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6 PRICED OUT OF A LIFESAVING DRUG:

7 GETTING ANSWERS ON THE RISING COST OF INSULIN

8 WEDNESDAY, APRIL 10, 2019

9 House of Representatives

10 Subcommittee on Oversight and Investigations

11 Committee on Energy and Commerce

12 Washington, D.C.

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16 The subcommittee met, pursuant to call, at 11:50 a.m., in

17 Room 2123 Rayburn House Office Building, Hon. Diana DeGette

18 [chairwoman of the subcommittee] presiding.

19 Members present: Representatives DeGette, Schakowsky,

20 Kennedy, Ruiz, Kuster, Castor, Sarbanes, Tonko, Clarke, Peters,

21 Pallone (ex officio), Guthrie, Burgess, McKinley, Griffith,

22 Brooks, Mullin, and Walden (ex officio).

23 Staff present: Kevin Barstow, Chief Oversight Counsel;

24 Jesseca Boyer, Professional Staff Member; Jeff Carroll, Staff

25 Director; Waverly Gordon, Deputy Chief Counsel; Tiffany
26 Guarascio, Deputy Staff Director; Judy Harvey, Counsel; Chris
27 Knauer, Oversight Staff Director; Jourdan Lewis, Policy Analyst;
28 Kevin McAloon, Professional Staff Member; C.J. Young, Press
29 Secretary; Jennifer Barblan, Minority Chief Counsel, O&I; Mike
30 Bloomquist, Minority Staff Director; Margaret Tucker Fogarty,
31 Minority Staff Assistant; Theresa Gambo, Minority Human
32 Resources/Office Administrator; Brittany Havens, Minority
33 Professional Staff, O&I; Ryan Long, Minority Deputy Staff
34 Director; and Natalie Sohn, Minority Counsel, O&I.

35 Ms. DeGette. The Subcommittee on Oversight and
36 Investigations hearing will now come to order. Today, the
37 Subcommittee on Oversight and Investigations is holding a hearing
38 entitled, "Priced out of a Lifesaving Drug: Getting Answers on
39 the Rising Cost of Insulin." This is the second part of a hearing
40 examining insulin affordability and ensuing financial and health
41 challenges and effects on patient lives. The chair now
42 recognizes herself for the purposes of an opening statement.
43 With seven and a half million Americans relying on insulin,
44 this problem that we are addressing today has affected countless
45 lives. That is why this committee is determined to find answers
46 and to find solutions. As the committee is well aware, despite
47 the fact that insulin has been around now for almost 100 years,
48 it has become outrageously expensive. For instance, the price
49 of insulin has doubled since 2012, after nearly tripling in the
50 past 10 years.
51 We have all heard stories of what happens when patients can't
52 afford their insulin. People have to forego paying their bills
53 or ration their doses or skip doses altogether. I had a listening
54 session in my district a couple of weeks ago and there was a woman
55 who came named Sierra. Sierra has been struggling for over a
56 year and a half to pay for her insulin. Even after rationing
57 her insulin, she is still paying over $700 a month. It is simply
58 unacceptable that anyone in this country cannot access the very

59 drug that their lives depend on all because of the price of insulin
60 has gotten out of control.
61 As the co-chair of the Congressional Diabetes Caucus, this
62 issue is personal with me. Along with co-chair, Congressman Tom
63 Reed, we examined these issues last year and we issued a report
64 exposing some of the underlying problems in the insulin market.
65 We put that report into the record at last week's hearing. What
66 we found during our investigation was a system with perverse
67 payment incentives and a complete lack of transparency and
68 pricing.
69 Then last week as I said, the subcommittee held its first
70 hearing on this issue in the new Congress. We heard testimony
71 from expert witnesses and patients in the diabetes space and their
72 message was clear. Insulin is unequivocally a lifesaving drug,
73 but because of a convoluted system it has become more and more
74 expensive to the point where far too many can no longer afford
75 it, even though their very lives depend on it.
76 We heard from Gail DeVore, who is a native of my hometown
77 of Denver, Colorado, who lives with type 1 diabetes. Ms. DeVore
78 described to the committee how the price of her insulin has shot
79 up and she has to ration her doses against the advice of her doctor.
80 We also heard from Dr. Alvin Powers on behalf of the Endocrine
81 Society who testified, "It is difficult to understand how a drug
82 that has remained unchanged for almost 2 decades continues to

83 skyrocket in price."

84 The subcommittee also received testimony last week from Dr.
85 William Cefalu on behalf of the American Diabetes Association.
86 Dr. Cefalu spoke about the national survey the ADA conducted
87 which found that over a quarter of the people they contacted had
88 to make changes to their purchase of insulin due to cost and those
89 people had higher rates of adverse health effects. The witnesses
90 last week had many different stories about the effects of rising
91 insulin prices, but one consistent theme that emerged was the
92 system is convoluted, opaque, and no longer serves the patients'
93 best interest.

94 The witnesses were some of the leading experts on diabetes
95 care, and yet they couldn't point to a reasonable explanation
96 for why these prices have gotten so high and that is what leads
97 us here today. We have representatives from the three drug
98 companies that manufacture insulin, as well as three of the
99 largest pharmacy benefit managers or PBMs. Together, these
100 companies are the ones that produce this drug, negotiate its
101 price, and make decisions that have consequences for the
102 availability and affordability of insulin for millions of
103 Americans.

104 I want to thank all of the representatives for coming today.
105 I know for some of you, you had to change schedules, you had to
106 make some adjustments and I appreciate it, because all of your

107 companies play a large role in the supply chain of critical drugs,
108 and all the companies have as you know received a lot of criticism.
109 But we are not interested in just finger pointing or passing
110 the buck. We are interested in finding a solution to this problem
111 and that is why we put everybody here together on one panel so
112 you can help us identify what the problem is and how we can fix
113 it. And again, it is not my intention, and I think Mr. Guthrie
114 agrees, it is not our intention to unjustly assign blame to any
115 one player. Instead, what I think is that many entities share
116 the blame for a system that has grown up and we need a frank
117 discussion about what is causing the increases and what we can
118 do to bring them under control.
119 As Ms. DeVore testified last week, "The relief we need is
120 right now, not next week, not next year. We need answers today
121 because the price of insulin has risen too far and too many people
122 are suffering and even risking death."
123 Thank you all again for being here today. I urge you to
124 be candid and forthcoming, and I am now very pleased to recognize
125 the ranking member, Mr. Guthrie, for 5 minutes for purposes of
126 an opening statement.

127 Mr. Guthrie. Thank you, Chair DeGette, for bringing this
128 hearing together and thank you all for being here. And I do echo
129 the remarks you just made.
130 Last week, we held a hearing on the rising cost of insulin
131 and heard from patients, doctors, and patient groups of how the
132 rising cost of insulin has affected Americans with diabetes.
133 More than 30 million individuals -- and I have two nieces -- 9.4
134 percent of the population in the United States have diabetes.
135 In 2016, about 6.7 million Americans age 18 and older use insulin.
136 The insulin prescribed today is different than the insulin
137 discovered over 100 years ago and the life expectancy of diabetes
138 has improved dramatically. These innovations should not be
139 underestimated and a lot of exciting research is on the horizon.
140 Someday soon, I hope we will have a cure for diabetes. As we
141 discussed last week, however, the average list price of insulin
142 nearly tripled between 2002 and 2013, making this vital drug
143 unaffordable for too many Americans.
144 Many argue that while list prices have been increasing, net
145 prices have stayed relatively the same or have even gone down.
146 This sounds great, because in theory no one is supposed to pay
147 the list price for insulin. However, if a patient is uninsured
148 or underinsured, they may end up paying the list price or close
149 to it. We have also heard that more Americans are paying the
150 list price at the pharmacy counter for part of the year because

151 the enrollment in high-deductible health plans has increased.
152 We have struggled to fully understand -- and I will emphasize
153 this -- fully understand while list prices for medicine such as
154 insulin have continued to rise, the prescription drug supply chain
155 is complex and lacks transparency.
156 We have had a lot of conversations with participants in the
157 drug supply chain over the last 2 years to better understand how
158 the pricing and rebating system works. We have been told that
159 manufacturers set the list price and therefore lowering the cost
160 of prescription drugs is as simple as manufacturers lowering their
161 list prices. On the other hand, we have heard that manufacturers
162 can't simply lower their list price because the pharmacy benefit
163 managers or PBMs demand larger rebates, and if the manufacturers
164 do not provide them with these rebates the PBMs won't put their
165 drugs on their formularies for health insurance plans.
166 Although they are not on the panel today, we have also heard
167 concerns about other entities in supply chains such as health
168 insurance companies. And as Chair DeGette said and I will
169 emphasize, we are not here to point fingers at that, that is what
170 we have heard. We want to try to get to a solution. While some
171 may think that one party in the supply chain is solely responsible
172 for the rising price of drugs, there are incentives to increase
173 list prices throughout the drug supply chain. Beyond the
174 potential for manufacturers to make more money by raising prices,

175 a higher list price allows manufacturers to provide larger rebates
176 to PBMs, most of whom have contracts that allow them to keep a
177 percentage of the list price or receive fees based on the list
178 price. Additionally, the health insurance companies decide
179 whether to pass the rebate along to the patient at the point of
180 sale or keep the rebate to lower premiums across the board for
181 all beneficiaries.

182 The current system contains many incentives for list prices
183 to increase rather than decrease. Unfortunately, while we keep
184 hearing assurances that net prices are staying flat or decreasing
185 and that almost all rebates are passed on to the health plans,
186 we know that many patients are being disadvantaged by this system
187 and are paying more for their insulin at the pharmacy counter.
188 Your companies have taken steps to try to reduce out-of-pocket
189 expenses for insulin to the patients who need them and that is
190 a good thing. I worry, however, that these are only short-term
191 solutions. It is important that we collectively find a permanent
192 solution that improves access to and affordability of medicine
193 such as insulin.

194 I thank our witnesses for being here today and I will yield
195 the remainder of my time to my friend from Indiana, Mrs. Brooks.

196 Mrs. Brooks. Thank you, Ranking Member Guthrie and thank
197 you to the subcommittee chairwoman for hosting this hearing, for
198 holding this hearing. It is continuing the important work that

199 was started last Congress in examining the impact that rising
200 costs of insulin has on patients struggling to afford this
201 lifesaving drug. Nearly 700,000 Hoosiers have diabetes or
202 pre-diabetes, which is why I serve as the vice chair of the
203 Congressional Diabetes Caucus founded by Diana DeGette and Tom
204 Reed. We have always worked in a bipartisan manner in that caucus
205 and I hope that we continue in that same spirit today to find
206 solutions.

207 One of the companies here today, Eli Lilly, has been
208 headquartered in Indianapolis for more than 100 years. They
209 employ thousands of hardworking Hoosiers, many of whom are my
210 constituents. And while I know that Lilly has put in place
211 programs to subsidize the cost of insulin for some -- and I have
212 read all of your written testimony and everyone has ideas and
213 everyone has recommendations and that is what we need to get to
214 today.

215 And so, I look forward to hearing from our witnesses on their
216 recommendations for change so that no American has to do without
217 insulin or take less insulin than what they must have to stay
218 alive and remain healthy. And I thank you all for being here
219 and I yield back.

220 Mr. Guthrie. I yield back.

221 Ms. DeGette. We are just waiting for the chair of the full
222 committee and the ranking member for their opening statements.

223 We will just wait one moment.

224 As soon as he is ready, the chair will recognize the ranking
225 member of the full committee for purposes of an opening statement,
226 5 minutes.

227 Mr. Walden. Thank you, Madam Chair. I appreciate your
228 indulgence. I know we are all coming back from votes and a few
229 things, so I am glad you are having this important hearing today.
230 It is really important.

231 Last week, we heard a lot of different opinions on why the
232 list price of insulin has increased significantly over the last
233 decade. One of the doctors on that panel commented she believed
234 that high list prices primarily benefit pharmaceutical companies.
235 Now another doctor argued the current rebating system encourages
236 high list prices, and as the list prices increase intermediaries
237 in the supply chain benefit. He argued the solution is not as
238 easy as manufacturers simply lowering their list price, it
239 requires a broader reform across the entire supply chain.

240 Now all of the witnesses last week agreed that the current
241 pricing system for insulin is actually harming many patients as
242 they make healthcare decisions. We heard stories of individuals
243 rationing their insulin and foregoing other necessities to make
244 ends meet and how this can lead to serious short- and long-term
245 health problems and hospitalization, which I am sure you all
246 understand. It is critical we work toward ensuring that all

247 diabetics have access to insulin. To do so, we need to identify
248 and break through barriers that make it challenging to bringing
249 down the cost of insulin for patients.

250 For more than 2 years, we have been examining the various
251 drivers of increased healthcare costs, so I am glad that effort
252 is continuing today. Earlier this year, as part of this work,
253 myself, and Republican leaders Guthrie and Burgess, sent a letter
254 to each of you that asked specific questions about the cost of
255 insulin and the barriers to competition in the insulin market.
256 We wanted to learn more about what is really going on, so I want
257 to thank each of you for your thorough responses to our questions.
258 They are most helpful as we work on this issue.

259 While the discussion today is centered around the cost and
260 the barriers that exist to reducing costs, it is important we
261 do not forget the critical role that both of you, the drug
262 manufacturers and the pharmacy benefit managers, PBMs, have in
263 making sure patients have access to lifesaving medicines such
264 as insulin. Now the insulin that is available today for diabetics
265 would not exist without significant investments Eli Lilly, Novo
266 Nordisk, and Sanofi have made to develop and improve these
267 medicines. These investments have saved the lives of many
268 diabetics. Insulin manufacturers have also created Patient
269 Assistance Programs to help patients get access to affordable
270 insulin.

271 While there will be questions today about whether the changes
272 in insulin over the past few decades justify how much the list
273 price for insulin has increased over the same period, we know
274 that manufacturers rarely receive the list price for their
275 medicine. Likewise, PBMs provide many important services to
276 patients and use different tools to help control costs while
277 promoting health care. For example, in addition to numerous
278 other programs, CVS Health created a Transform Diabetes care
279 program that uses several cost containment and clinical
280 strategies to help produce savings. OptumRx created a tool
281 to improve provider visibility to lower costs, clinically
282 equivalent alternative medicines at the point of prescribing.
283 Just last week, Express Scripts announced a new patient assurance
284 program that will ensure eligible people with diabetes
285 participating in Express Scripts plans pay no more than $25 for
286 a 30-day supply of insulin.
287 Now while these programs for manufacturers and PBMs are
288 important and useful in the short term, they are only a Band-Aid
289 so we have to work on the long-term and comprehensive solutions.
290 Many of the concerns we heard at last week's hearing on insulin
291 are very similar to the issues that were discussed at our hearing
292 examining the prescription drug supply chain over a year ago,
293 so I appreciate hearing directly from the manufacturers and the
294 PBMs today about your perspectives on why insulin costs are

295 rising.

296 But just like we heard at the hearing on drug pricing in
297 2017, to fully understand why the cost of insulin is increasing
298 for many patients we will need to hear from the other participants
299 in the supply chain including the distributors, health insurance
300 plans, and pharmacists. But at the end of the day, we have to
301 put the patient, the consumer, first in everything that we do.

302 So I want to thank our witnesses for responding to our
303 questions and I want to thank you for being here today. You will
304 contribute to our work and that is most valuable. And unless
305 somebody wants the remainder of my time, Madam Chair, I would
306 yield back.

307 Ms. DeGette. I thank the gentleman. The chair now
308 recognizes the chairman of the full committee, Mr. Pallone, for
309 5 minutes for purposes of an opening statement.

310 The Chairman. Thank you, Madam Chair.

311 Today, the committee is holding the second of a two-part
312 hearing on the increasing price for insulin. Millions of
313 Americans rely on this lifesaving drug and they are directly
314 affected by the ever-increasing prices. And people are having
315 to make sacrifices to be able to pay for their insulin and some
316 are even forced to go without it, sometimes with tragic
317 consequences.

318 Last week, the subcommittee heard from expert witnesses in

319 diabetes care. They provided testimony about the rising price
320 of various insulin medications and the effects it is having on
321 patients living with diabetes. We heard from a endocrinologist
322 who described a complicated system that makes it difficult if
323 not impossible for him to determine how much his patients will
324 have to pay for their insulin. And we heard from patient
325 advocates who described the hardship patients endure when they
326 can no longer afford their medication or are forced to switch.
327 These witnesses described a broken system where there is
328 not enough transparency surrounding prices and not enough
329 incentives to keep prices down. So today we have before us the
330 companies that make these drugs, negotiate their prices, and make
331 them available through health plans. Their actions and decisions
332 have a profound impact on the lives of everyday Americans and
333 we need to hear these companies' response to the criticism we
334 heard last week and their actions, and what their actions are
335 doing to contribute to rising prices or hopefully reduce prices.
336 We know that companies need to make money in order to succeed
337 and in a normal market price would reflect what the market can
338 bear. The problem is, the market for insulin is made up of people
339 who can't survive without the product. So I am concerned that
340 the market is simply broken down, as I said. It appears there
341 is a limited competition and little incentive to keep prices at
342 a level the patients can afford and perhaps there are incentives

343 in place to keep raising prices.

344 As a result, we are left with a drug that has been available
345 for nearly 100 years and yet the price tripled and then doubled
346 in just the last couple decades. Clearly, something is not right
347 here. Three companies currently manufacture insulin and they
348 are all represented at the hearing today. They not only make
349 the drug, but they also set the list price. While most people
350 do not end up paying this list price, uninsured patients often
351 do, and even insured patients can be affected when the list price
352 rises. And that is exactly what has been happening as the list
353 price has skyrocketed in recent years and it ripples through the
354 entire system.

355 We also have the pharmacy benefit managers or PBMs here whose
356 role it is to negotiate lower drug prices on behalf of the
357 insurance plans. But there is not much transparency in these
358 negotiations and there are questions as to whether discounts are
359 being passed down to the patient. When the manufacturers have
360 been criticized for raising their prices, they have often pointed
361 their finger at the PBMs. And when the PBMs have been questioned
362 about their practices, they often point their finger back at the
363 manufacturer and so we are left with no accountability.

364 For the millions of people who are suffering in the system,
365 these back-and-forth arguments are frustrating and frankly
366 unacceptable. Everyone seems to be coming out ahead here except

367 the patient and no one really should suffer because the high price
368 of insulin puts it out of reach. So I hope that we can all learn
369 today about why the costs of insulin are skyrocketing and the
370 role of manufacturers and PBMs have played and then figure out
371 how to deal with it so we can make insulin more affordable.

372 So unless somebody wants my time, Madam Chair, I will yield
373 back.

374 Ms. DeGette. I thank the gentleman. The chair asks
375 unanimous consent that the members' written opening statements
376 be made part of the record. Without objection, so ordered.

377 I would now like to introduce our first panel of witnesses
378 for today's hearing. Mr. Mike Mason, who is the Senior Vice
379 President, Lilly Connected Care and Insulins Global Business
380 Unit, welcome; Mr. Doug Langa, Executive Vice President, North
381 America Operations, and President of Novo Nordisk, Inc., welcome;
382 Ms. Kathleen Tregoning, who is Executive Vice President for
383 External Affairs, Sanofi; Mr. Thomas Moriarty, Executive Vice
384 President, Chief Policy and External Affairs Officer and General
385 Counsel, CVS Health; Ms. Amy Bricker, Senior Vice President,
386 Supply Chain of Express Scripts; and Dr. Sumit Dutta, Senior Vice
387 President and Chief Medical Officer, OptumRx. Welcome to all
388 of you.

389 I know you are all aware that the subcommittee is holding
390 an investigative hearing and when doing so has the practice of

391 taking testimony under oath. Do any of you have objections to
392 testifying under oath today?
393 Let the record reflect that the witnesses have responded
394 no.
395 The chair then advises you that under the rules of the House
396 and the rules of the committee, you are entitled to be accompanied
397 by counsel. Do any of you desire to be accompanied by counsel
398 during your testimony today?
399 Let the record reflect that the witnesses have responded
400 no.
401 If you would, please rise and raise your right hand so you
402 may be sworn in.
403 [Witnesses sworn.]
404 Ms. DeGette. You may be seated. Let the record reflect
405 that the witnesses have responded affirmatively. You are now
406 under oath and subject to the penalties set forth in Title 18
407 Section 1001 of the United States Code.
408 And now the chair will recognize our witnesses for a 5-minute
409 summary of their written statements. In front of each of you
410 is a microphone and a series of lights. The light will turn yellow
411 when you have a minute left, and red to indicate your time has
412 come to an end. And I would appreciate it if you would try to
413 keep your opening statements within the time frame because we
414 want to make sure that all of the members have the opportunity

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415 to ask their questions today.

