

**Hearing on Investing in the U.S. Health system by
lowering drug prices, reducing out-of-pocket costs,
and improving Medicare benefits**

HEARING
BEFORE THE
COMMITTEE ON WAYS AND MEANS
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HOUSE COMMITTEE ON WAYS & MEANS
CHAIRMAN RICHARD E. NEAL

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

FOR IMMEDIATE RELEASE
October 10, 2019
No. FC-17

CONTACT: (202) 225-3625

Chairman Neal Announces a Hearing on Investing in the U.S. Health system by lowering drug prices, reducing out-of-pocket costs, and improving Medicare benefits

House Ways and Means Chairman Richard E. Neal announced today that the Committee will hold a hearing entitled “Investing in the U.S. Health system by lowering drug prices, reducing out-of-pocket costs, and improving Medicare benefits” on Thursday, October 17, 2019, at 10:00 AM in room 1100 Longworth House Office Building.

In view of the limited time available to hear witnesses, oral testimony at this hearing will be from invited witnesses only. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit written comments for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, <http://waysandmeans.house.gov>, select “Hearings.” Select the hearing for which you would like to make a submission, and click on the link entitled, “Click here to provide a submission for the record.” Once you have followed the online instructions, submit all requested information. ATTACH your submission as a Word document, in compliance with the formatting requirements listed below, **by the close of business on Thursday, October 31, 2019**. For questions, or if you encounter technical problems, please call (202) 225-3625.

FORMATTING REQUIREMENTS:

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission but reserves the right to format it according to guidelines. Any submission provided to the Committee by a witness, any materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission not in compliance with these guidelines will not be printed but will be maintained in the Committee files for review and use by the Committee.

All submissions and supplementary materials must be submitted in a single document via email, provided in Word format, and must not exceed a total of 10 pages. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.

All submissions must include a list of all clients, persons and/or organizations on whose behalf the witness appears. The name, company, address, telephone, and fax numbers of each witness must be included in the body of the email. Please exclude any personal identifiable information in the attached submission.

Failure to follow the formatting requirements may result in the exclusion of a submission. All submissions for the record are final.

ACCOMMODATIONS:

The Committee seeks to make its facilities and events accessible to persons with disabilities. If you require accommodations, please call (202) 225-3625 or submit a request via email to WMDem.Submission@mail.house.gov in advance of the event (four business days' notice is requested). Questions regarding accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Note: All Committee advisories and news releases are available at <http://www.waysandmeans.house.gov/>

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WITNESSES

Samantha Reid

Patient, Crohn's Disease
Witness Statement

Catherine Alicia Georges, EdD, RN, FAAN

National Volunteer President, AARP
Witness statement

Mark E. Miller, PhD

Executive Vice President of Health Care, Arnold Ventures
Witness Statement

Judy Feder, PhD

Professor and former Dean, Georgetown University McCourt School of Public Policy
Witness statement

Benedic N. Ippolito, PhD

Research Fellow, American Enterprise Institute
Witness statement

Hearing on Investing in the U.S. Health system by lowering drug prices, reducing out-of-pocket costs, and improving Medicare benefits

U.S. House of Representatives
Committee on Ways and Means,
Washington, D.C

The committee met, pursuant to call, at 10:02 a.m., in Room 1100, Longworth House Office Building, Hon. Richard E. Neal [chairman of the committee] presiding.

*Chairman Neal. So we will bring this hearing to order this morning.

But before we begin today's business, it is with a heavy heart and deep sadness that we note the passing of our colleague and friend, Elijah Cummings. His death is a loss to our institution and to our country.

Chairman Cummings believed in the work of Congress on behalf of all Americans: a real institutionalist. Chairman Cummings believed in opportunity above all else for all members of the American family.

He was a proud, lifelong resident of Baltimore. He looked beyond his hometown to best serve the American people through his leadership on the Committee of Oversight and Reform.

He forged strong bipartisan relationships, despite leading a committee that could be easily pulled into partisan rancor. As we carry out our duties in Congress, I hope each of us carry on his deep belief in the strength of our government and how legislation evolves, and we attempt to do the right thing for our country today and into the future.

