. Drug companies take significant risks. They invest in research and development. I do believe that they should be rewarded for that risk. If they are not rewarded for the risk, I do not believe we will be ever discovering new medicines and new vaccines because there is no incentive to discover new medicines and new vaccine.

The PBMs were created to help drive down cost of prescription drugs. I do not think that is working. There are always going to be examples where you reduce the cost of prescription drugs, but overall, we have too many horror stories from pharmacists. We have too many horror stories from consumers about where they were gouged by the PBMs. And that is not what the PBMs were created for, and I do not believe the PBMs were created to be vertically integrated. I think that is a huge issue. And I do not know what our solution is for the PBMs. I would certainly support busting up the PBMs. I do not think a PBM should be owned by a health insurance company. I do not think a PBM should own a pharmacy, at the very least.

So, I think we are going to have many more discussions. We do a good job on this Committee of messaging. I think this report is excellent that we released today. We are going to continue to work and try to find a solution to the problem, and it is a problem. It is a problem, and we represent our constituents who demand that we do something about the problem. So, again, I want to thank you all for being here.

With that and without objection, all Members have 5 legislative days within which to submit materials and additional written questions for the witnesses, which will be forwarded to the witnesses.

Chairman COMER. If there is no further business, without objection, the Committee stands adjourned.

[Whereupon, at 2:33 p.m., the Committee was adjourned.]