416 So we will start with you, Mr. Mason. You are recognized

417 for 5 minutes for purposes of an opening statement. Thank you.

418 STATEMENT OF MIKE MASON, SENIOR VICE PRESIDENT, LILLY CONNECTED
419 CARE AND INSULINS GLOBAL BUSINESS UNIT, ELI LILLY AND COMPANY;
420 DOUG LANGA, EXECUTIVE VICE PRESIDENT, NORTH AMERICA OPERATIONS,
421 AND PRESIDENT OF NOVO NORDISK INC., NOVO NORDISK; KATHLEEN
422 TREGONING, EXECUTIVE VICE PRESIDENT FOR EXTERNAL AFFAIRS, SANOFI;
423 THOMAS MORIARTY, EXECUTIVE VICE PRESIDENT, CHIEF POLICY AND
424 EXTERNAL AFFAIRS OFFICER AND GENERAL COUNSEL, CVS HEALTH; AMY
425 BRICKER, SENIOR VICE PRESIDENT, SUPPLY CHAIN, EXPRESS SCRIPTS;
426 AND, SUMIT DUTTA, M.D., SENIOR VICE PRESIDENT AND CHIEF MEDICAL
427 OFFICER, OPTUMRx
428
429 STATEMENT OF MIKE MASON
430 Mr. Mason. Thank you. Chairwoman DeGette, Ranking Member
431 Guthrie, Chairman Pallone, Ranking Member Walden, and other
432 distinguished members, my name is Mike Mason. I am the Senior
433 Vice President for Connected Care and Insulins at Eli Lilly and
434 Company. Thank you for the opportunity to participate in today's
435 hearing. Thanks as well to your staff who met with us. I'm
436 pleased to be here today to continue that conversation.
437 Eli Lilly was founded in 1876, and today employs over 16,000
438 people in the United States. We are headquartered in
439 Indianapolis. Lilly is proud to have introduced the first
440 commercially available insulin product in 1923. For nearly a
441 century, we have committed to helping people with diabetes live

442 better and longer lives. We've invested billions in the
443 discovery of new treatments including biotech insulins Humulin,
444 Humalog, and Basaglar. And in 2018, we announced our commitment
445 to a research and development partnership that could eliminate
446 the need for insulin. Lilly is also actively developing
447 connected insulin devices that we hope will help people improve
448 outcomes and adherence.
449 Now, like many people who work at Lilly, I have a personal
450 connection to the issues we discuss today. Four of my immediate
451 family members live with diabetes. I've seen them cope with the
452 daily burdens of the disease including injections before each
453 meal. I've seen the devastating complications of diabetes in
454 their lives and I know firsthand that they benefit from new,
455 innovative treatments.
456 Often our phone calls and visits turn to their diabetes.
457 Over the years, we focused on these conversations on how they
458 were managing their diabetes, but within the last 2 or 3 years,
459 the conversations have changed. We now spend more and more time
460 talking about how much they pay out-of-pocket for insulin. As
461 a leader at Lilly, it's difficult for me to hear anyone in the
462 diabetes community worry about the cost of insulin. Too many
463 people today don't have affordable access to chronic medications.
464 My colleagues and I have reflected on how we got here and
465 what we can do to solve this problem in the short-term and

466 long-term. For starters, we have not increased the list price
467 for insulin since 2017, but we recognize that the issue is more
468 complex than list price and it's important to focus on what people
469 actually pay out-of-pocket for insulin. Most people who need
470 insulins have either private or government insurance that
471 requires them to pay a low, affordable co-pay. But some people
472 don't benefit from these low co-pays because their out-of-pocket
473 costs are based on so-called retail or list prices, not negotiated
474 prices or fixed co-pays.
475 The people most exposed in our current system are those in
476 the deductible phase of high-deductible health plans, those in
477 the Medicare Part D coverage gap phase, and individuals without
478 insurance. We know long-term solutions are necessary, but we
479 are not waiting to address the gaps in the short term. The Lilly
480 Diabetes Solution Center connects individuals to a suite of
481 affordability solutions including immediate access to savings
482 offers for the uninsured and privately insured, with no paperwork
483 or applications.
484 We provide automatic discounts at the pharmacy counter that
485 cap the cost of prescription for Lilly insulin at $95 for those
486 in the deductible phase of high-deductible plans. We recently
487 announced the upcoming launch of a half-price version of Humalog
488 called insulin lispro. With these and other meaningful
489 solutions, we've tried to build a safety net preventing anyone

490 from having to pay retail price for Lilly insulins.

491 Our solutions are working to reduce out-of-pocket costs.
492 Today, 95 percent of monthly Humalog prescriptions are less than
493 $95 at the pharmacy, 90 percent are less than $50 a month, and
494 43 percent are zero. As insulin lispro launches and is added
495 to formularies, even more people will pay less. Now while these
496 actions ease the burdens for most people in these coverage gap
497 areas, they are still stop-gap measures. Long-term, systematic
498 solutions are still needed.

499 A good place to start is to consider the policy ideas
500 suggested by CVS in their written testimony to foster the
501 widespread adoption of zero-dollar co-pays on preventive
502 medications like insulin. We agree that this solution would save
503 lives and money while cutting straight to the heart of the
504 affordability issue. Also, we thank this committee for its
505 bipartisan action last week on legislation including the CREATES
506 Act and a bill eliminating pay-for-delay tactics.

507 Systematic change in our healthcare system will require
508 action by all relevant stakeholders. We are ready to play our
509 role and we are confident that a solution is possible.

510 [The prepared statement of Mr. Mason follows:]

511

512 **********INSERT 1**********

513 Ms. DeGette. Thank you.

514 Mr. Langa, you are recognized for 5 minutes.

515

516 STATEMENT OF DOUG LANGA

517

518 Mr. Langa. Thank you, Chair DeGette, Ranking Member
519 Guthrie, and members of the subcommittee. My name is Doug Langa.
520 I am the Executive Vice President, North America, and I am the
521 President of Novo Nordisk Incorporated.

522 For over 90 years, Novo Nordisk has been dedicated to
523 improving the lives of people with diabetes. We care deeply about
524 the people who need our medicines and we're troubled knowing that
525 for some our products are unaffordable. For a company committed
526 to helping people with diabetes, patients rationing insulin is
527 just simply unacceptable. Even one patient rationing insulin
528 is one too many. We need to do more. We all need to do more.
529 This is why I appreciate the opportunity to take part in a
530 dialogue here today.

531 On the issue of affordability, we all hear a lot about list
532 price and I will tell you that at Novo Nordisk we are accountable
533 for the list prices of our medicines. We also know that list
534 price matters to many, particularly those in a high-deductible
535 health plan and those that are uninsured. So why can't we just
536 lower the list price and be done? In the current system, lowering

537 list price won't bring meaningful relief to all patients and it
538 may jeopardize access to the majority of patients who have
539 insurance and are able to get our medicines through affordable
540 co-pays. That's because list price is only part of the story.
541 Once we set the list price, the current system demands that we
542 negotiate with PBMs and insurance plans to secure a place on their
543 formularies. Formulary access is critical because it allows many
544 patients to get our medicines through co-pays at reasonable costs.
545 The demand for rebates has increased each and every year.
546 In 2018, rebates, discounts, and other fees accounted for 68
547 cents of every dollar of Novo Nordisk gross sales in the U.S.
548 As a result, net prices of our insulin products have declined
549 year over year since 2015. Despite the investment that we make
550 in rebates, some patients including those with insurance end up
551 paying list price or close to it at the pharmacy counter. As
552 a manufacturer, Novo Nordisk has no control over what insured
553 patients pay at the pharmacy counter. This is dictated by benefit
554 design.
555 In the last few years, we've seen more patients with benefit
556 designs that require them to pay high out-of-pocket costs, so
557 despite these ever-increasing rebates that we pay to get on
558 formularies, patients don't get the full benefit of those rebates
559 at the pharmacy counter. This needs to change. It's time for
560 people with diabetes to benefit directly from the rebates that

561 we pay. I take the mission of this company to help people with
562 diabetes very seriously and personally. I lost my own
563 father-in-law to this disease, so I do know firsthand what it
564 does and how it affects patients and their families.
565 When the healthcare market began to shift toward
566 high-deductible health plans and we saw that more people were
567 struggling to afford their medications, we took action. Back
568 in 2016, we pledged to limit list price increases to single-digit
569 percentages annually. We were one of the first companies to make
570 that commitment and we have honored it ever since. Our pricing
571 pledge complemented other programs that we've had in place for
572 years with the goal of reducing patients' out-of-pocket costs.
573 Through our nearly 2 decades old partnership with Walmart,
574 Novo Nordisk's high-quality human insulin is available at Walmart
575 pharmacies for less than $25 a vial. In 2017, we partnered with
576 CVS Health and Express Scripts to expand the $25 human insulin
577 offerings to tens of thousands of pharmacies nationwide. Our
578 human insulin is an FDA-approved, safe and effective treatment
579 for both type 1 and type 2 diabetes and it's used by about 775,000
580 patients today.
581 Since 2003, we have also provided free insulin to eligible
582 individuals through our Patient Assistance Program. Nearly
583 50,000 Americans received free insulin through the effort in 2018
584 alone. Today, a family of four making up to $103,000 a year could

585 qualify for a Patient Assistance Program. We also offer co-pay
586 assistance on a wide variety of our insulin medicines which last
587 year helped hundreds of thousands of patients lower what they
588 pay at the pharmacy counter.
589 Although these valuable programs help many people today,
590 we can't stop there. Patients are telling us that we need to
591 do more and we hear them. The challenge is that the current system
592 is broken. Bringing relief to patients is going to require
593 bigger, more comprehensive solutions built on cooperation between
594 all stakeholders in the insulin supply chain. We want to be a
595 part of those solutions and we look forward to working with all
596 stakeholders to ensure that this lifesaving medicine remains
597 available to everyone who needs it.
598 Thank you and I do look forward to answering the questions
599 today.
600 [The prepared statement of Mr. Langa follows:]
601
602 **********INSERT 2**********

603 Ms. DeGette. Thank you.

604 Ms. Tregoning, now you are recognized for 5 minutes.

605

606 STATEMENT OF KATHLEEN TREGONING

607

608 Ms. Tregoning. Chair DeGette, Ranking Member Guthrie, and
609 members of the subcommittee, thank you for the opportunity to
610 appear before you today to discuss issues related to pricing,
611 affordability, and patient access to insulins in the United
612 States. I am Kathleen Tregoning, Executive Vice President
613 External Affairs at Sanofi. My goal today is to have an open,
614 transparent discussion about how the system works, Sanofi's role
615 in it, and how it can be improved.

616 Patients are rightfully angry about rising out-of-pocket
617 costs for many medicines and we all have a responsibility to
618 address a system that is clearly failing too many people. As
619 a mom, I was heartbroken at hearing the testimony before this
620 subcommittee of other parents who have not only endured the
621 terrible challenge of facing illness, but have also struggled
622 to afford the medications that they or their children desperately
623 need.

624 My own family is the beneficiary of a breakthrough in
625 medicine. My husband, John, has FH, a genetic disorder that makes
626 the body unable to remove LDL or bad cholesterol from the blood.

627 He inherited this condition from his father who passed away from
628 a heart attack at 40 years of age when John was just 12 years
629 old. Despite taking statins, watching his diet, and exercising
630 regularly, John, himself, had a double bypass at the age of 36
631 and still couldn't get his cholesterol under control. Then came
632 a class of drugs called PCSK9 inhibitors, an innovative treatment
633 that helps people like my husband lower their bad cholesterol.
634 I cannot overstate what this breakthrough means for him,
635 our family, and our future, including for our 7-year-old son,
636 Jack, who has inherited the same condition as his father and
637 grandfather. I fully appreciate how important it is for science
638 to continue to solve the medical challenges that impact so many
639 families and I recognize that those breakthroughs are meaningless
640 if patients are not able to access or afford them.
641 Over the last 20 years, Sanofi has been a leader in the
642 advancement of new treatments to help people manage their
643 diabetes. At the same time, we recognize the need to address
644 the very real challenges of affordability. 2 years ago, Sanofi
645 announced our progressive and industry-leading pricing
646 principles. We made a pledge to keep list price increases at
647 or below the U.S. National Health Expenditure Projected Growth
648 Rate and we stand by this commitment. In 2018, our average
649 aggregate list price increase in the United States was 4.6
650 percent, while the average aggregate net price, that is the actual

651 price paid to Sanofi, declined by 8 percent, the 3rd consecutive
652 year in which the amount we receive across all of our medicines
653 went down.
654 Insulin is a clear example of the growing gap between list
655 and net prices. Take Lantus, for example, our most prescribed
656 insulin. The net price has fallen by over 30 percent since 2012,
657 and today it is lower than it was in 2006. Yet, since 2012,
658 average out-of-pocket costs for Lantus have risen approximately
659 60 percent for patients with commercial insurance and Medicare.
660 Every actor in the system has a role to play and Sanofi takes
661 our responsibility very seriously. In addition to our pricing
662 policy, we have developed assistance programs to help patients
663 afford their Sanofi insulin, including co-pay assistance for
664 commercially insured patients, including those in
665 high-deductible health plans, and free insulin for uninsured
666 low-income patients. Sanofi's commitment to patient
667 affordability means that today approximately 75 percent of all
668 patients taking Sanofi insulin pay less than $50 a month.
669 But we recognized that more needed to be done. Last year,
670 Sanofi launched a unique program that allowed individuals exposed
671 to high retail prices to access Sanofi insulins for $99 per vial,
672 the lowest available cash price in the United States. Based on
673 feedback from patients, providers, and the advocacy community,
674 today we announced that we are expanding this program. Beginning

675 in June, uninsured patients regardless of income level will be
676 able to access any combination of the Sanofi insulin they need
677 for $99 per month at the pharmacy counter.
678 This transformative and first-of-its-kind program is the
679 latest in a series of progressive and important steps Sanofi has
680 taken to help patients afford the insulin they need. This action
681 does not eliminate the need for broader system reform. I agree
682 with the witnesses from last week's subcommittee hearing that
683 holistic reforms to the system are not only needed but overdue.
684 Sanofi also supports a number of recommendations outlined in
685 my written testimony including many of the policies included in
686 Chair DeGette's Congressional Diabetes Caucus report.
687 Thank you for the invitation and I look forward to answering
688 your questions.
689 [The prepared statement of Ms. Tregoning follows:]
690
691 **********INSERT 3**********

692 Ms. DeGette. Thank you so much.

693 The chair now recognizes Mr. Moriarty for 5 minutes, thank

694 you.

695

696 STATEMENT OF THOMAS MORIARTY

697

698 Mr. Moriarty. Thank you, Chairwoman DeGette, Ranking

699 Member Guthrie, and members of the subcommittee. My name is

700 Thomas Moriarty and I serve as the Chief Policy and External

701 Affairs Officer and General Counsel for CVS Health. Thank you

702 for the opportunity to discuss ways to make health care more

703 affordable, particularly for the millions of Americans with

704 diabetes and those who are pre-diabetic.

705 A real barrier in our country to achieving good health is

706 cost, including the price of insulin products which are too

707 expensive for too many Americans. Over the last several years,

708 list prices for insulin have increased nearly 50 percent. And

709 over the last 10 years, list price of one product, Lantus, rose

710 by 184 percent. The primary challenge we face is that unlike

711 most other drug classes there have been no generic alternatives

712 available even though insulin has been on the market for more

713 than 30 years.

714 Despite this, CVS Health has taken a number of steps to

715 address the impact of insulin price increases. We negotiate the

716 best possible discounts off the manufacturers' price on behalf
717 of the employers, unions, government programs, and beneficiaries
718 that we serve. Our latest 2018 data indicates that we have been
719 able to reduce the total cost of diabetes drugs including insulin
720 by 1.7 percent, despite brand inflation in that year of 5.6
721 percent.
722 Importantly, patient adherence has also increased.
723 Specifically, we have replaced two very high cost insulins, Lantus
724 and Toujeo, with an effective lower-cost, follow-on biologic
725 called Basaglar. By making Basaglar preferred, member
726 out-of-pocket costs declined by over 9 percent. Among patients
727 who switched to Basaglar, their A1C or blood sugar levels were
728 improved by 0.43. To put this in perspective, every 1 point
729 improvement in A1C among patients with uncontrolled diabetes is
730 correlated with approximately $1,400 savings per year in medical
731 cost for each patient. This is a real-life example of how
732 competition works.
733 Despite these efforts, we know this is not enough. Let me
734 share a story about a company and their experience with diabetes.
735 This company saw the human toll on their colleagues and continued
736 to see escalating costs. In response, the company began offering
737 employees and their families zero-dollar co-pays for insulin,
738 providing coverage for diabetes medications even before the
739 deductibles were met. That means there are no out-of-pocket

740 costs, so employees are more likely to take their medications,
741 improve their health, and achieve lower costs. That company is
742 CVS Health. And when something works for us, we offer these
743 solutions to our clients.

744 We also offer a number of tools for patients to help reduce
745 their out-of-pocket costs and provide transparency at the
746 doctor's office, at the pharmacy counter, and directly to the
747 patient. For Caremark members, when they are in the doctor's
748 office getting a prescription, we provide their doctors with
749 real-time information about what is covered under their insurance
750 and if there are effective, lower cost, therapeutic alternatives
751 available. We also provide this information directly to patients
752 online or on their phone. For CVS Pharmacy customers, regardless
753 of their PBM or health plan, the Rx Savings Finder tool enables
754 our pharmacists to work with patients to find the most affordable
755 medications that they need.

756 Beyond these tools, a coordinated care approach to diabetes
757 is essential. We've taken the lead with a program we call
758 "Transform Diabetes Care" which furthers our focus on providing
759 patient care that eases the complexity of self-management,
760 improves health, and reduces overall costs. Using connected
761 glucometers, a high-touch engagement model, and local points of
762 care, clinicians are better able to support specific member needs
763 as their care requirements evolve.

764 And, finally, Madam Chairwoman, despite what we've
765 accomplished we know that more needs to be done. Let's bring
766 more effective, lower cost alternatives to market faster by ending
767 pay-for-delay schemes. Let's foster the widespread adoption of
768 zero-dollar co-pays on preventive medications like insulin,
769 recognizing that if we treat these diseases effectively, we can
770 save lives and save money, and let's pass your proposal to reform
771 Medicare to provide additional support services for patients with
772 diabetes to manage their own care.
773 We look forward to working with you and the committee to
774 help accomplish our shared goals. Thank you, and I'll answer
775 any questions that you may have.
776 [The prepared statement of Mr. Moriarty follows:]
777
778 **********INSERT 4**********

779 Ms. DeGette. Thank you so much, Mr. Moriarty.

780 Now, Ms. Bricker, you are recognized for 5 minutes.

781

782 STATEMENT OF AMY BRICKER

783

784 Ms. Bricker. Chair DeGette, Ranking Member Guthrie, and
785 members of the subcommittee, thank you for inviting me to testify
786 at this hearing. My name is Amy Bricker, Senior Vice President
787 of Supply Chain for Express Scripts. As a registered pharmacist,
788 I began my career in the community pharmacy setting. As Senior
789 Vice President of Supply Chain, I am now responsible for key
790 relationships and strategic initiatives across the
791 pharmaceutical supply chain working directly with drug
792 manufacturers and retail pharmacies with the objective of keeping
793 medicine within reach for patients including those with diabetes.
794 Diabetes is of particular interest to me as I have witnessed
795 the impacts of this disease personally. My younger brother,
796 Jeff, was diagnosed with type 1 diabetes as a child. Diabetes
797 is a life-changing diagnosis and can have devastating effects
798 if not managed appropriately. I am passionate about ensuring
799 patients have access to the medications they need. Today I will
800 provide an overview of Express Scripts innovative approach to
801 reduce the cost and raise the quality of care for people with
802 diabetes and the more than 80 million Americans we serve.