And with that, before I ask for a moment of silence, our colleague, Bill Pascrell, has suggested that, as this legislation makes its way through the House, that we might embrace the idea that the final bill be named in honor of Elijah Cummings, who has been a longtime advocate of the very issues that are in front of this committee this morning.

So I would also ask at this time for a moment of silence to reflect on the remarkable legacy of our beloved colleague.

[A moment of silence.]

*Chairman Neal. And with that we will proceed to the business that is in front of the committee this morning.

I want to thank our witnesses and guests for joining us today for our hearing on investing in the U.S. health system by lowering drug prices, reducing out-of-pocket costs,

and improving Medicare benefits.

Today we will continue our committee's work of addressing the precipitous rise in prescription drug costs that continue to burden families across the country. In the last elections, Americans made it clear that they want and need to see real action in Washington that will put patients first and bring down the price of prescription drugs.

Americans have been demanding action on rising prescription drug prices for years. And I remind my colleagues that during the last 7 years we have had 70 votes to repeal the Affordable Care Act. And while -- at the same time we saw the price of lifesaving drugs skyrocket. For example, the price of Advair Diskus, a popular inhaler, rose by 136 percent from 2013 to 2017; the price of Humira saw a 100 percent increase over 6 years; and the price of insulin increased by a 197 percent from 2002 to 2013.

A recent Ways and Means Committee report details, as it should, that our nation spends four times more than other similar countries on the same prescription drugs. This is outrageous, and not only is it an unfair deal for the American people, many Americans simply cannot afford to pay these exorbitant prices for prescription drugs.

The notion that the American consumer should be getting a fair deal at the pharmacy, one that allows them to afford lifesaving medicines, is not a radical nor partisan idea. In fact, this is something I believe that President Trump and I might even find agreement on. He, too, has questioned why other nations should pay less, saying that, "For years and years, other nations paid less for drugs than we do."

As chairman, one of my highest priorities is addressing the rising cost of prescription drug prices. I have said many times that there is no one-size-fits-all for the answer. This is a complicated issue that needs thoughtful and comprehensive proposals for solution.

The Ways and Means Committee has been putting hard work into identifying such a

solution. Earlier this year we held a hearing to identify the causes of prescription drug increases, followed by a subcommittee hearing that further examined the issue. Patients walked us through the hardships that they and their families experienced due to rising prescription drug costs. Experts described the systemic failure of the market, and how consumers continue to pay more and more every year without the benefits of clinically superior innovation.

Following these hearings, the committee passed the STAR Act, a bipartisan measure to design -- to provide drug pricing transparency. It was a very good piece of work. And today we will continue our work as we discuss H.R. 3, which will lower drug prices, reduce premiums and out-of-pocket costs, saving hundreds of billions of dollars for American families, businesses, Medicare, and taxpayers.

H.R. 3 is based on the simple notion that the Secretary of Health and Human Services, with whom I have discussed these proposals, should be allowed to negotiate for better prices on prescription drugs in Medicare. Among other things, the bill also caps Medicare beneficiaries' out-of-pocket spending on prescription drugs at \$2,000. The changes made by the bill will amount to American families saving \$158 billion in lower premiums and out-of-pocket costs. That is \$1,920 for every American family of 4.

The nonpartisan Congressional Budget Office estimates that Medicare provisions of Title 1 alone will reduce Medicare spending by \$345 billion over 10 years. And I want to highlight this, because this would be for beneficiaries who decide not to fill prescriptions because of the high cost, and would be more likely to fill prescriptions under H.R. 3. This increase in accessing medicine, CBO notes, reduces spending for other services under Medicare like hospital and physician services.

This could be good news all around. With these savings we have an opportunity to make necessary investments in Medicare, like adding coverage for dental, vision, and

hearing services, and improving access to low-income programs to help pay for premiums and out-of-pocket costs. And of course, we will increase the investments in the innovative research that National Institutes of Health conducts every day, which, again, has been a bipartisan endeavor.