803 At Express Scripts we negotiate lower drug prices with drug
804 companies on behalf of our clients, generating savings that are
805 returned to patients in the form of lower premiums and reduced
806 out-of-pocket costs. Additional savings are provided through
807 our clinical support services which enable individuals to lead
808 healthier, more productive lives. When it comes to prescription
809 drugs, our goal is the best clinical outcome at the lowest possible
810 cost.
811 We offer innovative programs to help us achieve that goal
812 including several programs that address the cost of insulin for
813 patients. One example, our Diabetes Care Value Program closely
814 manages the disease state through a holistic approach that
815 combines the highest level of clinical care, advanced analytics,
816 and patient engagement supported by technology. The program
817 offers remote monitoring so that our specialist team can intervene
818 when patient blood sugars are dangerously high or low. This
819 program resulted in a 19 percent reduction in drug spending for
820 diabetes.
821 We launched Inside Rx, a cash discount program for patients
822 that are either uninsured or faced with high co-insurance,
823 partnering with drug manufacturers to provide the negotiated
824 rebate at the point of sale resulting in average discounts of
825 47 percent per brand drugs including an average of $150 in savings
826 per insulin prescription. Our National Preferred Flex Formulary

827 provides employers and health plans the flexibility to
828 immediately add drugs to their formulary if a drug manufacturer
829 chooses to offer a lower priced version of a drug.
830 Recently, Eli Lilly announced it is reducing the list price
831 of its Humalog insulin by 50 percent. We are excited about their
832 decision to lower the list price on this medication and encourage
833 other manufacturers to do the same. Most recently, Express
834 Scripts announced the Patient Assurance Program which caps the
835 out-of-pocket costs at $25 for 30-day supplies of insulin. We
836 did this in collaboration with the manufacturers represented here
837 today.
838 Express Scripts remains committed to delivering
839 personalized care to patients with diabetes and creating
840 affordable access to their medication. As expressed in several
841 public statements, Express Scripts welcomes lower list prices.
842 However, list prices are exclusively controlled by
843 manufacturers. In the absence of lower list prices, the role
844 of negotiated rebates have become increasingly important as a
845 drug pricing strategy.
846 In today's system, rebates are used to reduce healthcare
847 costs for consumers. Employers use the value of these discounts
848 to keep benefit premiums affordable and offer workplace wellness
849 programs among other employee and member-focused health
850 initiatives. Half of Express Scripts clients receive 100 percent

851 of rebates negotiated on their behalf. In total, 95 percent of
852 rebates, discounts, and price reductions received by Express
853 Scripts are returned to employers, plan sponsors, and consumers.
854 Our 2018 Drug Trend Report showed a 4.3 percent decrease
855 in spending for diabetes medications for plans enrolled in our
856 clinical solutions. For insulin, the same plans saw a 1.5 percent
857 decline in unit cost. Express Scripts achieved this result by
858 driving competition among manufacturers while also leveraging
859 pharmacy discounts to drive savings. Looking to the future, we
860 continue to support efforts by Congress and the administration
861 to use market-based solutions that put downward pressure on
862 prescription drug prices through competition, consumer choice,
863 and open and responsible drug pricing.
864 In closing, we are proud of what we have done to date, and
865 we look forward to working with the committee to improve the
866 affordability of insulin products. Thank you for your
867 consideration of this testimony.
868 [The prepared statement of Ms. Bricker follows:]
869
870 **********INSERT 5**********

871 Ms. DeGette. Thank you.

872 Dr. Dutta, you are now recognized for 5 minutes.

873

874 STATEMENT OF SUMIT DUTTA

875

876 Dr. Dutta. Chair DeGette, Ranking Member Guthrie, Chairman
877 Pallone, Ranking Member Walden, and members of the subcommittee,
878 good morning. I am Dr. Sumit Dutta, Chief Medical Officer of
879 OptumRx, a pharmacy care services company whose dedicated
880 employees ensure the people we serve have affordable access to
881 the drugs they need. I'm honored to be here to discuss steps
882 we can all take to reduce the cost of insulin.

883 The OptumRx team includes 5,000 pharmacists and pharmacy
884 technicians who help patients learn how to take their medications,
885 avoid harmful drug interactions, manage their chronic conditions.
886 Our nurses infuse lifesaving drugs in patients' homes, our
887 efforts have helped lower overprescribing in opioids. Our
888 diabetes management program offers personalized patient-driven
889 services to high-risk members to help them manage their diabetes.

890 OptumRx's negotiated network discounts and clinical tools
891 are reducing annual drug costs on average by $1,600 per person
892 for our customers. Our efforts start with a clinical assessment
893 by our pharmacy and therapeutics committee comprised of
894 independent physicians and pharmacists. They evaluate our

895 formularies based on scientific evidence, not cost. These
896 meetings are open and transparent to our customers. Cost only
897 becomes a factor after this independent committee has identified
898 clinically-effective drugs in a therapeutic class.
899 Because OptumRx promotes the use of true generics to drive
900 costs lower through competition, about 90 percent of the
901 prescription claims we administer are for generics.
902 Unfortunately, in the case of insulin there are no true generic
903 alternatives. Because many branded insulin products are
904 therapeutically equivalent, we negotiate with brand
905 manufacturers to obtain significant discounts off list prices
906 on behalf of our customers.
907 Already, 76 percent of the people we serve who need insulin
908 pay either nothing at the pharmacy or have a fixed co-pay, most
909 commonly $35. For insulin users on high-deductible or
910 co-insurance plans, we have taken action to help them directly
911 benefit from the savings we're negotiating with manufacturers.
912 Last year, we dramatically increased the discounts at the
913 pharmacy counter for millions of eligible consumers who are now
914 seeing an average savings of $130 per eligible prescription and
915 the savings are even higher on insulin.
916 Last month, we announced the decision to expand this
917 point-of-sale discount solution to all new employer-sponsored
918 plans beginning January 2020. Nevertheless, the price of insulin

919 remains too high. A lack of meaningful competition allows
920 manufacturers to set high list prices and continually increase
921 them which is odd for a drug that is nearly 100 years old and
922 which has seen no significant innovation in decades. These price
923 increases have a real impact on consumers in the form of higher
924 out-of-pocket costs.

925 The most impactful way to reduce insulin prices is by opening
926 the market to true generics and biosimilars. This is why we
927 support efforts to reform the patent system and promote true
928 generic competition. For years, insulin manufacturers have used
929 loopholes in the patent system to stifle competition. One
930 manufacturer has filed 74 patents on one brand to prevent
931 competition. Others have engaged in multiyear patent disputes
932 to delay the introduction of lower cost products.

933 Congress can increase competition and lower prices by
934 passing the CREATES Act, prohibiting pay-for-delay deals and
935 evergreening of patents, accelerating biosimilar options, and
936 reducing the exclusivity period for drugs. We are committed to
937 doing our part to make insulin more affordable. I would be
938 pleased to answer any questions you have.

939 [The prepared statement of Dr. Dutta follows:]

940

941 *********INSERT 6**********

942 Ms. DeGette. Thank you, Dr. Dutta.

943 It is now time for the members to ask questions and the chair
944 recognizes herself for 5 minutes.

945 I appreciate all of your testimony. What strikes all of
946 us on this panel, which we have heard from all of the actors in
947 the system, is how the list price is really high, but then there
948 is all these workarounds that some people can get to get a lower
949 price of insulin. And let me just give you an example. Eli Lilly
950 increased the price of Humalog from $35 in 2001 to $275 today.
951 Novo Nordisk increased the list of NovoLog by over 350 percent
952 since 2001. And on January 8th of this year, the insulin products
953 of Novo Nordisk went up by five percent. Sanofi increased the
954 price of Apidra from $86 in 2009 to $270 last year. And so, since
955 January 1st, the three main brands were 4.4 to 5.2 percent gone
956 up this year.

957 And most everybody here now knows my daughter Francesca,
958 who is 25, she is a type 1 diabetic. I am not going to put anybody
959 on the spot, but she is on a newer kind of insulin and she has
960 insurance. She is still on my insurance for 8 more months --
961 who is counting -- and she renewed her prescription at the
962 beginning of the year. And for this insulin it says on the receipt
963 the retail price, 1,739.79, "Your insurance saved you 1,399.79."
964 But for her type of insulin she is on, the list price is $347.80
965 per bottle. Now she didn't pay that because she is on insurance,

966 but she still paid quite a bit because I have a pretty high
967 deductible.
968 So here is the thing is everybody is saying, "Well, sure
969 the list price is high, but there is all these workarounds."
970 But not everybody gets the workarounds, and the question is why
971 is the list price so high? So, I am going to ask each one of
972 you and I have really limited time.
973 So, Mr. Mason, I am wondering if you can tell me in 30 seconds,
974 how does Eli Lilly justify these huge increases in list prices
975 in the past 10 or so years?
976 Mr. Mason. Thank you for the question. I hope your
977 daughter is doing well.
978 Ms. DeGette. Yeah, forget about that. Just, please.
979 Mr. Mason. Seventy-five percent of our list price is paid
980 for rebates and discounts to secure access so people have
981 affordable access --
982 Ms. DeGette. So that is what is making the price go up and
983 up?
984 Mr. Mason. $210 of a vial of Humalog is paid for discounts
985 and rebates.
986 Ms. DeGette. Okay, Mr. Langa, same question.
987 Mr. Langa. So as you heard last week from Dr. Cefalu from
988 the ADA, there is this perverse incentive and misaligned
989 incentives and this encouragement to keep list prices high. And

990 we've been participating in that system because the higher the
991 list price, the higher the rebate.
992 Ms. DeGette. So you also think it is because the rebates
993 that the prices have gone up so much in the last 10 years?
994 Mr. Langa. There's a significant demand for rebates. We
995 spend almost $18 billion.
996 Ms. DeGette. Okay, I am sorry.
997 Ms. Tregoning?
998 Ms. Tregoning. Yes, as part of how we set list prices, we
999 have to look at the dynamics of the supply chain including the
1000 rebates. We have at Sanofi limited ourselves to list price
1001 increases no greater than national health expenditures across
1002 every one of our products.
1003 Ms. DeGette. Okay.
1004 Okay, now, Mr. Moriarty, I bet you have a different
1005 perspective on why the list price of insulin is so high.
1006 Mr. Moriarty. Chairwoman, rebates are discounts. And as
1007 we've disclosed, more than 98 percent of those discounts go back
1008 to our clients.
1009 Ms. DeGette. I understand, but why do you think the list
1010 prices are so high?
1011 Mr. Moriarty. I can't answer that. That is the
1012 pharmaceutical manufacturers' purview.
1013 Ms. DeGette. But you don't think it is because of discounts?

1014 Mr. Moriarty. I do not, no.

1015 Ms. DeGette. Ms. Bricker?

1016 Ms. Bricker. I concur. I concur. I have no idea why list
1017 prices are high and it's not a result of rebate.

1018 Ms. DeGette. Dr. Dutta?

1019 Dr. Dutta. We see list prices rising double digits in
1020 non-rebated drugs, in generics where monopolies lost, or where
1021 manufacturers buy up and create monopoly, so we can't see a
1022 correlation just when rebates raise list prices.

1023 Ms. DeGette. Okay, so of course my time is almost up, but
1024 I think this is a good example of the problem that the Members
1025 of Congress are dealing with in trying to figure out how to solve
1026 this problem. Because it seems to me what is happening is that
1027 every component of the drug system is contributing to an upward
1028 pressure on the list price.

1029 And I know the members are going to have a lot of questions
1030 around that and we will do some follow-up at the end, so I would
1031 like to recognize the ranking member for his input, for 5 minutes.

1032 Mr. Guthrie. Thank you very much. Thanks for being here.
1033 And I am going to use a quick example just because I am trying
1034 to make it simple. I have been wrestling with this for about
1035 a month in trying to figure out what is happening. If
1036 Chair DeGette was making this phone and I want to buy it and she
1037 said she is willing to take $100 for it, but she says, "I will

1038 sell it to you for 300," and give me 200 back, and that doesn't
1039 make sense. Or Chair DeGette is willing to take $100 and I say
1040 to her, "Hey, I am willing to pay 100, but charge me 300 and I
1041 will give you 200 back." And the whole idea is that Brittany
1042 is the purchaser at the end and I am passing, I am giving that
1043 to her for $100 because she is the plan, she is saving the money
1044 and passing it on to her consumers, and what we are trying to
1045 figure out is where that delta is going. It is just hard to figure
1046 out and I have been spending a lot of time on it.
1047 So on February 6th, so the three manufacturers, I want to
1048 try to, because I have a few questions so try to go fast, you
1049 said that your list price has gone up, but your net price has
1050 gone down. What would happen if you just said, "Hey, I want to
1051 make my list price my net price," and put it out on the marketplace?
1052 So I'll let you three.
1053 Mr. Mason. First of all, we are dropping our list price
1054 of Humalog by 50 percent with our launch of lispro insulin. For
1055 us there is many people who have access. The majority of people
1056 have access for insulin at affordable cost through their plans.
1057 That's not tied to list price, so we don't want to disrupt those
1058 by lowering list price. And so, we think the best way is to
1059 provide in the short term is to keep our list price at the way
1060 it is so we don't disrupt those individuals, we don't harm the
1061 access that they have.

1062 Mr. Guthrie. But if you are willing to take, I think you
1063 said you had, I don't know, whatever the net price is, I know
1064 net prices are different with different plans. There is not one
1065 net price, I get it. But if you are willing to take a net price
1066 for your product and three of you here, why wouldn't that be
1067 something out there for everyone to pay? I mean that is what
1068 you are willing to charge, right?
1069 Mr. Mason. It's just more difficult to do that to disrupt
1070 that for a product that's on the marketplace today because people
1071 have affordable access.
1072 Mr. Guthrie. But you have had your net price and according
1073 to your testimony go up 207 percent while your list price dropped
1074 by 3 percent, according to the letter on February 6th on Humalog.
1075 And I think you all are similar too. I don't want to just
1076 do Lilly, all of you guys as well. I mean that is kind of, so
1077 we see the net price going -- I understand what you are saying,
1078 but we see the net price rising. And we want to know why is it
1079 doing it, maybe there is a market reason for that and it is
1080 benefiting consumers, but we want to know.
1081 Mr. Langa. So in the current system today, the most
1082 important thing for us is for the most number of patients to get
1083 our brands at the most affordable prices and in the system today
1084 that is the current formulary positions. Just the three PBMs
1085 here today represent over 220 million covered lives.

1086 Mr. Guthrie. Okay, you said they were perverse. Okay, I
1087 am running out of time.
1088 Mr. Langa. So that is 80 percent of the lives, so for us
1089 to lose one of those positions that would be a dramatic impact
1090 to patients in terms of the medicine that they are on, physicians
1091 in terms of their choice.
1092 Mr. Guthrie. And your argument is --
1093 Mr. Langa. And there would be --
1094 Mr. Guthrie. -- you would lose your position on the
1095 formulary if you lowered your price?
1096 Mr. Langa. In the current system if we eliminated all the
1097 rebates, yes.
1098 Mr. Guthrie. And you are shaking your head, the same way?
1099 Mr. Langa. We believe that we would be in jeopardy of losing
1100 those positions.
1101 Mr. Guthrie. You said there were perverse incentives.
1102 What are the perverse incentives?
1103 Mr. Langa. Well, we're spending almost $18 billion a year
1104 in rebates, discount, and fees, and we have people with insurance
1105 with diabetes that don't get the benefit of that.
1106 Mr. Guthrie. What are the perverse incentives for that 18
1107 billion in rebates? You said they are perverse --
1108 Mr. Langa. They're going into the system and they're
1109 misaligned, right, so that's, we believe that they should go back

1110 to the diabetic patient.

1111 Ms. Tregoning. The issue here, Congressman, is not one of

1112 negotiation. The PBMs are very effective negotiators. It's

1113 what happens with the results of that negotiation. Those rebates

1114 are not necessarily going all the way through to patients.

1115 They're being used for other parts of the system and we don't

1116 have visibility to how those rebates get used. Those rebates

1117 are part of how we secure formulary placement and cost sharing

1118 for the patients that are covered by those plans.

1119 Mr. Guthrie. So you say, "I am willing to take X for a

1120 product, but for me to get on their formulary I know I am going

1121 to have to raise my list price because they then want rebates;"

1122 is that what you are arguing?

1123 Ms. Tregoning. The rebates is how the system has evolved.

1124 The rebates are part of the negotiation to secure formulary

1125 placement and associated --

1126 Mr. Guthrie. I went too long on that side because I am not

1127 giving you -- you already talked to that, I guess. So I had other

1128 questions, but I would rather hear your responses to that.

1129 Ms. Bricker. So as mentioned previously by my colleague

1130 to my left, of course we're looking at the clinical attributes

1131 of a product and I know you want to get to the economics. The

1132 way we make formulary decisions is based on net price. And if

1133 every one of the manufacturers to my right wanted to reduce their

1134 list price, there would be no implication to the rebate status
1135 so long as the net price remained the same.
1136 Mr. Guthrie. So on my example, if she is willing to sell
1137 for me a hundred and I sell to Brittany for a hundred, and you
1138 are saying rebates keep the price down, but in the end because
1139 you are selling to her at the net price, so why wouldn't the net
1140 price be -- what we are trying to figure out is it seems like
1141 there is a price that is marked through the system that seems
1142 to be based on something, but there seems to be an inflation and
1143 another higher price that just seems to be caught up in the system.
1144 But what really affects people as we have talked about, when
1145 they are going to the point of sale when they haven't hit their
1146 deductible. I know you have these plans in place and those are
1147 great, but we need to figure out the economics behind it so if
1148 we need to do something here to help people out, we need to
1149 understand that.
1150 I wish we had more than 5 minutes. I yield back.
1151 Ms. DeGette. The chair recognizes Mr. Kennedy for 5
1152 minutes.
1153 Mr. Kennedy. Thank you. And I want to thank the witnesses
1154 here and I want to thank the chair and ranking member for holding
1155 this hearing.
1156 I am going to follow up on some of the questions that have
1157 already been asked. I want to submit for the record though a

1158 Boston Globe piece from last November. I have done this before
1159 in other hearings about individuals, two mothers that brought
1160 ashes of their children in front of Sanofi in Boston, in Cambridge,
1161 back in November trying to protest these prices.
1162 You all have, you know why we are here and you know what
1163 the challenges are. I can tell you even from being here for a
1164 couple minutes how frustrating it is to be on this side of the
1165 dais and watch everyone do this. So I also, I hope and I expect
1166 that you will also understand that if that is the result of this
1167 hearing that we are not, you are hearing bipartisan frustration
1168 on this. You are not going to -- the status quo is not going
1169 to continue, it can't.
1170 We heard testimony last week from patients that were
1171 literally rationing, putting their lives on hold or taking serious
1172 risk for themselves and their children to be able to get access
1173 to medicine that was patented and sold for a dollar.
1174 And, sir, Mr. Mason, you began by saying about the 75 percent
1175 of that increase over the course of the past several years increase
1176 in list price goes to PBMs. The data that I have indicates that
1177 over the past, since 2002 to 2013, Endocrine Today estimated the
1178 average price went from $231 in 2002 to $736 in 2013, inflation
1179 adjusted. Seventy-five percent of that is roughly $375. That
1180 means 127, fifty percent of that baseline price is not PBMs.
1181 So where is the other 50 percent? What justifies the other

1182 $127 increase?

1183 Mr. Mason. You know, our net prices have gone down since

1184 2019, so the -- or since 2009. We haven't taken a price increase

1185 until since 2017.

1186 Mr. Kennedy. Sir, have you ever lowered a price off of your

1187 formulary?

1188 Mr. Mason. We are launching a lower priced Humalog that's

1189 50 percent off.

1190 Mr. Kennedy. So it took 15 years and global outcry on this

1191 to do it? What factors go into -- have you ever lowered the price

1192 off of a formulary?

1193 Mr. Mason. We have lowered our net price over the last 10

1194 years.

1195 Mr. Kennedy. And what factor goes into lowering that price?

1196 What evaluation do you take to lower that price?

1197 Mr. Mason. What evaluation, you know, a decade ago we were

1198 on formularies, all formularies, now we're on formularies about,

1199 you know, half, about half of formularies, patients in America

1200 have our insulins because we're moving to strictly formularies.

1201 We have to provide rebates in order to provide and compete for

1202 that so people can use our insulin.

1203 Mr. Kennedy. And, Mr. Langa, have you ever lowered a list

1204 price?

1205 Mr. Langa. We have not.

1206 Mr. Kennedy. And why not?

1207 Mr. Langa. For two reasons, as I said the biggest vehicle
1208 today for the most majority of patients in this country --

1209 [Simultaneous speaking.]

1210 Mr. Langa. No, it's formulary position. So that's the best
1211 way for us today to reach the most amount of patients in an
1212 affordable way and anything that risks that is something that
1213 we have to strongly consider. Everything's on the table right
1214 now for Novo Nordisk. We want to be part of the solution.

1215 Mr. Kennedy. If it takes us hauling you in after people
1216 are telling us that they are rationing the lives of their children,
1217 how does this work? And I understand that part of this comes
1218 back on us. You guys are responding to incentives that Congress
1219 sets and a lack of regulation, a lack of oversight to allow this
1220 to happen. But from my position at the moment, trying to figure
1221 out what levers to push and pull, we are asking what goes into
1222 the factors to set that list price, we don't get an answer. To
1223 lower risk price, it either hasn't happened or we don't know.
1224 You place the blame on the major of the hike of it to going on
1225 the PBMs and the PBMs are putting it back at you.

1226 So if you were in my position, what do we do to try to make
1227 sure that patients in this country get access to lifesaving
1228 medication that was initially discovered for a buck and sold to
1229 a university to ensure that every person could get access to it?

1230 What do you suggest?

1231 Mr. Langa. I suggest that we all come together to come up
1232 with solutions, get together with Congress to make sure that
1233 rationing never happens again. As I mentioned in my opening
1234 statement, one patient is too many. And as an organization that's
1235 for 90 years been committed to patients with diabetes, it's tragic
1236 and it should never happen.

1237 Mr. Kennedy. Ms. Tregoning?

1238 Ms. Tregoning. Congressman, no one should be rationing
1239 insulin. No one --

1240 Mr. Kennedy. And they do every day.

1241 Ms. Tregoning. And we need to make those patients more aware
1242 of the programs that are available.

1243 Mr. Kennedy. And so what do you do -- the programs, ma'am,
1244 there were people here last week that said those programs take
1245 weeks to get into that there is not transparency on it. They
1246 can't wait 6 weeks to get an insulin shot.

1247 Ms. Tregoning. Congressman, our co-pay assistance programs
1248 can be accessed in a matter of minutes online. And so, people
1249 with high-deductible health plans --

1250 Mr. Kennedy. Do you have any patients that don't have access
1251 to internet?

1252 Ms. Tregoning. We also have phone numbers where patients
1253 can call.

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1254 Mr. Kennedy. How long does it take for them to be able to
1255 access those programs? What percentage of folks do you deny?
1256 Ms. Tregoning. For co-pay assistance and for -- we have,
1257 it's literally a matter of moments for the VALyou Savings Program
1258 that we accessed, that we announced today, the expansion --
1259 Mr. Kennedy. That you announced today when you are in front
1260 of Congress?
1261 Ms. Tregoning. It's an expansion of a program that we
1262 started last year, $99 for the insulin that they need in any
1263 combination at the pharmacy counter people can get access to that.
1264 It's for uninsured patients. For those with high-deductible
1265 health plans, they can access co-pay assistance that's no more
1266 than a $10 co-pay.
1267 Mr. Kennedy. I am way over time.
1268 But for the folks that are uninsured that are paying your
1269 full list price --
1270 Ms. Tregoning. For the folks that are uninsured paying full
1271 list price --
1272 Mr. Kennedy. Yield back.
1273 Ms. Tregoning. -- they now have access as of June, $99
1274 at the pharmacy counter for the insulin that they need per month.
1275 Ms. DeGette. The chair recognizes the ranking member of
1276 the full committee, Mr. Walden, for 5 minutes.
1277 Mr. Walden. Thanks again, Madam Chair, for having this

1278 hearing. Thanks again to our witnesses for being here.

1279 Ms. Tregoning, in 2018, Sanofi launched Admelog. Now I
1280 understand that is a follow-on biologic to Eli Lilly's Humalog.
1281 Now according to press articles, Sanofi launched Admelog at a
1282 list price that is about 15 percent less than the list price for
1283 Humalog. Is that pretty close?

1284 Ms. Tregoning. Yes. It's the lowest rapid-acting list
1285 priced insulin.

1286 Mr. Walden. Okay. Typically, when a generic medicine
1287 enters the market we expect for the price of the generic to be
1288 less than the branded and many patients to switch from the brand
1289 medicine to the generic medicine. You have told us, however,
1290 that Admelog is not on the formulary for any commercial plans.
1291 I believe that is correct?

1292 Ms. Tregoning. No. Yes, correct. It's only available
1293 through Managed Medicaid.

1294 Mr. Walden. So given that Admelog was launched at a lower
1295 list price than Humalog, what barriers are preventing patients
1296 from this alternative and are there issues gaining formulary
1297 access for Admelog?

1298 Ms. Tregoning. Congressman, we were unable to secure
1299 formulary access through rebating with Admelog. As to exactly
1300 why those decisions were made I'd have to defer to my colleagues
1301 on the other side of the panel.

1302 Mr. Walden. Has Sanofi faced these barriers for launching
1303 any other products?
1304 Ms. Tregoning. Yes, Sanofi has brought a number of products
1305 to patients at lower prices including Kevzara, which is a lower
1306 list price of a rheumatoid arthritis medicine, and we similarly
1307 face challenges.
1308 Mr. Walden. Given Sanofi's experience with Admelog, do you
1309 think more follow-on biologics and biosimilars of insulin will
1310 help reduce the list price of insulin or does the biologic market
1311 function differently than introduction of a generic of a small
1312 molecule drug?
1313 Ms. Tregoning. There is already competition in the insulin
1314 market as I believe one of the colleagues referenced. Eli Lilly
1315 introduced a follow-on biologic version of Lantus several years
1316 ago and so there is competition. And CVS in its testimony spoke
1317 to the fact that they were able to leverage greater rebates and
1318 negotiate through that.
1319 Mr. Walden. Now I want to switch to Mr. Mason and thanks
1320 again for being here. We have heard that sometimes a branded
1321 biologic manufacturer may tell pharmacy benefit managers, PBMs,
1322 and health insurance plans that they will no longer provide
1323 rebates for their branded product if the PBM or health insurance
1324 plan puts a follow-on biologic or biosimilar on the formulary.
1325 Has Eli Lilly told any PBMs or health insurance plans that it

1326 will no longer provide rebates for Humalog if the PBM or health
1327 insurance plan puts Admelog on its formulary?
1328 Mr. Mason. No, we haven't.
1329 Mr. Walden. All right.
1330 Ms. Tregoning, similarly did Sanofi tell any PBMs or health
1331 insurance plans that it would stop providing rebates for Lantus
1332 if the PBM or health insurance plan put Basaglar on their
1333 formulary?
1334 Ms. Tregoning. No, nothing.
1335 Mr. Walden. Mr. Moriarty, has a manufacturer ever said they
1336 would stop providing you rebates for a product if you put a
1337 competing product on your formulary?
1338 Mr. Moriarty. Not that I'm aware of, sir.
1339 Mr. Walden. Okay, so that has never happened.
1340 And then for Mr. Moriarty, Ms. Bricker, and Mr. Dutta, why
1341 isn't Admelog included on your formulary?
1342 Ms. Bricker. So the challenge that we have with Admelog
1343 specifically is one of net cost and so through the mechanisms
1344 that we use today which are rebates or discounts it was more
1345 expensive than competing product. Manufacturers do give higher
1346 discounts for exclusive position, so I think that was your
1347 question to my counterpart here on the right.
1348 Mr. Walden. Yeah, if each of you could answer that.
1349 Ms. Bricker. Yes, so to the extent that we have recognized

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1350 one product as exclusive, other manufacturers will -- that
1351 exclusive product will receive less discount if additional
1352 products are added.
1353 Mr. Walden. So why not include both?
1354 Ms. Bricker. We'll receive less discount in the event that
1355 we do that.
1356 Mr. Walden. Huh.
1357 So what about the others on the panel, Mr. Dutta and Mr.
1358 Moriarty, can you speak to this?
1359 Dr. Dutta. The lowest cost product gets preferential
1360 position on our formulary. So, for example, generics which are
1361 very low cost have preferential position.
1362 Mr. Walden. Okay.
1363 Mr. Moriarty?
1364 Mr. Moriarty. And similarly, we drive to lowest available
1365 cost, lowest cost product. And with the example of Basaglar we
1366 were able to move that follow-on biologic to preferred status
1367 and actually have most, if not all, patients now on that one.
1368 Mr. Walden. So we keep hearing the manufacturers should
1369 just lower their list prices, but a lower list price doesn't
1370 necessarily guarantee that a manufacturer will have access to
1371 patients or that that patient will pay a lower price at the
1372 pharmacy counter. Do you take the list price of a medicine into
1373 consideration when making formulary decisions?

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1374 Mr. Moriarty. We do not. We focus on the lowest available
1375 cost, the lowest net cost.
1376 Mr. Walden. All right.
1377 Ms. Bricker?
1378 Ms. Bricker. The same, yes, lowest net cost.
1379 Mr. Walden. Mr. Dutta?
1380 Dr. Dutta. Lowest net cost, and for the member we consider
1381 their cost by using point-of-sale discounts and in order to lower
1382 their cost out-of-pocket.
1383 Ms. DeGette. So I just want to follow up on the ranking
1384 member's questions for Mr. Moriarty and Dr. Dutta. Why then if
1385 you look at generics and the lowest cost, why aren't either of
1386 your PBMs putting Admelog on these plans?
1387 Mr. Moriarty. Madam Chair, we have gone with Basaglar as
1388 the follow-on biologic alternative and the preferred status for
1389 that category.
1390 Ms. DeGette. Okay.
1391 Dr. Dutta?
1392 Dr. Dutta. It would cost the payer more money to do that.
1393 Ms. DeGette. Why?
1394 Dr. Dutta. Because the list price is not what the payer
1395 is paying. They're paying the net price.
1396 Ms. DeGette. The chair now recognizes Dr. Ruiz.
1397 Mr. Ruiz. Thank you, Chairwoman.

1398 The rising cost of drugs is such a big problem that it has
1399 reached kitchen table, family conversations across America.
1400 Those families are struggling, worried about having to decide
1401 between paying for insulin or paying their bills. There has been
1402 a lot of rhetoric today and finger pointing in the drug pricing
1403 debate and oftentimes the conversation is based on theoretical
1404 arguments about what will work for manufacturers or PBMs or
1405 insurance companies, with little regard to what works for
1406 patients.
1407 As a doctor, I put my patients' needs above all else and
1408 our solutions should do the same and reduce out-of-pocket costs
1409 for patients. In my district, according to the Health Assessment
1410 & Research for Communities 2016 survey, one out of four adults
1411 diagnosed with diabetes in the Coachella Valley are living below
1412 the federal poverty line and over ten percent of adults diagnosed
1413 with diabetes do not have health insurance that covers some or
1414 all of the cost of their prescription drugs. And this is not
1415 just a problem for the uninsured or underinsured either.
1416 Just this week I heard from Tamara Smith and David Richard,
1417 two constituents who had to go on a specialized form of insulin
1418 that isn't covered by their insurance. That means hundreds of
1419 dollars more out-of-pocket every month. So reducing the list
1420 prices of drugs or increasing the number of generics does not
1421 solve the problem if these savings are not lowering out-of-pocket

1422 costs for people like Tamara and David. The CEO of Diabetes
1423 Patient Advocacy Coalition drove home this point in her testimony
1424 last week in stating, "Somebody's making a profit and it's not
1425 the patients."
1426 So, Mr. Mason from Eli Lilly, who is making a profit from
1427 these increases in insulin prices?
1428 Mr. Mason. You know, I think, first of all, we don't want
1429 anyone not to be able to afford their insulin.
1430 Mr. Ruiz. Who is making a profit with these increases in
1431 insulin prices that patients have to pay for?
1432 Mr. Mason. Our net price is the price that we receive are
1433 going down.
1434 Mr. Ruiz. Are you?
1435 Mr. Mason. No.
1436 Mr. Ruiz. Are you making a profit? Are the CEOs of your
1437 companies making these profits?
1438 Mr. Mason. Our net prices, the price that we receive has
1439 gone down since 2009.
1440 Mr. Ruiz. Well, somebody is making a profit. Somebody is
1441 getting richer on the backs of our patients.
1442 Mr. Langa from Novo Nordisk, what entity in the supply chain
1443 is prioritizing affordability and access of insulin for patients?
1444 Mr. Langa. Well, we'd like to think we are. I mean we
1445 participate in as many formularies as we can. As I've mentioned

1446 that is critically most important. We have Patient Assistance
1447 Programs as well as co-pay assistance programs.
1448 Mr. Ruiz. So who is making a profit then?
1449 Mr. Langa. Well, our nets are going down as well, but there
1450 is a small profit that --
1451 Mr. Ruiz. Your nets, but your overall profits for the
1452 company and CEOs have been going up, haven't they?
1453 Mr. Langa. No. Our profit has been --
1454 Mr. Ruiz. Take-home pay from CEOs?
1455 Mr. Langa. Our profits have been relatively stable.
1456 Mr. Ruiz. From CEO pay hasn't gone up in the past several
1457 years?
1458 Mr. Langa. His pay has increased, yes.
1459 Mr. Ruiz. Okay.
1460 So last week, Dr. Cefalu from the American Diabetes
1461 Association noted that PBMs' primary customers are the health
1462 plans and insurers not the patients. He testified, "We don't
1463 know whether those transactions are actually benefiting the
1464 patient at the point of sale."
1465 Ms. Bricker from Express Scripts, does Express Scripts pass
1466 any savings on to beneficiaries and how do we know what the
1467 difference is if there is not that transparency?
1468 Ms. Bricker. So yes, thank you for the question. For over
1469 20 years, Express Scripts has supported point-of-sale rebates.

1470 We do have clients and plan sponsors that are --

1471 Mr. Ruiz. So how do we know what the percentage of that
1472 cost savings to patients if we don't have transparency of what
1473 the savings are? Are they going to your clients' profit or are
1474 they going to reducing out-of-pocket costs? How do we know?

1475 Ms. Bricker. So we support transparency for our plan
1476 sponsors, those that hire us. They absolutely have the ability
1477 to look at all of our rebate negotiated contracts as well as our
1478 retail contracts. We believe in transparency for patients.

1479 Mr. Ruiz. So we need to look into what you say and what
1480 is actually being done with implementation and that is what the
1481 purpose of this is for.

1482 Mr. Moriarty from CVS Health, are these barriers to passing
1483 discounts on to patients at the point of sale and, if so, what
1484 are they?

1485 Mr. Moriarty. Sir, we have over ten million lives covered
1486 in a point-of-sale rebate program today. We also, as you heard
1487 in my written testimony and oral testimony, we really advocate
1488 a zero co-pay for insulin and other preventive medications. The
1489 cost savings associated with adherence is significant.

1490 Mr. Ruiz. Okay, I got 20 seconds so let me ask this question
1491 directly. So what are each one of you willing to give up to make
1492 sure that every patient who needs insulin will get insulin? Mr.
1493 Mason?

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1494 Mr. Mason. We are willing to provide solutions and we are
1495 providing solutions that close the gap to anyone paying
1496 out-of-pocket --
1497 Mr. Ruiz. What are you willing to give up?
1498 Mr. Mason. We're willing to give up, we gave up $108 million
1499 last year.
1500 Mr. Ruiz. Mr. Langa, what are you willing to give up?
1501 Mr. Langa. Last year we invested almost $18 billion in
1502 rebates, discounts, and fees. And we also spent 200 --
1503 Mr. Ruiz. But yet the prices are still going up, so the
1504 status quo isn't working.
1505 Ms. Tregoning, what are you willing to give up?
1506 Ms. Tregoning. We are willing to contribute to solutions
1507 to allow patients to access and that's why the program that we
1508 have that allows $99 at the pharmacy for the insulin --
1509 Mr. Ruiz. Those solutions aren't working if we are seeing
1510 doubling, tripling cost of insulin and our patients are having
1511 to ration and not afford their insulin.
1512 Ms. Tregoning. -- and that costs are going down.
1513 Ms. DeGette. The gentleman's time has expired.
1514 The chair now recognizes the gentleman from Virginia, Mr.
1515 Griffith, for 5 minutes.
1516 Mr. Griffith. Thank you, Madam Chair.
1517 Mr. Mason, Ms. Tregoning, and Mr. Langa, we have heard that

1518 there are numerous fees and discounts in the prescription drug
1519 supply chain that are calculated based on insulin prices.
1520 According to what I have read, you all have fees with your supply
1521 chain partners that are based on a percentage of the list price
1522 of insulin. Why are they structured this way?

1523 You are up first, Mr. Mason, let's go. Time is running.

1524 Mr. Mason. We don't -- the PBMs kind of own the paper of
1525 the contracts and that's what we have to work with.

1526 Mr. Griffith. All right.

1527 Mr. Langa?

1528 Mr. Langa. It's the current system.

1529 Ms. Tregoning. Agreed, it's the current system.

1530 Mr. Griffith. All right. Have any of your companies tried
1531 to negotiate flat fees with your supply chain partners?

1532 Mr. Mason. Yes, we have.

1533 Mr. Langa. We have tried a variety of different avenues
1534 with contracting.

1535 Mr. Griffith. But you have not been successful, why?

1536 Mr. Mason. No, our efforts were pushed away.

1537 Mr. Langa. I think it's because it's the current system
1538 and again in this demand for rebates today.

1539 Mr. Griffith. Ms. Tregoning?

1540 Ms. Tregoning. Yes, again it's the system under which we
1541 operate.

1542 Mr. Griffith. So other than just it's the system, what
1543 reasons did the other participants in the supply chain provide
1544 to justify a fee based on the list price of the medicine rather
1545 than a flat fee?
1546 Mr. Mason. It's the current system.
1547 Mr. Griffith. Just the current system, everybody agree with
1548 that? All right, because I will move on.
1549 Mr. Moriarty, in the February 6th letter that we sent to
1550 CVS Health, we specifically asked CVS Health to list all the
1551 contractual terms in your existing contracts that are impacted
1552 by the list price of a medicine. CVS Health did not directly
1553 answer whether there were any fees charged by CVS that are
1554 calculated as a percentage of a list price.
1555 While reviewing the standard contract template commonly
1556 utilized between CVS Caremark and a health plan client for several
1557 lines of business that the committee received in response to a
1558 letter that we sent to CVS Health last August, we saw that there
1559 was a section in the template on disclosure of manufacturer fees
1560 that are disclosed that Caremark Part D services may also receive
1561 administrative fees from pharmaceutical companies that are based
1562 on a percentage of the list price of the medicine. It therefore
1563 appears as though CVS Health may use administrative fees that
1564 are based on a percentage of the list price of a medicine. This
1565 is correct, isn't it?

1566 Mr. Moriarty. Congressman, over 98 percent of all the fees,
1567 rebates that we obtain across our services and 100 percent in
1568 Medicare go back to the plan sponsors.
1569 Mr. Griffith. That is not what your contract says. Your
1570 contract says you all can charge a one percent fee, an
1571 administrative fee based on the price of the medicine. And the
1572 question that I have is, it doesn't cost your company any more
1573 to process a $4 drug than it does a $40,000 drug; isn't that
1574 correct?
1575 Mr. Moriarty. It represents the costs associated with that
1576 processing, sir.
1577 Mr. Griffith. Well, wouldn't it make more sense from a
1578 consumer's standpoint that you came out and be more transparent,
1579 but that you came out with a flat fee and worked with these folks
1580 over here to come up with a flat fee? Because I understand in
1581 Part D on Medicare you are just charging the one percent, but
1582 across the board according to your information you sent us you
1583 are charging two percent. As a part of the rebate you are getting
1584 two percent of that and I don't know whether you are charging
1585 those folks an administrative fee or not, but wouldn't it make
1586 more sense just to have a flat fee for doing what you all do?
1587 Mr. Moriarty. If the flat fee represents what the current
1588 net pricing, the lowest pricing it is in the market, yes, we will
1589 do that.