I am proud of the world-renowned health care innovation that we have in the United States. And I am very proud of what we have done in Massachusetts. It has opened the doors to treating numerous diseases and has been instrumental to our local and regional economy. However, what is the point of innovation if we can't afford it? With H.R. 3 Americans will be able to afford this innovation that they need to lead healthier and longer lives.

I look forward to hearing from our witnesses today.

[The statement of Chairman Neal follows:]

*****COMMITTEE INSERT*****

*Chairman Neal. And with that, let me recognize the ranking member, Mr. Brady.

*Mr. Brady. Thank you, Chairman Neal, and I join with you in honoring Chairman Cummings for his service, and for his caring, and for his character.

In 2003, as a member of the Ways and Means Committee, I was proud to help enact into law the Prescription Drug Improvement and Modernization Act, creating for the first time an affordable, lifesaving prescription drug plan for our seniors. Led by President Bush and a Republican Congress, this was the largest overhaul of Medicare in the program's history.

Regrettably, Democrats on this committee and in Congress overwhelmingly opposed helping seniors get their medicines affordably. Led by Democrat leader Nancy Pelosi, who famously declared then, "We must stop them, this is the beginning of the end of Medicare as we know it," and they voted no, almost in lockstep.

America's elderly are grateful Democrats failed to kill the Medicare Part D drug program because today 43 million Americans are enrolled in this lifesaving program. Not only is it one of the most popular health care programs, but came in 50 percent under budget, and still gives seniors affordable premiums even 16 years later. Since then the program has withstood assaults from Democrats in Congress who slashed \$800 billion from Medicare in the Affordable Care Act.

When Speaker Pelosi took the House gavel last January, she declared, "I pledge that this Congress will be transparent, bipartisan, and unifying, that we will seek to reach across the aisle in this chamber." None of this is true. This bill was written in secret, behind closed doors. Republicans in Congress were excluded. By abandoning the bipartisan work to lower drug prices, H.R. 3 is dividing Congress and being rushed to the floor, just like the secret impeachment investigation. We are seeing this bill for the first time, nor does it have a complete CBO score.

Republicans agree we do need to work together to crack down on overpriced drugs. There is no excuse for massive price hikes on existing drugs, or price spikes during the year that leave patients and families in the lurch.

But H.R. 3 is best described as the Fewer Cures for Patients Act, and it is dangerous. And as the Congressional Budget Office has conceded, it will stop lifesaving cures from getting to the patients who need them most. These are the medicines that could be the answer to some of the most heartbreaking and devastating diseases our kids, seniors, and families are facing.

Why would Congress punish companies taking the biggest and most costliest risks to find lifesaving cures for rare and orphan diseases?

Why favor new serums for longer eyelashes over a cure for Alzheimer's?

Why incentivize higher launch prices and slash the crucial investments in research and development?

I worry about the 300,000 Texans who live with Alzheimer's and their caregivers. Over 120 promising drugs have failed to be approved for this devastating disease. Under H.R. 3, where is the hope for a cure?

I think about my neighbor, whose husband died of a rare brain disease; another neighbor whose previously vibrant husband is struggling today with Parkinson's; my two friends, who died from ALS. Their hopes and mine for a cure are at risk in this bill. Supporters of H.R. 3 will tell you, "Oh, don't worry, only 15 or so diseases will be left behind." But one cure lost is one cure too many. And I believe CBO has woefully underestimated the lifesaving cures that will be lost from this bill.

Americans have been clear: lowering out-of-pocket costs for prescription drugs should be a priority for this Congress. So should accelerating lifesaving cures, which is why Republicans have worked in good faith with their Democrat colleagues on bipartisan

legislation like the 21st Century Cures Act, the prescription drug STAR Act, and the SPIKE Act. They accelerate cures, promote transparency, inject accountability in the drug chain so people can pay less at the counter for the prescriptions they need.