1590 Mr. Griffith. You are willing to do a net, even if it costs
1591 your company some profit you are willing to do a flat fee?
1592 Mr. Moriarty. And here's the issue. I think what's been
1593 proposed before actually results in not lower costs, actually
1594 higher costs. If it results in lower costs, we will implement
1595 that.
1596 Mr. Griffith. I mean because one of the problems we have
1597 is if you are not in one of the magic companies you are paying
1598 the list price and you are not able to afford it, or you are paying
1599 the high deductible in order to get there because you haven't
1600 reached your deductible yet. And lots of people have opted for
1601 these plans, and so the consumer is having to pay that higher
1602 list price, they aren't getting all those rebates all the time,
1603 and as a result of that their net price has gone up substantially.
1604 And that is what we're hearing from our constituents who are
1605 having to pay that. And it just seems to me that it ought
1606 to be something that we all can look at, the whole system needs
1607 to be more transparent and that you all ought to be paid for
1608 processing that prescription whether it is a $4 drug or a $40,000
1609 drug, you ought to be charged a set standard fee that doesn't
1610 have the drug companies coming in here saying, "We are raising
1611 our list price," so they can get more.
1612 By the way, how many billions of dollars or at least hundreds
1613 of millions of dollars is represented by that one or two percent?

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1614 Mr. Moriarty. We pass back as I said over 98 percent, and
1615 we had disclosed publicly what the retained number is.
1616 Mr. Griffith. What is the dollar number?
1617 Mr. Moriarty. The total number across is $300 million.
1618 Mr. Griffith. I yield back.
1619 Ms. DeGette. Thank you.
1620 Mr. Kennedy offered an article for the record and, without
1621 objection, it shall be entered.
1622 [The information follows:]
1623
1624 **********COMMITTEE INSERT 7**********

1625 Ms. DeGette. The chair now recognizes the chairman of the
1626 full committee, Mr. Pallone, for 5 minutes.
1627 The Chairman. Thank you, Madam Chair. I missed a lot of
1628 the hearing because we had other hearings and we were on the floor
1629 today with net neutrality. But I just want to say this. All
1630 I hear from my constituents, they are just totally disgusted,
1631 right. They figure particularly for insulin it has been around
1632 a long time, you know, they don't even believe in a market-based
1633 system anymore.
1634 I mean, frankly, I believe in a market-based competitive
1635 system. I think that, you know, that is what the country is all
1636 about. But what they tell me is, just set the price. They will
1637 literally say to me, "You in Congress or some government agency
1638 should just set the price and that is it." They just don't believe
1639 in a competitive model anymore. So, you know, you keep saying
1640 the system, the system, the system doesn't work, well, I guess
1641 part of what I would like to know is why this marketplace
1642 competitive model doesn't work anymore. What has happened?
1643 So, you know, last week the committee heard from Dr. Lipska,
1644 who is a clinician and researcher, and she said, and I quote,
1645 "Drug makers make excuses for why prices have gone up. They say
1646 it's the fault of PBMs or wholesalers or the high deductible
1647 insurance plans, but the bottom line is that drug prices are set
1648 by drug makers. The list price for insulin has gone up

1649 dramatically and that's the price that many patients pay. That
1650 is what needs to come down. It's as simple as that." Now, many
1651 of my constituents say, very simple, set the price. Have the
1652 government set the price and not have the company set the price.
1653 But I mean that is not the competitive model obviously. So let
1654 me just start.

1655 Mr. Mason, you set the list price for your insulins, not
1656 the PBMs or anyone else in the supply chain. Why are we talking
1657 about high drug prices when it is within your power to bring the
1658 list prices down? Why don't you just bring the list price down,
1659 or do you want us to set it? Because that is what my constituents
1660 say. Don't have Mr. Mason set it, you set it. Let the government
1661 set it. Why not, if you are not going to do anything?

1662 Mr. Mason. Okay, so we -- well, we actually buy down
1663 everyone in a high-deductible plan down to $95, so we're doing
1664 that today. Everyone who has, on a Lilly insulin at the pharmacy
1665 we buy every prescription down to $95, so we are reducing the
1666 list price. We're paying rebates in order to get access and --

1667 The Chairman. Are you willing to reduce it more?

1668 Mr. Mason. We right now reduce, you know, no matter how
1669 much their -- you mean, they can use multiple vials, multiple
1670 pen packs. We've brought it down to --

1671 The Chairman. All right. What would be the problem if the
1672 government lists the price and just brings it down and says that

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1673 is what you have to charge?

1674 Mr. Mason. I mean right now we have -- the competition is

1675 fierce. I mean our net prices are lower today than --

1676 The Chairman. So you think competition is working, the

1677 marketplace is working.

1678 Mr. Mason. I think it's working, yeah. Yeah.

1679 The Chairman. I don't hear that from my constituents.

1680 Mr. Langa, it is unconscionable that these essential drugs

1681 have seen dramatic price increases. Why isn't Novo Nordisk

1682 reducing its list price? Again, my constituents say force them

1683 do it.

1684 Mr. Langa. Well, we do believe in a market-based system.

1685 And I would also say if we reduced our list price, we would put

1686 all of our formulary positions in jeopardy. Just here at the

1687 table, these three PBMs represent 220 million covered lives.

1688 And for us the risk that --

1689 The Chairman. So you are going to blame the PBMs again.

1690 Mr. Langa. It's not the blame. We don't want to put those

1691 lives at risk, but we are willing to --

1692 The Chairman. All right, so then let's get rid of the PBMs

1693 and we will just set the price, the government will set the price

1694 and you don't have to worry about the PBMs. What do you think?

1695 Mr. Langa. It's not what we believe in. We take a

1696 market-based approach and it is competitive.

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1697 The Chairman. I agree with you, but nobody thinks it is
1698 competitive anymore.
1699 Mr. Langa. So if you look at our rebates, the average rebate
1700 for Novo Nordisk in 2014 was 48 percent. The average rebate just
1701 4 years later in 2018 was 68 percent. That's a 40 percent
1702 increase. We spent up to $18 billion last year in rebates,
1703 discounts, and fees to provide formulary access, so.
1704 The Chairman. All right, let me -- I think you are just
1705 passing it on to the PBMs.
1706 Ms. Tregoning, same question is people being forced to ration
1707 their insulin because they can't afford it. What is stopping
1708 Sanofi from lowering its list price? Why don't we just set the
1709 price ourselves?
1710 Ms. Tregoning. Congressman, unfortunately, under the
1711 current system simply lowering list price as I believe some of
1712 the witnesses last week attested to might not help patients and
1713 actually could cause some patients, who are on their formularies
1714 where we've secured position with rebates, to lose access. If
1715 we could get --
1716 The Chairman. But if we set the price there would be no
1717 PBMs anymore.
1718 Ms. Tregoning. Congressman, I believe that the
1719 market-based system is very important for continued innovations.
1720 We don't --

1721 The Chairman. I agree, but you guys have got to convince
1722 us that it is working and that the, you know, the problem that
1723 we have is we always end up having to interfere with the market
1724 when it becomes monopolistic, when it is not working, and my
1725 constituents say it is not working. "What are you doing, Pallone?
1726 It is not working."

1727 Ms. Tregoning. Congressman, competition is working. The
1728 net prices are coming down. The issue we have is that the results
1729 of that negotiation are not finding their way to patients, and
1730 that's the issue at hand. We at Sanofi are working, where
1731 patients are exposed to those high list costs, we are effectively
1732 de facto having a lower list price and covering through co-pay
1733 assistance or VALyou Savings Programs. But we don't control the
1734 out-of-pocket costs.

1735 The Chairman. I mean the problem is, Madam Chair, I know
1736 my time is up, but everybody just blames, you know, the PBMs blame
1737 the companies, the companies blame the PBMs, and our constituents
1738 say they are all no good, just get rid of the system. And I am
1739 reluctant to do that because I believe in a market-based system.
1740 But this is, you know, this is what I hear. Thank you.

1741 Ms. DeGette. Thank you, Mr. Chairman.

1742 The chair now recognizes Mrs. Brooks from Indiana, for 5
1743 minutes.

1744 Mrs. Brooks. Thank you, Madam Chairwoman.

1745 I think everyone is focused and the answers all seem to be
1746 focused on the system which I think we all are acknowledging and
1747 are very frustrated. It seems to be very broken. In the February
1748 6th letter that we sent to the manufacturers we heard it is
1749 becoming increasingly common for insurers and PBMs to only offer
1750 one insulin manufacturers' line on their formularies.
1751 And I want to ask some questions about formularies and
1752 because it sounds like everyone in this finger pointing is having
1753 to do with formularies. And so, I am curious, why are, and not,
1754 you know, being involved in, but we are all learning a lot more
1755 about this system, why is it that you might have one insulin on
1756 a formulary? Why wouldn't you want all of them to be on your
1757 formularies?
1758 And then I also have a question because if you are, say,
1759 an employee's daughter or son and you are used to one insulin
1760 then the company switches their insurance program and then that
1761 child has to go to different insulin, why would we not offer as
1762 many options as possible?
1763 I will start with you, Dr. Dutta. If you could, you know,
1764 why do we make this change and then the rebates get in the middle
1765 of it and the discounts, and can you just help us? The system
1766 seems really broken and it sounds like that is part of it.
1767 Dr. Dutta. So thank you for the question. The first
1768 assessment is purely clinical. It is about whether a product

1769 is unique or if there are therapeutic alternatives. So when you
1770 have a unique product, price is high. It's put on our formulary,
1771 there is no competition. Then as manufacturers produce more
1772 products that are therapeutically equivalent, in the case of
1773 insulins rapid-acting insulins, long-acting insulins, in a
1774 category then there's an opportunity when they're equivalent to
1775 negotiate price down off of list price. However, to your
1776 specific question, if there's a patient that requires a medication
1777 that is not our preferred product or not formulary, we offer a
1778 process for the patient and their doctor to request and provide
1779 rationale for their product. And if there's a good reason like
1780 an allergy or something like that, then they would be allowed
1781 to have that product.
1782 Mrs. Brooks. Thank you.
1783 Ms. Bricker, what would happen in the market for you to stop,
1784 for you, not just your company, but all of the PBMs here, what
1785 would happen if you stopped excluding certain insulin products
1786 from the formularies, if you allowed all of them in the different
1787 categories of insulins as I understand, if you allowed all of
1788 them to compete and be on each of your formularies?
1789 Ms. Bricker. Yes, thank you for the question. We don't
1790 have one formulary. We have many, many, many formularies. The
1791 formulary that provides the greatest savings for our clients
1792 actually limits through exclusivity or exclusive placement

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1793 insulin options. We do that because we're able to secure the
1794 deepest discount from the manufacturer once we award that
1795 placement. And so, they're offering discount in exchange for
1796 market share and in exchange for access.
1797 But to your point, we have other options and we believe that
1798 choice to our plans is critical and they absolutely can select
1799 formularies that have all insulin on the formulary.
1800 Mrs. Brooks. And what if we removed exclusivity from
1801 formularies?
1802 Ms. Bricker. Prices would go up.
1803 Mrs. Brooks. And why do you believe prices would go up?
1804 Mr. Moriarty, why would prices go up if all of the companies
1805 were able to be a part of your formulary? Mr. Moriarty?
1806 Mr. Moriarty. Because the drug companies would not offer
1807 the discounts that currently exist in the system.
1808 Mrs. Brooks. And so if we were to remove all exclusivity
1809 from formularies, Mr. Mason?
1810 Mr. Mason. You know, our rebates went up during the period
1811 were removed from kind of dual access to exclusive formularies.
1812 That's what caused the list prices to go up.
1813 Mrs. Brooks. Mr. Langa?
1814 Mr. Langa. Our rebates have been competitive for years.
1815 Year over year over year they're competitive. And we believe
1816 in choice, choice for the physician and choice for the patient.

1817 Someone that -- a physician should be able to use their clinical
1818 experience to make decisions, not a formulary.
1819 Mrs. Brooks. What if we got rid of rebates and discounts,
1820 Ms. Tregoning?
1821 Ms. Tregoning. We would support moving to a system in which
1822 you had fixed fees for PBMs and that we removed rebates. As long
1823 as patient access and affordability could be guaranteed, we would
1824 be more than happy to move to that system.
1825 Mrs. Brooks. And do you think if we had systems like that
1826 you all would lower your insulin prices that would be offered?
1827 Ms. Tregoning. If we could be assured that patient access
1828 and affordability would be maintained we would certainly be
1829 willing to lower our list prices if we moved away from a rebate
1830 system.
1831 Mrs. Brooks. Mr. Langa?
1832 Mr. Langa. Yeah, we support the rebate rule and we also
1833 support that if as long as there's access and affordability we
1834 are open to that option.
1835 Mrs. Brooks. Mr. Mason?
1836 Mr. Mason. Same answer.
1837 Mrs. Brooks. Thank you. I yield back.
1838 Ms. DeGette. The chair now recognizes the gentlelady from
1839 New Hampshire, Ms. Kuster, for 5 minutes.
1840 Ms. Kuster. Thank you.

1841 And thank you very much for your testimony today and as we
1842 unravel this whole process of rebates and volume discounts the
1843 high cost that patients and families are facing for insulin.
1844 In New Hampshire we have 121,000 Granite Staters, just give or
1845 take ten percent of our population, actually, have either type
1846 1 or type 2 diabetes. And these are the people that I have in
1847 mind, the families that we have been hearing from.
1848 But I want to understand, the frustration that the diabetic
1849 Americans come not just from the dramatic increases in the
1850 out-of-pocket costs, but the mind-numbing complexity of how the
1851 drugs are priced and a belief that insulin manufacturers and
1852 pharmacy benefit managers may have lost focus on who they are
1853 truly meant to be working for, the patient. So that is really
1854 where we are coming from is to try to understand as we unravel
1855 this.
1856 And you have heard some of the ideas here, which I would
1857 imagine would be a dramatic change in the way you do business
1858 on certainly from the conversations I have had with the PBMs,
1859 but also from the manufacturers' point of view. I mean I don't
1860 think anyone really comes to this with totally clean hands because
1861 you are chasing the profits of the quarterly earnings as well
1862 as anyone else.
1863 And I think, you know, part of what is difficult for us to
1864 understand is these are medicines that have been around for a

1865 long, long, long time without a great deal of innovation, without
1866 a change in the chemistry and the medication itself. Maybe there
1867 has been a change I understand in the delivery mechanism, you
1868 know, maybe there is a medical device change in having a longer
1869 lasting impact on patients and certainly for patient convenience
1870 and patient health that is important.
1871 But we are trying to get to the bottom of why this has gone
1872 up so much. It is one thing for us to consider that in a field
1873 of medicine that has dramatic new innovations and the R&D costs,
1874 but it is all the more complex for us to sort that out with
1875 something like insulin.
1876 So I want to get at two areas, if I could. Just, Mr. Mason,
1877 what efforts would you recommend to Congress to improve price
1878 transparency for patients? You obviously have taken a stand on
1879 getting rid of rebates or those types of things, but what is it
1880 that should be happening in terms of the patient understanding
1881 the pricing?
1882 Mr. Mason. We're open for transparency to help patients.
1883 We think the biggest issue that we're hearing right now -- we
1884 want the same thing. We're not defending the system, we're just
1885 explaining the system up here. We want reform. We want, you
1886 know, anything that provides better access to patients. The
1887 heart of what we're hearing from patients is those with
1888 high-deductible plans, about half of those high-deductible plans

1889 will take the rebates that are given to them and they use those
1890 to afford chronic, or affordable care for those with chronic
1891 disease. About half of them decide to actually put that back
1892 and actually lower premiums for the general population.
1893 So what we hear and what you're probably hearing is for those
1894 individuals who are in those high-deductible plans where that
1895 employer has decided to say, "I'm going to pick the plan design
1896 that gives me lower premiums," because they're prioritizing that.
1897 They're making that conscious plan decision and that leaves
1898 individuals with chronic medication paying this price. That is
1899 a gap in the system right now that is leading to what we're hearing
1900 the most from diabetes patients.
1901 Now we're providing now a stop-gap measure to buy all those
1902 people down to $95, but that's a short-term fix. Long-term fixes
1903 should really be focused on what can we do with these
1904 high-deductible plans so that they have affordable coverage from
1905 day one and that decision is universal.
1906 Ms. Kuster. So you would agree that there is a discount
1907 for volume purchasing, and are you saying they fall outside --
1908 and I can ask Ms. Bricker to explain this.
1909 But -- well, let me go to you, Ms. Bricker. What he is
1910 saying, how do we get to transparency for the patient and how
1911 do we get all the patients to benefit from a mechanism that makes
1912 sense to me that you have described which is a volume discount,

1913 essentially? That is what the rebates are.

1914 Ms. Bricker. A couple of things, if I may, so believe
1915 strongly in having real-time benefit check at the time of
1916 prescribing that the physician has at his or her fingertips, what
1917 product is covered under the formulary and what it will cost the
1918 patient, absolutely critical to ensuring that there isn't
1919 friction at the counter. Transparency, also, to plan sponsors
1920 so that they fully understand the value that we've negotiated
1921 for them by way of rebates and discounts.

1922 And so of course we've got to continue to do more. We've,
1923 as mentioned previously, announced a program for $25 insulin for
1924 all of our commercial patients. But clearly where we're still
1925 faced with challenges in the Part D benefit and we are absolutely
1926 in support of continuing to modernize that benefit such that
1927 patients, you know, have caps and don't have, aren't exposed to
1928 these high list prices, essentially.

1929 Ms. Kuster. My time is up, but thank you.

1930 Ms. DeGette. Thank you. The gentleman from West Virginia
1931 is now recognized for 5 minutes.

1932 Mr. McKinley. Thank you, Madam Chairman. I apologize.
1933 I have been back at two other committee meetings going on, so
1934 I have missed some of your -- but I heard enough of it.

1935 So, Mr. Langa, I probably would focus most of my remarks
1936 towards you on this. I was here, and so just begin, for my records

1937 the only thing that we have some information that we were -- a
1938 vial of insulin in '67 cost a dollar. If just the CPI went up
1939 $17, but yet your NovoLog is now with a list price of 237, not
1940 $17.
1941 So many times, when we have our meetings back in the district
1942 in our roundtable discussions they talk about how people in West
1943 Virginia, probably no different than around the country, having
1944 three and four hundred dollars a month. I just talked with that
1945 fellow this morning, he said he just wrote a check for a thousand
1946 dollars for his insulin in excess of his insurance.
1947 What I was hearing not only similar dollar increases like
1948 this, but I was hearing all of you say it was caused by innovation,
1949 in part by innovation. So I am curious what kind of innovation
1950 have we implemented over the last few years that would cause such
1951 a drastic increase in the price of insulin, the innovation part
1952 of it? Because let me just, I am a strong, strong supporter of
1953 innovation, so help me out a little bit. Why is innovation
1954 causing the increase in price?
1955 Mr. Langa. Sure, so innovation is very important to us as
1956 an organization, we're an innovator company. And I would tell
1957 you that what's most important, and I think it was mentioned
1958 earlier, is that we keep the patient in mind. Because even that
1959 word "incremental," it's not incremental to patients.
1960 So when you think about going from four to six injections

1961 a day to one, if you think about being able to take a mealtime
1962 insulin at or right after you eat versus an hour to an hour and
1963 a half before, if you think about basal insulin or long-acting
1964 products today that give you the support of hypoglycemia, maybe
1965 the best way I could describe it is we have patients that want
1966 to work for Novo Nordisk because of the mission that we're on
1967 to defeat diabetes. And we have these patients sometimes speak
1968 at our company meetings.
1969 Mr. McKinley. I am just trying to understand the innovation
1970 part of it.
1971 Mr. Langa. But I am going to, I think, get to it.
1972 Mr. McKinley. Please get to it because we have run out of
1973 -- I don't need someone to filibuster here on me.
1974 Mr. Langa. It's not filibustering, it's this individual
1975 talks about what he lives with is night terror. And night terror
1976 is something called low hypoglycemia at night and actually makes
1977 him do things that are out of what he normally does. And because
1978 he got on a product called Tresiba that reduces hypoglycemia 40
1979 percent --
1980 Mr. McKinley. You are saying, you saying the innovation
1981 that --
1982 Mr. Langa. -- he has not had a night tremor since.
1983 Mr. McKinley. I am saying if -- were prior to having the
1984 innovation that prices were lower, now they are skyrocketing up

1985 to 237. Can we just stop the innovation? If it worked before,
1986 why in the last 5 years through innovation we have gone from 17
1987 or $20 up? I don't want to go there, because as an engineer I
1988 believe very much in research and to do that, but if we are driving
1989 the price up -- innovation is supposed to drive the price down,
1990 not up.