Today Democrats will likely loudly ask, "Where is your plan?" But they already know the answer. We were working with you at your invitation to find bipartisan consensus to lower drug prices. Mr. Chairman, you and I put our names on solutions we shared with the public on how we lower prices for seniors, including an out-of-pocket cap on drug expenses. That effort has now been trashed with H.R. 3.

It doesn't have to be this way. Let's go back to the table to work together to give patients more power to choose the right medicines for them, to get incentives right within Medicare to punish bad drug actors and reward lower prices without jeopardizing the innovative cures that give hope to patients and their families.

Instead, what the secret partisan bill does is tell creators of these lifesaving drugs Washington will dictate the price. If you don't agree, we will tax your drug out of existence. That isn't negotiation. It is government price-fixing and extortion. And as dangerous as its chilling impact on life saving cures, not a dime of these savings from the bill will go to make Medicare solvent.

How can you justify expanding Medicare when its hospital trust fund will go bankrupt in a mere seven years?

How fiscally irresponsible can Congress be?

I will close with this. The truth is the only bill that will make the President's desk is a bipartisan one. Together we need to find solutions that will lower out-of-pocket costs for patients and seniors. Let's get this right, and do it right together.

Thank you, Chairman.

[The statement of Mr. Brady follows:]

*****COMMITTEE INSERT*****

*Chairman Neal. Thank you, Mr. Brady. And without objection, all members' opening statements will be made part of the record.

I want to thank our distinguished witnesses for taking time to appear before us today to discuss these important issues.

First we will hear from Mark Miller, the executive vice president of health care at Arnold Ventures. Dr. Miller is a former executive director of the Medicare Payment Advisory Commission, MedPAC. He is a nationally-recognized expert on Medicare payment policies.

Our next witness is Catherine Alicia Georges, a volunteer spokesperson and board member of AARP. In addition, Dr. Georges is a professor and chair of the Department of Nursing at Lehman College of the City of New York, among other many impressive roles.

Next we will hear from Judy Feder, professor in the McCourt School of Public Policy at Georgetown University, who will join us to discuss some of the long-overdue investments Congress should consider in Medicare to improve coverage and lower out-of-pocket costs.

Samantha Reid is a patient with Crohn's Disease who understands the daily struggle of the high cost of prescription drugs in the United States.

Mr. Ben Ippolito from the American Enterprise Institute, AEI, will be a final witness on the panel.

Each of your statements will be made part of the record in its entirety. I would like to ask that you summarize your testimony in five minutes or less. To help with that time there is a light on at your table. When you have one minute left the light will switch from green to yellow, and then finally to red when the five minutes are up.

Mr. Miller, would you please begin?

STATEMENT OF MARK E. MILLER, PHD, EXECUTIVE VICE PRESIDENT OF
HEALTH CARE, ARNOLD VENTURES

*Mr. Miller. Chairman Neal, Ranking Member Brady, distinguished members of the committee, I am Mark Miller, executive vice president of health care at Arnold Ventures. I appreciate you asking us here to testify today.

Prior to Arnold Ventures I served both Republican and Democratic administrations at the Office of Management and Budget and CMS. And, as you mentioned, for 15 years I served as the executive director of the nonpartisan Medicare Payment Advisory Commission.

Arnold Ventures is a philanthropy dedicated to addressing complex problems. We believe in markets, but we also believe in evidence-based intervention when markets fail. We believe that there are reasons for the Congress to act to restrain drug spending.

We spend 500 -- over \$500 billion annually on drugs. That number grew 30 percent over the last 5 years, and is projected to grow 80 percent over the next 10. Affordability is an issue.

From a taxpayer's perspective, we currently carry a debt equal to 77 percent of the size of the economy, and that debt is growing.

More importantly, from a patient perspective, nearly 1 in 3 Americans say they can't fill a script due to its cost; 42 percent of cancer patients will be financially depleted in the first 2 years of their treatment; and 40 percent of American families can't produce \$400 in an emergency situation.

American voters are aware that we pay two to four times more than other countries for the same drugs, and they support aggressive action on the part of the Congress.

Several factors drive drug prices, but the most important reason is that the

government grants a monopoly to the manufacturer and then fails to manage that monopoly. Predictably, manufacturers take advantage by setting high launch prices and escalating those prices. They often engage in anti-competitive practices to protect the monopoly, rather than to move on to the next innovation.

Based on our analysis, we believe the Congress needs to legislate in three areas.

Number one, end anti-competitive behaviors and reform patent law. Committees in both the House and the Senate have voted out bills that address some of those issues.

Number two, end supply chains, distortions. Now, this sounds like -- and it is -- a set of complex issues. But let me focus you on one. Both the Senate Finance Committee bill and H.R. 3 include an idea to restructure the Medicare Part D catastrophic cap. This change would protect the beneficiary. It would reduce the taxpayer's liability by putting the PBM and the manufacturer at greater risk when the beneficiary experiences catastrophic drug costs.

Number three, directly address prices where PBMs have little leverage, and directly address annual price increases that are unjustified by the cost of the drug or the value of the drug. Both the Senate Finance Committee bill and H.R. 3 include an inflation rebate that would limit the taxpayer subsidy of those increases, reduce Medicare beneficiary liability, and indirectly reduce commercial sector prices.

H.R. 3 goes further and introduces secretarial negotiation for a select set of drugs that have little or no competition. This legislation would require the Secretary and the manufacturer to agree to a price that is bound at the high end by 120 percent of the price that is paid by 6 other countries. Both CBO and the Office of Actuaries has shown that the negotiation structure reduces drug prices, reduces cost to the taxpayer and to employers, and reduces the premiums and out-of-pocket for Medicare beneficiaries and the commercially insured.

Pharma will say that R&D will be undermined. The CBO estimate clearly suggests that the vast majority of R&D will continue uninterrupted. And this makes sense. R&D drives future revenue and future profits. The size of the U.S. market is 6 to \$7 trillion over the next 10 years, and U.S. prices, even with this legislation, will continue to be the highest in the world. This will continue to be an attractive market. There are industry dollars that could be redeployed to R&D. Pharma's own numbers suggest that they will spend 300 billion on marketing over the next 10 years. Moreover, the savings from this bill could be devoted to R&D.

But there is also a different way to think about this. The tradeoff may be worth it. Savings could be put into other needed medical care, like primary care or long-term care, or other social needs like food, housing, or education, all of which could have an impact on population health.

In closing, Arnold Ventures believes that the Senate Finance bill and H.R. 3 are constructive steps to -- forward to lower drug spending and to not disrupt innovation. We have legislation in both houses of Congress. We have a President who seems willing to act. We have voters demanding action. At Arnold Ventures we don't view this as an opportunity, we view this as an obligation. We believe the time to act is now.

Thank you for your attention. I look forward to your questions.

[The statement of Mr. Miller follows:]

*****INSERT 1*****

*Chairman Neal. Thank you, Dr. Miller. Let me recognize Ms. Reid.
Would you proceed, please?

STATEMENT OF SAMANTHA REID, PATIENT, CROHN'S DISEASE

*Ms. Reid. Chairman Neal, Ranking Member Brady, and members of the committee, I am honored to be here today.

I would like to start by telling you a story about my 18th birthday. The thing that made that day remarkable was that I don't actually remember much about it at all. Science suggests that trauma can cause us to repress memories. And in the early days of my 18th year, I experienced a substantial medical trauma. I was living in constant pain, unable to eat solid foods, and dropping weight at an alarming pace, and no one was able to tell me why. Then, a few days after my 18th birthday, I was officially diagnosed with Crohn's Disease and became someone who will be sick forever.

I have come a long way since the winter of 2010, but with a formal diagnosis came treatments, and with those treatments came high-priced drugs.

The main drug treating my Crohn's right now is an infusion called Entyvio. This one drug costs over \$6,000 a month, and I get it every month. Since I started on the drug in 2016 the price has gone up nearly \$1,500.

The second drug I take is called Xolair. It is one of the most expensive drugs in Medicare. In 2017 this drug cost taxpayers over \$375 million, and the drug maker, Novartis, has raised the price every year, often multiple times a year, for the last 16 years without once decreasing it.