1991 So I am really troubled with it. But I think it is --

1992 Mr. Langa. Innovation is for today, and tomorrow I think
1993 it's important because we're innovating for the future and the
1994 future of people living with diabetes. So it's a partnerships
1995 with MIT. It's our partnerships with the University of
1996 California San Francisco.

1997 Mr. McKinley. And I want to respond back to why that in
1998 the past, until the last few years that I am sure you were
1999 innovating back in the '70s and '80s, the innovation and it wasn't
2000 skyrocketing like it is right now. So it is just counterintuitive
2001 that why innovation is driving the price up now in the last few
2002 years.

2003 Let me go back to the list prices because I am not going
2004 to -- we are going to run out of time. But I don't understand
2005 that -- I come from the construction industry, but also in life
2006 I need to see some examples of why we have these list prices set
2007 up for discounts I have heard you talk about. If we don't have
2008 rising list prices for cars and appliances and construction

2009 material, why is it that pharmaceuticals are jazzing up the list
2010 price so they can offer discounts? Why is that unique to the
2011 pharmaceutical field?

2012 Mr. Langa. Again, I know you've heard a lot about this
2013 today, but it is about these misaligned incentives in the system.
2014 The higher the rebate -- excuse me. The higher the list price,
2015 the higher the rebate.

2016 Mr. McKinley. Yes.

2017 Mr. Langa. And the rebates are used within the system.
2018 And that is and again and those rebates don't get passed through
2019 to the people living with diabetes and that is there that lies
2020 the challenge.

2021 Mr. McKinley. Should we eliminate or discourage the
2022 rebates?

2023 Mr. Langa. Well, certainly we're supportive of the rebate
2024 rule and we're supportive of the pass-through of those rebates
2025 to benefit patients and we think that would be something that
2026 would be healthy for patients.

2027 Mr. McKinley. Okay, I have run out of time. I am sorry.
2028 I yield back.

2029 Ms. DeGette. The chair now recognizes the gentlelady from
2030 Florida for 5 minutes.

2031 Ms. Castor. Well, thank you, Chair DeGette for holding this
2032 hearing to tackle the skyrocketing insulin prices.

2033 I recently met with a family from back home in Tampa.
2034 9-year-old Brooke and her father Todd explained to me how she
2035 was diagnosed when she was 3 days old in the hospital and how
2036 they have struggled with her diabetes since then. But it is not
2037 just -- the big struggle hasn't really been on the health side.
2038 It has been with affording insulin and drugs. They have had
2039 to change their lifestyle a little bit and Todd told me at one
2040 point they had run out of insulin 2 weeks before the end of the
2041 month and had to borrow a vial from an adult friend of ours who
2042 was using Humalog and had numerous vials stockpiled.
2043 And that is how, he said, "That is how we do it now. We
2044 tell our endocrinologist that we use more insulin than we need
2045 in a month, so she writes prescriptions for slightly more than
2046 we use. Since the vials are good for 2 years, we have extra in
2047 case anything happens. At the end of the day, we count ourselves
2048 blessed that both my wife and I work and our insurance sufficiently
2049 helps pay for all of Brooke's type 1 diabetes supplies, but the
2050 beginning of the year is still very difficult until we pay our
2051 deductibles. And we choose to pay more for our insurance
2052 out-of-pocket to make those deductibles." But he says, "I cannot
2053 fathom how a family can choose to limit or ration insulin for
2054 their children. The system needs to be fixed."
2055 And then I asked Brooke, I said, "What would you as a
2056 9-year-old having to deal with this, what would you want me to

2057 ask?" She says, "Why do we have laws that protect kids' safety
2058 like bike helmets, seatbelts, and indoor smoking bans, but not
2059 laws that would allow them to get the medicines they need to stay
2060 alive?"
2061 So this, things have got to change. So let's start with
2062 manufacturers' list prices and how we get them under control.
2063 It seems to be that just about everyone in the supply chain except
2064 the patient is benefiting from increasing list prices.
2065 Mr. Mason, if rebates and fees tied to list price were to
2066 be restricted or eliminated, do we have any guarantee from Eli
2067 Lilly that prices would go down and patients would pay less?
2068 Mr. Mason. We would definitely consider it.
2069 Ms. Castor. And, Mr. Langa?
2070 Mr. Langa. Yeah. We would consider that, yes.
2071 Ms. Castor. Is there a guarantee?
2072 Mr. Langa. Well, what's important to us again is that the
2073 majority of patients can have access at affordable pricing and
2074 as long as there was that in place then, yes, we would consider
2075 that.
2076 Ms. Castor. Ms. Tregoning?
2077 Ms. Tregoning. Yes, as long as we can ensure patient access
2078 and affordability in formularies then we would certainly lower
2079 list price with the elimination of rebates.
2080 Ms. Castor. Okay. There is another hitch in the system

2081 here and that is kind of the gaming of charitable contributions.
2082 It has been reported that some manufacturers use the Patient
2083 Assistance Programs to reduce their own tax burden. That by
2084 donating drugs to these Patient Assistance Programs, the company
2085 is able to deduct the value of the donated drugs from its taxes.
2086 In 2015, I understand Lilly donated 408 million worth of
2087 drugs to the Lilly Cares Foundation. Mr. Mason, should
2088 manufacturers be able to benefit financially from the Patient
2089 Assistance Programs?
2090 Mr. Mason. We do it only to help patients. We don't want
2091 anyone not to afford --
2092 Ms. Castor. But boy, that is a big -- 408 million, then
2093 I would think we would see some commensurate of the list price
2094 that would be tied to that.
2095 Mr. Mason. Our net prices are going down, and then what
2096 you're not seeing is we spent $108 million last year on savings
2097 offers that helped 525,000 people. Those aren't a tax write-off.
2098 Those are --
2099 Ms. Castor. I think there is an issue here though with these
2100 kind of charitable contributions. You seem to be benefiting on
2101 both sides and patients aren't.
2102 So turning to the PBMs, Ms. Bricker, if fees paid to PBMs
2103 and wholesalers are standardized and entirely delinked from the
2104 list price, what impact would it have on what the patient

2105 ultimately pays?

2106 Ms. Bricker. Over 50 percent of our clients receive all
2107 fees that are collected from manufacturers and 95 percent of all
2108 fees and discounts and rebates are passed on to our plan sponsors.
2109 And so ultimately when you delink the fee from the list price,
2110 there really is nothing that prevents the manufacturer from
2111 continuing to increase the price.

2112 Ms. Castor. So, Mr. Dutta, the mission of PBMs is to get
2113 the lowest price possible for drugs for their clients, but that
2114 clearly isn't happening. How can we change the system to better
2115 align out-of-pocket patient cost to negotiate a net cost instead
2116 of the list prices?

2117 Dr. Dutta. Well, 76 percent of our members today either
2118 pay zero-dollar co-pay or most commonly a flat co-pay of $35.
2119 And for that other percentage that you're asking about that are
2120 on a co-insurance or a high-deductible plan we advocate for
2121 point-of-sale rebates as well as preventive drug lists such that
2122 insulins would not apply to the deductible.

2123 Ms. Castor. I yield back my time, thank you.

2124 Ms. DeGette. Thank you. The chair now recognizes Mr.
2125 Mullin for 5 minutes.

2126 Mr. Mullin. Thank you, Madam Chair, and thanks for holding
2127 this meeting. It is not too often we get together and actually
2128 agree on issues, but we are all talking about the same thing and

2129 we are all scratching our head trying to figure out how we got
2130 to this point.
2131 Real quick, I want to go back to what was just asked about
2132 you guys' tax advantage for taking the rebates. Is there a tax
2133 advantage for you all's companies for those rebates, yes or no?
2134 Mr. Mason. No.
2135 Mr. Mullin. No?
2136 Mr. Langa. No.
2137 Ms. Tregoning. No.
2138 Mr. Mullin. Well, what about the charitable contributions?
2139 Is that not a tax advantage?
2140 Mr. Mason. We only give insulin and what people use.
2141 Mr. Mullin. Well, because if it is at $300, and I am just
2142 using generic numbers, if the list price is 300, you put your
2143 rebates in and you get it all the way down to 100, who absorbs
2144 those rebates?
2145 Mr. Mason. That's not why we're doing it. We're doing it
2146 for --
2147 Mr. Mullin. No, who absorbs those rebates?
2148 Mr. Mason. Those --
2149 Mr. Mullin. Who absorbs those rebates? Do you guys absorb
2150 those rebates? If you are giving the rebates and the list is
2151 at $300, you are getting it to $100, who absorbs those rebates?
2152 Ms. Tregoning. The rebates go to the PBMs with whom --

2153 Mr. Mullin. It doesn't go to the patient though, right?

2154 Ms. Tregoning. That's based on the -- that's the concern

2155 that we have.

2156 Mr. Mullin. And so do you write that off as a charitable

2157 contribution?

2158 Ms. Tregoning. That's different than a charitable

2159 contribution. The free drug program which are run through

2160 Patient Assistance Programs --

2161 Mr. Mullin. Okay.

2162 Ms. Tregoning. -- that's different. That's providing

2163 free drug to patients below a certain income threshold. That's

2164 separate from rebate --

2165 Mr. Mullin. You all know what Mr. Griffith asked back here

2166 in the back, the innovation -- no, I am sorry, McKinley asked

2167 about the innovation. When you are talking about the innovation

2168 side of things, are you using insulin today to help pay for future

2169 drugs? Is that the innovation that you guys are using for

2170 research? Does the price of insulin help offset the cost of

2171 research for future drugs?

2172 Ms. Tregoning. Revenues from all of our business, in part,

2173 go back to fund research and development across all areas. For

2174 diabetes in the United States, I would point out our revenues

2175 have gone down.

2176 Mr. Mullin. But I can understand price. A lot of you guys

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2177 come in and you talk to me in my office and you say, "Look, the
2178 price of the drug is so we can recoup our cost to develop it.
2179 That was the cost so that is why it is set at where it is because
2180 we are trying to recoup the cost of it." And I totally get that.
2181 You have got to recoup the cost especially when you start having
2182 patents that are going to run out and you need to recoup your
2183 costs in time.
2184 But the cost is already recouped in this, so you are using
2185 insulin today, the cost of insulin today to pay for future drugs
2186 that are outside of insulin; is that correct?
2187 Ms. Tregoning. We continue to invest in research --
2188 Mr. Mullin. That is why you are seeing it go up so much?
2189 Ms. Tregoning. No, because our revenues from diabetes are
2190 going down. The net prices are going down. Our revenues from
2191 --
2192 Mr. Mullin. But you don't have any costs associated with
2193 it because it has already been developed. It has already been
2194 paid for.
2195 Ms. Tregoning. But again, the revenues for Sanofi's
2196 diabetes business in the U.S. --
2197 Mr. Mullin. Okay.
2198 Ms. Tregoning. -- have gone down by half over the last
2199 4 years because net prices have gone down so dramatically.
2200 Mr. Mullin. I have some quick questions I need to get to.

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2201 If a patient qualifies for you all's programs, how much does
2202 it cost? How much does their insulin cost at that point?
2203 Mr. Langa. Patient assistance is free.
2204 Ms. Tregoning. For co-pay assistance they'll pay no more
2205 than a $10 co-pay.
2206 Mr. Mullin. Okay.
2207 Ms. Tregoning. But if they qualify for the charitable then
2208 it is free drug.
2209 Mr. Mullin. Okay.
2210 Mr. Mason. Patient assistance is free.
2211 Mr. Mullin. Is free.
2212 Ms. Bricker, with the Express Scripts you guys came up with
2213 no more than a $25 charge to customers. You just rolled that
2214 out recently, right? How long did it take you to develop that?
2215 Ms. Bricker. We've been working on it for a few months.
2216 Mr. Mullin. For a few months. Has the companies here on
2217 the panel, have they agreed to participate in that with you?
2218 Ms. Bricker. Yes, they have.
2219 Mr. Mullin. So it took you 2 months to come up with that.
2220 How are you guys able to offer that?
2221 Ms. Bricker. In collaboration with the manufacturers as
2222 well as in collaboration with the plan sponsors.
2223 Mr. Mullin. When a patient qualifies for you all's
2224 programs, how long do they typically stay on those Patient

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2225 Assistance Programs? Either one.

2226 Mr. Langa. It varies. It varies, really, by patient

2227 program. So they have renewal periods, but it could be 1 year,

2228 3 years.

2229 Mr. Mullin. Do you know what average the patient stays on

2230 the program?

2231 Mr. Langa. I'd have to get back to you on the average.

2232 I don't know what that is.

2233 Ms. Tregoning. I don't have that information.

2234 Mr. Mullin. Mason?

2235 Mr. Mason. Our separate foundation does that so we don't

2236 have that data.

2237 Mr. Mullin. Okay, I will yield back.

2238 Thank you so much for your time.

2239 Ms. DeGette. Thank you. The chair now recognizes the

2240 gentleman from New York, Congressman Tonko, 5 minutes.

2241 Mr. Tonko. Thank you, Madam Chairwoman.

2242 I would like to begin by asking our panel a number of simple

2243 yes or no questions. During our hearing last week, patient

2244 advocate Gail DeVore testified that against her doctor's orders

2245 she had rationed and diluted a bottle of insulin because she

2246 couldn't afford to pay the $346.99 it cost her per month. Are

2247 you aware of stories like Gail's, and we will start with you,

2248 Mr. Mason, and go across, but yes or no, are you aware?

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2249 Mr. Mason. Yes.

2250 Mr. Langa. Yes, we are.

2251 Ms. Tregoning. Yes, we're aware.

2252 Mr. Moriarty. Yes.

2253 Ms. Bricker. Yes.

2254 Dr. Dutta. Yes.

2255 Mr. Tonko. Have any of you personally ever had to ration
2256 a vial of insulin?

2257 Mr. Mason. I have not.

2258 Mr. Langa. I have not personally.

2259 Ms. Tregoning. No, I have not.

2260 Mr. Moriarty. I have not.

2261 Ms. Bricker. I have not.

2262 Dr. Dutta. No, and no one should.

2263 Mr. Tonko. Similarly, I hear stories from my constituents
2264 frequently about the struggle to afford lifesaving medications
2265 including having to make tough choices about putting food on the
2266 table or simply buying medication. Have any of you ever
2267 personally had to choose between feeding your family or buying
2268 a life-sustaining medication?

2269 Why don't we start with you, Dr. Dutta, and go the opposite
2270 way.

2271 Dr. Dutta. No, and no American should.

2272 Ms. Bricker. No, I have not.

2273 Mr. Moriarty. I have not.

2274 Ms. Tregoning. No, I have not and agree no one should.

2275 Mr. Langa. I have not and no one should.

2276 Mr. Mason. I have not and no one should.

2277 Mr. Tonko. In a broader sense, have any of you ever
2278 struggled to afford a medication that was recommended to you by
2279 your doctor?

2280 Mr. Mason. I have not.

2281 Mr. Langa. There once was a time when one of my children
2282 had to be on a growth hormone product and we were not able to
2283 get reimbursement. At that time, it was going to be several
2284 thousand dollars and that was going to be a challenge for us.
2285 So yes, there was a time in my life.

2286 Mr. Tonko. Thank you.

2287 Ms. Tregoning. I'm fortunate not to have faced that
2288 situation.

2289 Mr. Moriarty. I have not.

2290 Ms. Bricker. I have not personally, but yes, my family
2291 members have struggled.

2292 Dr. Dutta. No, I have not and no one should.

2293 Mr. Tonko. Well, I thank you for your candor. I want to
2294 be clear that I am not asking these questions as a gotcha moment,
2295 but as a reminder that we need to approach this issue with empathy
2296 and compassion. We never know what the person next to us might

2297 be going through. These stories we have all heard and are sharing
2298 today are from real people.
2299 Modern medicines like insulin save lives, but when we dangle
2300 these life-sustaining medications just out of reach from those
2301 who need them, we are engaging in a most cruel form of torture.
2302 According to Dr. Lipska's testimony last week, one in four
2303 individuals reported using less insulin than prescribed over the
2304 past year specifically because of cost. Let's put ourselves in
2305 their shoes for the day.
2306 We can get bogged down here in Washington with the blame
2307 game and talk about esoteric issues like rebates and list prices
2308 and Patient Assistance Programs, but the reality is that when
2309 I go this weekend back to my hometown to Amsterdam, New York,
2310 there will be people in my community that are in the hospital
2311 putting their lives at risk because they are so desperate for
2312 this medication that they are priced out of that they deliberately
2313 let their blood sugar crash just so they can get free samples
2314 of insulin on their way out of the door. Regardless of where
2315 you pin the blame, the system as it exists now is horrendously
2316 broken and the companies represented at the witness table are
2317 benefiting while patients across the country are losing. That
2318 is unacceptable and we need answers.
2319 So last week, in testimony before the committee we heard
2320 from the Endocrine Society that in 2017 expenditures for insulin

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2321 in the United States reached some $15 billion. They also told
2322 us that three of the top ten medication costs were for a type
2323 of insulin. Where is all this money going?
2324 And let's start with you, Mr. Mason.
2325 Mr. Mason. Our net prices are going down. Why we hear so
2326 much of why people can't afford their insulin today, it's those
2327 individuals in about half the high-deductible plans that don't
2328 benefit from the rebates and have high out-of-pocket costs because
2329 the rebates are being used to buy down the premiums.
2330 Mr. Tonko. Do those net prices need to go down further?
2331 Mr. Mason. Our net prices are going down.
2332 Mr. Tonko. No, you said they are, but do they need to go
2333 down further? In order for people to -- we hear about CEOs getting
2334 an increase in their salary and we -- tell us, well, the response
2335 is our net prices are going down. Do they need to go down further
2336 or do we need to take from the CEO?
2337 Mr. Mason. All I'm saying is our net prices are going down.
2338 The price that plans pay, payers pay to get insulin is going
2339 down, but those costs are not being used to help people who have
2340 diabetes in about half of the high-deductible plans. Those
2341 rebates are used in order to buy down premiums for the general
2342 population leaving those with chronic medications like insulin
2343 exposed to a deductible. That's what we're hearing. That's the
2344 point that we need to focus on solutions. That's the gap in the

2345 current system. The current system's not working. We agree a
2346 hundred percent. That is the heart of the issue.
2347 Mr. Tonko. Well, I see my time is up, I will yield back.
2348 But again a crisis that we need to resolve as soon as possible,
2349 quickly here. Thank you and I yield back.
2350 Ms. DeGette. The chair now recognizes the gentlelady from
2351 New York, Ms. Clarke, for 5 minutes.
2352 Ms. Clarke. Thank you very much, Madam Chair, and I thank
2353 our ranking member. This is a very important hearing today and
2354 I wanted to ask a couple of questions.
2355 We have heard a number of examples of the dramatic rise of
2356 insulin prices this afternoon and I am still not clear on the
2357 flow chart. You know, we have heard a whole lot of different
2358 things about net pricing, list pricing, and that net pricing is
2359 going down.
2360 Is that what you are saying, Mr. Mason? And, okay, now is
2361 that subject to ebbs and flows? In other words, if you are saying
2362 that price is going down as we sit here, is there a point where
2363 that price gets settled at a lower price or is there the
2364 possibility that it rises again? Is it like oil?
2365 MS. TREGONING: No, it's not like oil. I mean this has been
2366 pretty flat over the last 10 years. We can provide the, I think
2367 we provided the data as part of our written testimony.
2368 Ms. Clarke. Well, how is it then if they are going down

2369 over the past 10 years that it is still unaffordable? That is
2370 the flow chart that I am talking about. If you are going down
2371 -- first of all, it spiked for some strange reason, I guess the
2372 change in the system or the, you know, modernization of the system
2373 that included this rebate, you know, shenanigan, because that
2374 is what it is at the end of the day, if you have a 100-year-old
2375 product that increased in value because all of these other
2376 dynamics got involved and, you know, it is the same product.