The final drug pricing story I want to tell you happened to me just last month. I was experiencing extreme abdominal pain and weight loss, so my doctors prescribed a steroid called Entocort to stabilize my symptoms. The catch was that Entocort costs over \$2,000 for a month's supply, in spite of the fact that it is an old drug. Because of the high price, I was forced to take Prednisone instead. The side effects of prednisone include

insomnia, depression, permanent bone damage, joint pain, weight gain, and much more. I was forced to take a drug that made me sicker in other ways, all because Entocort was priced far too high.

Crohn's Disease is a chronic, incurable illness, meaning I will be paying these prices every month for the rest of my life. Every choice I make revolves around the price of my drugs. I live in constant fear of an economically unstable future. I make every career move not based on what is best for me professionally, but based on which options provide the most stable health insurance. I don't plan for parenthood or home ownership because, with my disease and the price of my meds, I can barely stay above water paying for the basics like food and rent.

And I am not alone. Our country is putting an entire generation of young patients at a financial disadvantage for no reason other than to field drug company profits. We have to change that system. It is not good for patients, and it is not good for our economy.

Drug companies will try to scare patients by telling us that if we lower drug prices by even a nickel, innovation will come to a screeching halt. But that is just not true. The drug industry enjoys some of the highest profits in the world, and spends most of it on expenses outside of research and development. Nine out of ten Big Pharma companies spend more on marketing and advertising than they do on research. So, instead of cutting innovation, drug companies could simply cut the \$6 billion they spend on the annoying TV ads.

In light of these facts, I refuse to buy into Big Pharma's scare tactics. So I would like to instead tell you three ways H.R. 3 could help me.

First, it would allow Medicare to negotiate the price of the costliest drugs. All 3 of the drugs I have mentioned today are within Medicare's top 250 costliest drugs.

Second, it would ensure that Americans, regardless of insurance type, have access

to those lower-priced drugs. For people like me who are on private insurance, that provision is critical.

Finally, H.R. 3 would penalize unjustified price hikes by companies like mine.

As part of my advocacy work I have spent a lot of time volunteering with kids as young as eight who have been diagnosed with Crohn's. It breaks my heart to hear them talk about the ramifications of this illness. They should have a chance to enjoy their childhoods, but instead they see their parents sacrificing to afford their treatments. They are dealing not only with the physical and emotional toll of chronic illness, but the financial burden. For me, that burden means sacrificing my savings, my job opportunities, my future.

I am not naive. I know Congress can't cure my Crohn's Disease. But you can help Americans like me create a more stable future, because good health isn't a moral virtue and bad health isn't a moral failing. Whether you are 18 or 80, we are all one diagnosis away from staring down a bill for a prescription drug that could bankrupt us. That is why I believe Congress must act.

Thank you for your attention.

[The statement of Ms. Reid follows:]

*****INSERT 2*****

*Chairman Neal. Thank you, Ms. Reid.

Let me recognize Dr. Georges.

STATEMENT OF CATHERINE ALICIA GEORGES, EDD, RN, FAAN, NATIONAL
VOLUNTEER PRESIDENT, AARP

*Ms. Georges. Good morning, Chairman Neal, Ranking Member Brady, and members of the committee.

I am Dr. Catherine Alicia Georges, and I am the national volunteer president for AARP, a nonpartisan, nonprofit, nationwide organization with nearly 38 million members across the country. For more than 40 years I have also been a nurse and involved in academic nursing.

Thank you for the opportunity to discuss rising prescription drug prices, their impact on older Americans and enhancements to the Medicare program.

AARP supports H.R. 3 because it will help lower drug prices and the costs older Americans face. We are also pleased the committee is considering making key investments in the Medicare program.

Prescription drug prices are a high priority for AARP and its members. All Americans struggle to afford needed and lifesaving medications. The average Medicare Part D enrollee takes more than four prescriptions per month, and over two-thirds have two or more concurrent chronic illnesses. At the same time, most Medicare beneficiaries live on modest incomes, with an annual median income of just over \$26,000. This is not a population that has the resources to absorb rapidly escalating prescription drug prices. Many are facing the very real possibility of having to choose between their medication and other basic needs, such as food or housing.