2377 So can you give me a sense of what happens when you produce
2378 this product, what the cost is, and then how it gets to the point
2379 where the average American can't afford, who needs it, can't
2380 afford to access it? That is the crux of this for, I think, the
2381 listening public. Because we have talked about a lot of terms
2382 of art here, but Americans need to know how you got to where you
2383 are given what we know. Can you explain? Can you explain, or
2384 is there anyone on the panel that can explain it in layperson's
2385 terms?

2386 Ms. Tregoning. Congresswoman, first, the insulins of today
2387 are very different than the insulins of the past so I think that's
2388 also very important to keep in mind. That the insulins today
2389 --

2390 Ms. Clarke. We understand that. We understand that.

2391 Ms. Tregoning. In terms of the list versus net prices, the
2392 net prices have been going down steadily. We talked about our

2393 insulins. Our list price has gone down 25 percent over the last
2394 5 years, or since 2012, and that is expected to continue. The
2395 issue here is that the savings --
2396 Ms. Clarke. What precipitated that?
2397 Ms. Tregoning. It's additional competition and rebating
2398 --
2399 Ms. Clarke. Are you sure it wasn't the outcry of the public
2400 that could no longer afford it that are watering down their
2401 insulin?
2402 Ms. Tregoning. Unfortunately, Congresswoman, the lower net
2403 prices are not finding their way to patients, exactly to your
2404 point. That the rebates that exist in the system that gap between
2405 the list and the net prices is being used to subsidize other parts
2406 of the system. And so, unfortunately, patients --
2407 Ms. Clarke. So the system became far more complex over time.
2408 Is that what you are --
2409 Ms. Tregoning. I think the system became complex and
2410 rebates generated through negotiations with PBMs are being used
2411 to finance other parts of the healthcare system and not to lower
2412 prices to the patient.
2413 Ms. Clarke. If we extract rebates from the system, what
2414 happens?
2415 Ms. Tregoning. If we moved to a system of fixed fee, we
2416 support the rebate rule then we would be able to lower our list

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2417 prices, but we would need to ensure that the formulary position
2418 --
2419 Ms. Clarke. No, no, no. I just want to know if we removed
2420 the rebates.
2421 Ms. Bricker, I think you had --
2422 Ms. Bricker. If you remove the rebates, the discounts,
2423 there is no one that's advocating then for the patient and the
2424 plan sponsor to drive discounts and affordability. The rebates
2425 are discounts. They sound mysterious. It's just a discount and
2426 it's a volume discount.
2427 Ms. Clarke. Right.
2428 Ms. Bricker. And so PBMs serve a critical function in
2429 ensuring affordability. Are there people that slip through the
2430 cracks? Absolutely, and we're absolutely committed to figuring
2431 out how to serve each and every patient. But I would caution,
2432 doing away with rebates will only increase costs.
2433 Ms. Clarke. Okay.
2434 Ms. Tregoning. We support having rebates pass through to
2435 patients, pass through to the patients who use the drugs upon
2436 which the rebates have been negotiated. That's --
2437 Ms. Clarke. This is a circular issue, because you want that
2438 passed on to the patient.
2439 Mr. Langa. Yes.
2440 Ms. Clarke. So that you can continue to push up the price.

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2441 Ms. Tregoning. We don't receive list price. We receive
2442 the net price. We don't receive the list price.
2443 Ms. Clarke. You don't receive the list price.
2444 Ms. Tregoning. No. The price that is paid to manufacturers
2445 is ultimately the net price.
2446 Ms. Clarke. Right.
2447 Ms. Tregoning. So the rebates now are being used to offset
2448 other costs in the system. And what Sanofi would advocate for
2449 is ensuring that those rebates are provided to patients who are
2450 using the drugs upon which those rebates are negotiated to lower
2451 their out-of-pocket costs.
2452 Ms. Clarke. So are you saying that the PBMs' demand for
2453 increased rebates is the reason you are forced to keep raising
2454 your list prices?
2455 Ms. Tregoning. It is one component of how we consider and
2456 at Sanofi we have limited our list price increases. But one
2457 component of that decision making is the dynamics of the supply
2458 chain.
2459 Ms. Clarke. And what are the other components?
2460 Ms. Tregoning. The other components include the need to
2461 continue to invest in R&D and the competitive environment.
2462 Ms. Clarke. I yield back. I think it is more P&G. That
2463 is profit and greed. I yield back, Madam Chair.
2464 Ms. DeGette. The chair now recognizes the gentleman from

2465 Maryland, Mr. Sarbanes, for 5 minutes.

2466 Mr. Sarbanes. Thank you.

2467 Is the rebate, Ms. Bricker, is the rebate system transparent
2468 right now would you say?

2469 Ms. Bricker. The rebate system is 100 percent transparent
2470 to the plan sponsors and the customers that we service. To the
2471 people that hire us, employers of America, the government, health
2472 plans, what we negotiate for them is transparent to them.

2473 Mr. Sarbanes. So we can track the list price, then we can
2474 see the rebate, then we can see the net price, then we can see
2475 the savings that you pass along to the consumer. That is all
2476 completely transparent to the public?

2477 Ms. Bricker. It's not transparent to the public unless they
2478 are our patient.

2479 Mr. Sarbanes. Should it be?

2480 Ms. Bricker. We don't believe so.

2481 Mr. Sarbanes. Should it be trade secret, is that the
2482 problem, like proprietary --

2483 Ms. Bricker. The reason I'm able to get the discounts that
2484 I can from the manufacturer is because it's confidential.

2485 Mr. Sarbanes. It is a secret.

2486 Ms. Bricker. Because it's confidential.

2487 Mr. Sarbanes. Yeah, because it is a secret. What about
2488 if we made it completely transparent? Who would be for that?

2489 Ms. Tregoning. We would support transparency along the
2490 entire chain. That's the important thing is if we have
2491 transparency all along from the list price all the way through
2492 to patients.
2493 Mr. Sarbanes. Do you all support that?
2494 Ms. Bricker. Absolutely not, but --
2495 Mr. Sarbanes. No, you can't, because then it will end up
2496 hurting the consumer.
2497 Ms. Bricker. It will hurt the consumer.
2498 Mr. Sarbanes. Yeah, it will hurt the consumer to have
2499 transparency, you know?
2500 Ms. Bricker. It will hurt the consumer, Congressman,
2501 because --
2502 Mr. Sarbanes. I don't buy it.
2503 Ms. Bricker. -- prices will be held high.
2504 Mr. Sarbanes. I am not buying it. I think a system has
2505 been built that allows for gaming to go on and you have all got
2506 your talking points.
2507 Ms. Tregoning, you have said you want to guarantee patient
2508 access and affordability at least ten times, which is great, but
2509 there is a collaboration going on here. I know there is this
2510 going on too, but the system is working for both of you at the
2511 expense of the patient.
2512 Now I reserve most of my frustration for the moment in this

2513 setting for the PBMs, because I think the lack of transparency
2514 is allowing for a lot of manipulation. I think the rebate system
2515 is totally screwed up, that without transparency there is
2516 opportunity for a lot of hocus-pocus to go on with the rebates.
2517 Because the list price ends up being unreal in certain ways except
2518 to the extent that it leaves certain patients holding the bag,
2519 then the rebate is negotiated, but we don't know exactly what
2520 happens when the rebate is exchanged in terms of who ultimately
2521 benefits from that.

2522 And I think we need more transparency and I do not buy the
2523 argument that the patient is going to be worse off, the consumer
2524 is going to be worse off if we have absolute transparency. I
2525 think just to get the lobbyists in the room to shudder a little
2526 bit, I think the PBMs should be utilities or converted to
2527 nonprofits or something. I know when you started out, I
2528 understand what the mission was originally with the PBMs. It
2529 is a complicated industry. You need an intermediary to assemble
2530 all the information on both sides, to weigh in, to assemble the
2531 bargaining position so that you can get the best price, and in
2532 the early days that was a good argument.

2533 But now things have gotten out of control. You are too big
2534 and the lack of transparency allows you to manipulate the system
2535 at the expense of the patient. So I don't buy the argument that
2536 the patient and consumer is going to get hurt if we have absolute

2537 transparency. And if we can't get it from a for-profit entity
2538 like the PBM, then we ought to look at other ways of doing it,
2539 including having the government get into this space and compete
2540 in providing that important function. And with that I will yield
2541 back my time.
2542 Ms. DeGette. The chair now recognizes the gentlelady from
2543 Illinois, Ms. Schakowsky, for 5 minutes.
2544 Ms. Schakowsky. Thank you, Madam Chair, for holding this
2545 hearing.
2546 I don't know if I have any questions at all, but I want to
2547 tell you something. In the 2018 election, the number one concern
2548 of Americans, the high cost of prescription drugs. We have the
2549 names of people who have died because they couldn't get their
2550 insulin. A young man who was trying to control it himself after
2551 going off his parents' policy, dead. We know that a huge number
2552 of people are not taking the insulin that they need because they
2553 can't afford it. So then they get sick, they get sicker, and
2554 maybe they die because of it. I don't know how you people sleep
2555 at night.
2556 Between 1996 and now, when you have Eli Lilly from $21 a
2557 bottle to $275, you heard Mr. McKinley -- am I saying that right
2558 -- who went through all that, interesting by the way. So for
2559 Eli Lilly it is now 275. For Sanofi it is $270. For Novo Nordisk
2560 it is $280. Curiously close in price and way too high. I want

2561 to tell you something. That will not stand in this Congress.
2562 I heard Ms. Brooks say the system is broken and I think on both
2563 sides of the aisle there is a commitment. And we have even heard
2564 the President of the United States talk about price gouging.
2565 Yes, we need transparency. I have a strong transparency bill
2566 that is going to hold you guys accountable and make you notify
2567 how you justify raising those prices. You talked about
2568 another -- Mr. Langa, you talked about another drug that you are
2569 developing and that somehow that is an excuse because it helps
2570 diabetics and that is the research and development that you do.
2571 You are in trouble. And the lobbyists out here, or maybe that
2572 is you, need to understand that this is a commitment on the part
2573 of the Congress to get drug prices, particularly lifesaving, life
2574 necessities, to get those prices under control. And if you think
2575 you can, you know, just out-talk us without any transparency,
2576 without any accountability, I just want you to know your days
2577 are numbered.
2578 You know, when Mr. Azar became the Secretary of Health and
2579 Human Services, I wanted to remind him that he came from Eli Lilly
2580 at the very time that those insulin prices went through the roof,
2581 and we are seeing that on drugs that have been like yours on the
2582 market for decades. And if you want to try and explain -- I
2583 totally agree, isn't that a good thing that now people may be
2584 able to take one vial and not have to shoot up all the time because,

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2585 you know, and the delivery system. But we had no clue if that
2586 means that you can raise those prices a thousand percent.
2587 And you think you can get away with that kind of secrecy
2588 or just blaming the PBMs. I am not holding them unaccountable
2589 here, we need to do that. But don't excuse yourselves from this
2590 and don't tell us about the wonderful charity prices that you
2591 give and then you do get tax breaks, I am assuming -- contradict
2592 me if I am wrong -- when you give charity care to people. I believe
2593 that that is a tax-deductible kind of item for you, I am not hearing
2594 anybody contradict that. I resent that very much, because then
2595 everybody else is still paying those very, very high prices.
2596 So just know something is going to happen here if you don't
2597 decide in your own interests to lower those prices so people don't
2598 have to die. And I yield back.
2599 Ms. DeGette. The gentlelady yields back. The gentleman
2600 from California, Mr. Peters, is recognized for 5 minutes.
2601 Mr. Peters. Thanks. I have heard a lot of this discussion
2602 and it has been very edifying for me. And actually, I don't want
2603 to blame you for a system that we have set up here that encourages
2604 these bizarre incentives. The fact is that it is a system that
2605 incentivizes people to charge higher list prices so they can give
2606 rebates that give them access to customers.
2607 And, you know, I am pretty much a believer in markets.
2608 Someone called this a free market. This is really not. I don't

2609 think that we should suggest that this is the kind of competition
2610 that is going to take care of our problems. What we have here
2611 is what economists call a "market failure" at best. That is when
2612 it is appropriate for government to take action in a capitalist
2613 system. I think most people agree with that and I think that
2614 is what we are going to see.
2615 We are going to have to take out the incentive, this crazy
2616 incentive to charge higher prices so that you can get the customers
2617 and no one knows what the real prices are. I mean it is impossible
2618 for us to understand, you know, we have access to all this
2619 information, this is a really, really opaque system and so we
2620 are going to have to change that.
2621 So I appreciate the input. I don't ever suggest that
2622 companies aren't going to make money when they are allowed to
2623 do it. I just think that this is a perverse system that has to
2624 be changed so that if we want competition, we get real competition.
2625 But this system of rebates is really encouraging an
2626 anti-competitive behavior.
2627 Also, I know that -- I will just express a concern and this
2628 is in the courts. But, you know, now we have companies owning
2629 PBMs and plans without any assurance of the relationship between
2630 the sister companies, the PBM and the plan. Again, I think there
2631 is a real risk of anti-competitive behavior.
2632 So I mean I think you have come here and done the best job

2633 you can answering these questions. It is a system that no one
2634 should have to apologize for, but it is a system that we are going
2635 to have to change here in Congress and I think that is what you
2636 will see going forward. So I yield back.
2637 Ms. DeGette. The gentleman yields back.
2638 We now have several members who are not on this subcommittee
2639 but who have been gracious enough to be here for most of all of
2640 the hearing and I appreciate their attendance and input. So I
2641 would like to first recognize Congressman Bucshon for 5 minutes.
2642 Mr. Bucshon. Thank you, Madam Chairwoman.
2643 I was a physician before I was in Congress, so these types
2644 of issues are extremely important to me. For me it is all about
2645 people and taking care of people, making sure especially when
2646 it is a life-sustaining drug. And I appreciate all of your input.
2647 It is a system that needs changed.
2648 And, you know, we did a hearing last Congress and we had
2649 eight stakeholders in the entire supply chain and we pretty much
2650 got this, you know, the whole time, and I get that. I am not
2651 blaming anybody. I am just saying I think it is just, we have
2652 developed a system over time that is going to need changed. And
2653 I am going to have questions for both the PBMs and the companies.
2654 And, Dr., is it Dutta, yeah, I understand that
2655 representatives from your company testified in front of the Senate
2656 Finance Committee yesterday. My understanding is that your

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2657 company was asked questions about contracting practices and
2658 relationships with manufacturers. I would like to just follow
2659 up on those and then Ms. Bricker and Mr. Moriarty can comment
2660 also.

2661 Can you talk about the following: Has your company ever
2662 proposed in contract or otherwise demanded that manufacturers
2663 give advance notice of list price decrease? And remind you,
2664 everybody, we are all under oath here, so, and we have access
2665 to information potentially that could counteract a questioned
2666 answer that isn't accurate.

2667 Dr. Dutta. Yes.

2668 Mr. Bucshon. Okay. And then the manufacturers pay a higher
2669 fee, a rebate, if list prices do not increase above a certain
2670 percentage in that contract year? So, for example, if they don't
2671 increase their list price above a certain percent that they may
2672 have to pay a higher fee or rebate for that drug?

2673 Dr. Dutta. I'm not aware of that.

2674 Mr. Bucshon. Okay. And that manufacturers pay a certain
2675 rebate amount even if they decrease their list price?

2676 Dr. Dutta. I'm not --

2677 Mr. Bucshon. My point is if you have a list price here and
2678 the company says, "We are going to go down to here," and the rebate
2679 was based on the higher list price, does that amount stay the
2680 same?

2681 Dr. Dutta. I'm not aware of that.

2682 Mr. Bucshon. Okay.

2683 Same questions, Ms. Bricker, is do you have contractual or
2684 otherwise demanded that manufacturers give advance notice of list
2685 price decrease?

2686 Ms. Bricker. No, we welcome lower list prices.

2687 Mr. Bucshon. Okay, great. And that manufacturers pay a
2688 higher fee or rebate if list prices do not increase above a certain
2689 percentage in that contract year?

2690 Ms. Bricker. No.

2691 Mr. Bucshon. Okay. And the manufacturers pay a certain
2692 rebate even if they decrease their list?

2693 Ms. Bricker. No.

2694 Mr. Bucshon. Okay. We hear that they do.

2695 But, Mr. Moriarty, same thing, I mean do you have contractual
2696 relationships that otherwise demand that the manufacturers give
2697 you advance notice of decrease in the list?

2698 Mr. Moriarty. No.

2699 Mr. Bucshon. Okay, great. The manufacturers pay a higher
2700 fee or rebate if list prices do not increase above a certain
2701 percentage in a contract year?

2702 Mr. Moriarty. No.

2703 Mr. Bucshon. Okay, great. And the manufacturers pay a
2704 certain rebate amount even if they decrease the list?

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2705 Mr. Moriarty. No.

2706 Mr. Bucshon. Okay.

2707 Mr. Moriarty. We are all about net price.

2708 Mr. Bucshon. Understood.

2709 I am going to focus on the 340B program real quickly. I
2710 have been an advocate for reforming that program. Information
2711 that Novo Nordisk provided to the committee indicated that many
2712 of Novo Nordisk's insulin products are at penny pricing in the
2713 340B program. Moreover, information Novo Nordisk provided the
2714 committee showed that for one of these insulin products at penny
2715 pricing the number of packages provided to 340B entities increased
2716 from just over 270,000 packages in 2014 to over 735,000 packages
2717 in 2018. That is more than 172 percent increase in the number
2718 of packages supplied to 340B entities. And many of the Novo
2719 Nordisk other insulin products also saw a significant increase
2720 in the number of packages sold in the 340B program during this
2721 period.

2722 Can you explain the impact that the 340B program has had
2723 on Novo Nordisk's pricing in the private and commercial markets?

2724 Mr. Langa. We have over 18,000 facilities, I believe, at
2725 this point roughly and it is at penny pricing. So it's literally
2726 99.9 percent and the packaging is, I believe, as you reference
2727 it so, and has been going up. Is the question its influence on
2728 the commercial market?

2729 Mr. Bucshon. Yeah, I mean because of that, because of its
2730 penny pricing and the volume has gone up dramatically, has that
2731 had an effect on the overall pricing structure in the rest of
2732 the marketplace, essentially?
2733 Mr. Langa. I think the challenge has been the 340B entities
2734 and who actually gets the designation and not. And I think that's
2735 been more of the complexity and the challenge than it has been
2736 the spillover.
2737 Mr. Bucshon. Okay.
2738 Mr. Mason, same thing. I mean 340B has dramatically
2739 expanded as we all know, right?
2740 Mr. Mason. And a similar question, I mean obviously it does
2741 take away our net sales. If those are legitimately helping, you
2742 know, individuals that need that help we're fine that our product
2743 is going --
2744 Mr. Bucshon. I understand that. I mean, but, and quickly.
2745 I am out of time.
2746 Ms. Tregoning. Yes. I think the issue is the heavily
2747 discounted products that go into the 340B system, but are those
2748 heavily discounted prices making their way to patients.
2749 Mr. Bucshon. Yeah. I am going to just quickly say, with
2750 your indulgence, Madam Chairwoman, that in the 340B program I
2751 firmly believe based on this subcommittee's report that was
2752 released last Congress that we need to seriously look at and reform

2753 the 340B program so that it continues to exist for the hospitals
2754 and patients that need it, but add a degree of transparency because
2755 it is spiraling.

2756 Thank you, I yield back.

2757 Ms. DeGette. I thank the gentleman. The chair now
2758 recognizes the very, very patient woman from California, Ms.
2759 Barragan, for 5 minutes.

2760 Ms. Barragan. Thank you very much.

2761 You know, I am sitting here and I have been hearing this
2762 back-and-forth for the last couple of hours, and the way I think
2763 I would summarize this is it sounds like we are playing a
2764 middleman. It just sounds like we are playing a middleman for
2765 prescription drugs to be on a preferred list. And that is not
2766 just to put all the blame here, but then these list prices have
2767 just been skyrocketing and then when we ask about pricing what
2768 we are hearing back from the drug companies is, well, the net
2769 price is actually declining. Last time I checked I think Lilly
2770 was doing pretty good. Wouldn't you say so, Mr. Mason? Why
2771 don't you tell me what the revenue was for this coming year?
2772 What is Lilly's revenue this coming year?

2773 Mr. Mason. $21 billion.

2774 Ms. Barragan. Okay, I saw $25.3 billion for the coming year.
2775 Your CEO in 2014 was making 14.5 million in a pay package. That
2776 was in 2014. The new CEO, 2018, is making $17.2 million in a

2777 pay package. You guys are doing okay. I would think so. The
2778 American people sees that and they say, "W4why can't we just get
2779 pricing for insulin, a lifesaving drug that we need? Not that
2780 we want, but that we need?" And they say Congress has to do
2781 something.

2782 And when you see what, when you hear what is happening here
2783 today that is exactly what is going to have to happen. I don't
2784 see anything happening here. I mean, look, I represent a
2785 congressional district that is a majority minority. People of
2786 color are disproportionately impacted by diabetes, Latinos,
2787 African Americans. I happen to represent a district that
2788 includes Compton and Watts, very low-income, working class
2789 families who are struggling. And my report says there is over
2790 80,000 uninsured there, a lot of people who probably can't afford
2791 to pay for their insulin.

2792 And do you all recognize that your pricing policies and your,
2793 this system is causing people to die every day? Do you all
2794 recognize that? Mr. Mason, do you recognize that? Let me just
2795 go down the list here, yes or no, do you all recognize this?

2796 Mr. Mason. We don't want anyone not to be able to provide
2797 their insulin. We --

2798 Ms. Barragan. I understand that. But do you recognize that
2799 this pricing system and model is causing people to die?

2800 Mr. Mason. We need to do something about it collectively.

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2801 Ms. Barragan. Okay, that is a yes.

2802 Mr. Langa?

2803 Mr. Langa. We recognize the model is certainly a challenge,

2804 yes.

2805 Ms. Barragan. And you are playing a role in that model.

2806 Let's not mince any words here, is these companies and the PBMs

2807 are playing a role in this model and that is why we are having

2808 this hearing is because we are trying to get to the bottom of

2809 it.

2810 Ms. --

2811 Ms. Tregoning. Tregoning.

2812 Ms. Barragan. -- Tregoning.

2813 Ms. Tregoning. Yes, we recognize that's happening and

2814 that's why we put in place the programs, to address the

2815 inadequacies of the current system so that that doesn't happen,

2816 so people aren't forced into rationing their insulin. We don't

2817 want to see that.

2818 Ms. Barragan. Mr. Moriarty?

2819 Mr. Moriarty. There's no question there's a portion of the

2820 population where this needs to be addressed very directly, no

2821 question.

2822 Ms. Barragan. Ms. Bricker?

2823 Ms. Bricker. Absolutely there are patients falling through

2824 the cracks. We exist only to make medication more affordable

2825 and --

2826 Ms. Barragan. Okay. I am not obviously going to get you
2827 to tell me that you are a part, because I mean and the reality
2828 is what we heard today that that is what is happening here. You
2829 know, I wish that you all would just come together and collaborate.

2830 A moment ago, Ms. Bricker, I believe you are the one who
2831 said that the way you were able to get the $25 plan and the deal
2832 that you were able to get for the insulin, the new program that
2833 you just rolled out, was that you collaborated together, that
2834 you worked together. So if you could do it there, how come you
2835 all can't do it for others, right? And so, this is where Congress
2836 has to step in and do something. It is because of profits. It
2837 is because of greed. The American people are tired. And when
2838 people die, when people die and that is what is happening, make
2839 no mistake about it, we hear about it. The country hears about
2840 it and it is outrageous. It is completely outrageous.

2841 I want to end on just a quick on the Medicare Part D. You
2842 know, in 2018, more than 43 million seniors enrolled in Part D
2843 plans. Currently, the government is prohibited from negotiating
2844 directly with the drug manufacturers on behalf of Medicare Part
2845 D enrollees. If this prohibition were lifted the government
2846 would be able to provide the leverage needed to bring down
2847 prescription drug pricing.

2848 On a yes or no real quick because I only have 10 seconds,

2849 starting on the end, yes or no, do you support Medicare being
2850 able to negotiate drug prices under Part D?
2851 Mr. Mason. Prices are getting better in Part D --
2852 Ms. Barragan. Yes or no, would you support negotiating drug
2853 prices under Medicare Part D?
2854 Mr. Mason. Just don't think they're needed.
2855 Ms. Barragan. Okay.
2856 Mr. Langa. I think everything we would consider if it helped
2857 the patient.
2858 Ms. Barragan. So that is a yes?
2859 Mr. Langa. I think we'd consider everything. I think the
2860 fair market, the free market that's playing right now is working
2861 because we have some of the heaviest discounts in Part D.
2862 Ms. Barragan. It is not working because people are dying
2863 and they can't afford it.
2864 But next?
2865 Ms. Tregoning. The PBMs are very effective negotiators.
2866 The question is what do we do with the results of those
2867 negotiations.
2868 Ms. Barragan. So you don't have an answer on whether you
2869 support Medicare being able to negotiate drug prices under Part
2870 D?
2871 Ms. Tregoning. Don't support direct negotiation because
2872 the PBMs are effective negotiators.

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2873 Ms. Barragan. You do not. Okay, you do not. Okay.

2874 Mr. Moriarty. We do not. We drive very effective

2875 discounting.

2876 Ms. Barragan. Okay.

2877 Okay, Ms. Bricker?

2878 Ms. Bricker. Similarly, yes. The government --

2879 Ms. Barragan. You do not?

2880 Ms. Bricker. Do not support.

2881 Ms. Barragan. Okay.

2882 Mr. Dutta?

2883 Dr. Dutta. We do not.

2884 Ms. Barragan. Okay. I can understand why that might be

2885 the case. It is unfortunate, but my time is up. I yield back.

2886 Ms. DeGette. Thank you. I thank the gentlelady.

2887 Now pleased to recognize the gentleman from Georgia, Mr.

2888 Carter, for 5 minutes.

2889 Mr. Carter. Thank you, Madam Chair, and thank you for

2890 allowing me to participate in this.

2891 Ladies and gentlemen, thank you for being here today. Just

2892 a full disclosure, currently I am the only pharmacist serving

2893 in Congress. I practiced pharmacy, community pharmacy,

2894 independent community pharmacy for over 30 years. You know, I

2895 remember and just FYI, I started when I was 10. But I can

2896 remember that -- I can remember when PBMs evolved. I can remember

2897 when PSC was nothing more than a processor. That is all they
2898 did was process claims before PBMs got involved in setting up
2899 formularies. And I can remember ordering directly from drug
2900 companies and not going through a wholesaler or anyone, just
2901 getting a shipment every week, a delivery every week from Eli
2902 Lilly or any other of the companies, Upjohn, or any of the number
2903 of companies that we ordered from.
2904 You know, my colleague, Mr. Tonko, mentioned earlier about
2905 patients having to make choices between eating and between paying
2906 for their medications. I have seen it firsthand. I have
2907 witnessed it firsthand.
2908 Ms. Bricker, you said you were a pharmacist and practiced
2909 in community forums. I don't know what your experiences were.
2910 You are obviously a lot younger than me, but at the same time
2911 I can tell you I have seen it. I have seen patients at the counter
2912 having to make a decision between buying medicine and between
2913 buying groceries. I have seen mothers in tears because they
2914 couldn't afford their medications. I have witnessed it
2915 firsthand. I was the boots on the ground there. That is why
2916 I am so passionate about that.
2917 I wanted to start with you, Mr. Langa. During a briefing
2918 with committee staff, I don't know if it was you or a member or
2919 a representative of your company, but they said that list prices
2920 started to increase more rapidly around the same time that there

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2921 started to be more consolidation throughout the drug pricing
2922 supply chain and that there have been increasing demands on
2923 rebates. Has consolidation impacted the list price of
2924 medications?
2925 Mr. Langa. I think it was a factor. I think that as the
2926 PBMs today, as I mentioned the three here today represent almost
2927 220 million covered lives or 80 percent of the lives, so.
2928 Mr. Carter. And that is probably, the three here today I
2929 believe represent over 70, between 70 and 80 percent of all the
2930 PBMs in America.
2931 Mr. Langa. Correct. And so I think that as the
2932 consolidation that purchasing power got bigger, the rebate
2933 challenges got heavier.
2934 Mr. Carter. Absolutely.
2935 And, Mr. Mason, would you agree with that? And in fact,
2936 I believe that you responded to a letter and said the same thing.
2937 Mr. Mason. Yes.
2938 Mr. Carter. Okay.
2939 I would like to ask you, Mr. Moriarty, you are with CVS
2940 Health. CVS is a drugstore, right?
2941 Mr. Moriarty. That's correct.
2942 Mr. Carter. And then Caremark is the PBM.
2943 Mr. Moriarty. That's correct.
2944 Mr. Carter. And that is owned by CVS, the same company?

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2945 Mr. Moriarty. That's correct.

2946 Mr. Carter. And then Aetna Insurance is the same company?

2947 Mr. Moriarty. That's correct.

2948 Mr. Carter. Okay, so we got Aetna the insurance company,
2949 we got Caremark the PBM, and we got CVS the drugstore, all the
2950 same company, right?

2951 Mr. Moriarty. That's correct.

2952 Mr. Carter. Okay.

2953 Ms. Bricker, I believe that Express Scripts, you are here
2954 today representing the PBM?

2955 Ms. Bricker. Yes, I am.

2956 Mr. Carter. And you are also -- you just bought out CIGNA
2957 Insurance. That is right?

2958 Ms. Bricker. CIGNA acquired Express Scripts.

2959 Mr. Carter. CIGNA acquired Express Scripts. And you also
2960 have your own mail-order pharmacy; is that correct?

2961 Ms. Bricker. We do have a mail-order pharmacy.

2962 Mr. Carter. Okay.

2963 And, Dr. Dutta, same thing with you. Optum is the PBM,
2964 United Healthcare is the insurance company, and you also have
2965 your own mail-order pharmacy; is that correct?

2966 Dr. Dutta. So Optum and United Healthcare are sister
2967 companies, yes.

2968 Mr. Carter. And you do have a mail-order pharmacy that you

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2969 own as well?

2970 Dr. Dutta. OptumRx has a mail-order pharmacy.

2971 Mr. Carter. Yes. Okay, that is a long yes answer.

2972 Nevertheless, when you have been saying during these

2973 hearings that you are returning money to the plan sponsors, can

2974 you define plan sponsors for me? Is that the insurance companies?

2975 Mr. Moriarty?

2976 Mr. Moriarty. It is the employers, state and federal --

2977 Mr. Carter. The insurance, are you sending the money back

2978 to the insurance company?

2979 Mr. Moriarty. As well as health plans, but it's much more

2980 than just health plans. Yes, sir.

2981 Mr. Carter. You are sending it back to -- and, Ms. Bricker,

2982 you are sending it back to the insurance companies?

2983 Ms. Bricker. So we send back to the clients that hire us.

2984 Those are employers --

2985 Mr. Carter. At the end do you send it back to the insurance

2986 -- please remember you are under oath here. Let's get on. Do

2987 you send it back to the insurance companies?

2988 Ms. Bricker. In the event that the plan sponsor is an

2989 insurance company, yes.

2990 Mr. Carter. Right.

2991 Ms. Bricker. But that's not the only --

2992 Mr. Carter. Okay.

2993 And, Dr. Dutta, same thing with you?

2994 Dr. Dutta. In the event that the plan sponsor is the
2995 insurance --

2996 Mr. Carter. Okay, same thing. So essentially you are the
2997 PBM managing money and you are sending the money back to another
2998 company that you own. In some cases that could be the case; isn't
2999 that right, Dr. Dutta?

3000 Dr. Dutta. So we have many health plans that --

3001 Mr. Carter. I understand that. But it is possible you
3002 could be sending it back to the -- owned by the same company.
3003 So this vertical integration that we are talking about here that
3004 I have been on the FTC and the Department of Justice about, that
3005 is something that certainly we need to be aware of.

3006 Boy, 5 minutes flies, let me tell you. But before I
3007 relinquish my time, I want to congratulate all of you because
3008 you have done something here today that we have been trying to
3009 do in Congress ever since the 4 years and 3 months that I have
3010 been here and that is to create bipartisanship, because what you
3011 have witnessed here today is bipartisanship.

3012 This is going to end. I have witnessed it. I have seen
3013 what you have done with the PBMs. I have seen what you have done
3014 with DIR fees. I see what you are trying to do now with GER fees
3015 and BER fees. And let me tell you, what the CMS is proposing
3016 in the way of doing away with DIR fees and the way of having

3017 discounts at the point of sale, that is going to happen. We are
3018 going to make sure that happens and that is going to bring more
3019 transparency to the system and we are not going to stop there.
3020 Thank you, Madam Chair, and I yield back.
3021 Ms. DeGette. Thank you, Mr. Carter. I was just saying I
3022 never thought I would see the day when Buddy Carter was channeling
3023 Jan Schakowsky. Congratulations.
3024 I now want to recognize Mr. Guthrie for closing questions
3025 and a statement.
3026 Mr. Guthrie. I just want to close and when the chair and
3027 I were discussing having the hearing we thought insulin was a
3028 proper one to have. One, I know it is different than 100 years
3029 ago today. But we had a lady before, a doctor, physician from
3030 Yale that said that there was -- held up an insulin and said this
3031 is the same insulin from the 1990s as it is today and the price
3032 has moved forward.
3033 And we wanted to because we wanted to look at the entire
3034 system, but we thought if we looked at one drug that affects almost
3035 -- like I said, I have two nieces with diabetes -- it affects
3036 almost every family, that we could look at what is going on and
3037 then we could extrapolate to bigger.
3038 And I will tell you, and you were talking about Ms.
3039 Schakowsky, my friend Ms. Schakowsky from Illinois, she also
3040 talked about President Trump in saying that this is important

3041 to him. And my experience with him in meeting with him is that
3042 drug pricing is important to him, so it is everybody. It is
3043 uniting everyone.
3044 And I am going to be quick. I know 5 minutes went fast
3045 before, I didn't get all my questions. I am not going to ask
3046 a question because that is not what I have been recognized for.
3047 But innovation is important. I saw a film yesterday of a father
3048 talking about his daughter, I don't know if "cured" is the right
3049 word, but not having any symptoms from sickle cell. I mean it
3050 is just -- Hepatitis C, you can take with, and you talk about
3051 medical devices. You can do the artificial pancreases here.
3052 So innovation and having a market-based system and a free
3053 enterprise system is absolutely important and -- but what we are
3054 trying to get at with this is, and hopefully you can see our
3055 frustration, is that we see the pharmaceutical companies say,
3056 "Our net price is going down." We see the list price going up.
3057 And I have friends here from Bardstown that are in the Buddy
3058 Carter situation, are community pharmacists, and they see, have
3059 described to me situations that he just described and they have
3060 to pay the list price to sell to somebody who is not through the
3061 -- when they sell, so it is a cash flow to those kind of businesses.
3062 And what we are trying to figure out is if the net price
3063 is the net price, then why isn't that what is paid to the -- if
3064 the idea is we are going to get the lowest price for our insurance

3065 companies, then why isn't selling something for $135 that is
3066 costing them $135 better than selling something 300 or $400 and
3067 getting 300 or 400 back, other than saying I saved you that money?
3068 Just trying to figure out where the money is going and so this
3069 has been informative.

3070 I think one question I wanted to ask that I am going to do
3071 for the record is, so what you put on the formulary, is it better
3072 for a high list price with a lower net or that is better for the
3073 insurance company, but it is not as good for a -- if it is just
3074 a lower net price or just lower list price, it is actually lower
3075 for the consumer going to the counter at the pharmacy?

3076 So this is just hopefully the beginning of a series of
3077 hearings and it has been informative. And we do appreciate you
3078 willing to come here and your testimony and trying to inform us
3079 because we do have to make some decisions. And we don't want
3080 unintended consequences because you could get into -- if you get
3081 into price controls you get into rationing and you get into
3082 shortages and that is not where we want to -- that is not where
3083 I want to go. We want people to have a fair price that they can
3084 pay and if they can't pay to have the assistance to have that
3085 because it is lifesaving.

3086 So thank you for your indulgence and I yield back.

3087 Ms. DeGette. I thank the ranking member. And I do want
3088 to thank the witnesses. I know people asked you hard questions.

3089 It was important to us to get everybody in here, and I think
3090 we can all agree that the system is broken and it has grown up
3091 in a way over time that people didn't anticipate. But here is
3092 the thing. The people who are suffering are the patients. And
3093 in the case of insulin, the people who are suffering are people
3094 who need insulin every second of every minute of every day or
3095 they will die. And that is the issue that we have here.
3096 And I now, having done this investigation last year with
3097 my colleague from New York, Tom Reed, and now doing this
3098 investigation, I think I have a pretty good grip and I think the
3099 members of this committee are getting a better and better grip
3100 of what is going on. And what is going on is the system has grown
3101 up in this country where we are continually -- it is a
3102 smoke-and-mirror system where we are continually increasing the
3103 list price of insulin in order to try to do negotiations to somehow
3104 get the price of insulin down.
3105 But let's look at the reality of the situation. The members
3106 of this panel kept saying over and over again net prices of insulin
3107 have gone down and one person even said that nobody pays list
3108 price, they all pay net price. But that is not exactly true.
3109 So I just want to give you the example of Humalog, because
3110 Humalog is one of those insulins, it is not 100 years old, but
3111 it is over 20 years old and in 2001, Humalog cost $35 a vial.
3112 Today, no change to Humalog -- it is not Tresiba, which by the

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3113 way Tresiba is not an insulin, it is another drug to help
3114 absorption of insulin that is given to type 2 diabetics -- so
3115 Humalog, it is still the same formulary. It is $275 today for
3116 a bottle of the same insulin that I bought for Francesca when
3117 she was 6 years old. And the generic Humalog that Lilly has come
3118 up with, good news, it is only $137 a bottle. So it is still
3119 way beyond where it was in 2001.
3120 Well, now Sanofi has a new generic alternative, Admelog.
3121 I just sat here and looked and Admelog, it might not cost as
3122 much as Humalog, but it costs over $200 a bottle. So let's not
3123 kid ourselves that the generic equivalent of this is really any
3124 cheaper for that young woman in my district who doesn't have
3125 insurance who is desperately trying to find two bottles of insulin
3126 every month. That is $400 for her even if she bought that.
3127 So when you say nobody is paying list price, there are people
3128 paying list price. And the people who are paying list price are
3129 the people who have high-deductible plans who have to pay for
3130 the list price when they go in to the pharmacy and they are on
3131 their deductible, the people who are in the doughnut hole of
3132 Medicare Part D, and the people who are uninsured.
3133 And I know all of the, everybody here, the PBMs and the
3134 pharmaceutical companies all have these efforts to give cheaper
3135 insulin to people like this, but I am going to tell you, the lady
3136 I talked to in Denver, she didn't know how to get that insulin.

3137 She had no idea how to get it. And our witnesses last week said
3138 many people in that situation don't. It is not a solution to
3139 the problem, it is just a temporary Band-Aid and it is one that
3140 we have to stop with a wholesale innovation.

3141 And let me just say, finally, this. It is not like the
3142 pharmaceutical companies or anybody else in the system is doing
3143 this for a public interest reason. The pharmaceutical companies
3144 had $323 billion in profits last year. The PBMs had $23 billion
3145 in profits last year. And so everybody is making a profit and
3146 the people who are really suffering here are the people who either
3147 have to pay list price or even after their deductible have to
3148 pay an unacceptable price and nobody here in this room wants that.

3149 So what we are going to do, we are going to get together
3150 in a bipartisan way and we are going to work with all of you,
3151 plus everybody else in the distribution center, to figure out
3152 how we can provide insulin to diabetics at a cost that they can
3153 afford and we are going to do that as quickly as we can.

3154 So as you heard we are having an ongoing investigation here.
3155 We are prepared to talk to you now and we are prepared to bring
3156 you all back in July or in September to talk about the progress
3157 that we have made, because this is not optional and it is going
3158 to happen. So I want to thank you all again for coming today
3159 and we are not going to have any more testimony, but I really
3160 want to thank you for coming and I want to thank you for being

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3161 part of the solution and not a continuing part of the problem.

3162 And in closing, I will remind members that pursuant to

3163 committee rules they have 10 business days to submit additional

3164 questions for the record to be answered by witnesses who have

3165 appeared before the subcommittee. I ask that the witnesses agree

3166 to respond promptly to any such question should you receive any,

3167 and with that the subcommittee is adjourned.

3168 [Whereupon, at 2:37 p.m., the subcommittee was adjourned.]