It should come as no surprise that our members consistently tell us they cannot afford the medications they need, and are forced to make difficult choices as a result. In a recent survey of voters aged 50 and older, 40 percent responded that they did not fill a

prescription prescribed by their physician in the past two years. The vast majority of people reporting such behavior blamed higher drug prices for their decision.

For example, one of our members, Doug, who is with me here today, lives in Iowa. He had a kidney transplant a few years ago, and now takes 32 pills every single day. The cost of his medication increased by \$500 a month, and those costs have forced him to sell his home and to get a part-time job in order to afford them.

It is with Doug and millions of other older Americans struggling to afford their medications in mind that AARP launched our Stop Rx Greed campaign. We are calling on state and federal legislators to enact solutions that target the root of this problem: the high prices set by drug companies. AARP has been tracking the prices of widely used prescription drugs since 2004. A recent Prescription Price Watch report found that retail prices of widely-used brand drug names increased by an average of 8.4 percent in 2017, 4 times the rate of inflation.

Current drug prices are not sustainable. There is no reason Americans should continue to have to pay the highest brand name drug prices in the world. It is time for Congress to take action to lower prescription drug prices.

Additionally, AARP has long supported closing the gaps in health coverage by including dental, hearing, and vision coverage in a Medicare program. The lack of coverage for these important health benefits leads to worse health outcomes for older Americans, and could actually cause higher Medicare spending.

We know the majority of Medicare spending is on a fraction of beneficiaries with chronic conditions such as diabetes and heart disease.

We know social isolation can hasten the onset of dementia, and an AARP study shows it costs Medicare an additional \$6.7 billion a year.

And we know that falls are resulting from imbalance. Weakness or poor eyesight

can lead to costly hospitalization and long-term care.

Meanwhile, Medicare does nothing to prevent infections originating in the mouth. It does nothing to help people retain or replace their teeth in order to be properly nourished and socially engage. And it does little to help people hear and see obstacles.

In short, Medicare will cover the expense aftermath.

Congress should rein in high drug prices and add essential coverage like hearing, dental, and vision benefits. We appreciate the leadership of this committee to help ensure that all Americans have affordable access to the drugs and care they need.

[The statement of Ms. Georges follows:]

*****INSERT 3*****

*Chairman Neal. Thank you, Doctor.

Let me recognize Dr. Feder.

STATEMENT OF JUDY FEDER, PHD, PROFESSOR AND FORMER DEAN,
GEORGETOWN UNIVERSITY MCCOURT SCHOOL OF PUBLIC POLICY

*Ms. Feder. Chairman Neal, Ranking Member Brady, and members of the committee, I am pleased to speak with you this morning on improvements in the benefits Medicare now provides to 60 million older people and disabled Americans with disabilities.

The -- investments will be facilitated by lower drug prices and federal savings that the bill before you would achieve.

My goal this morning is to highlight four features of the Medicare program that demand remedies through more investment.

First is excessive exposure of beneficiaries to out-of-pocket costs. Medicare lacks the caps on out-of-pocket deductibles and cost sharing that employer-sponsored insurance typically provides and that the Affordable Care Act now requires.

Although private Medicare Advantage plans must now include these caps, no such protection is available for the two-thirds of beneficiaries who prefer to retain choice of provider by remaining in traditional Medicare. Beneficiaries must, therefore, seek protection against catastrophic costs by purchasing Medigap insurance, for which premiums rise as health costs rise. It is past time to legislate a cap on Medicare beneficiaries' out-of-pocket spending, not just for part D, but for part A and part B expenses, as well.

Equity also requires the expansion of Medicare's cost sharing subsidies so that modest-income beneficiaries have the same financial supports as younger Americans receive through the Affordable Care Act.

The second investment issue is specific gaps in Medicare benefits. Caps on out of

spending -- on out-of-pocket spending for services that Medicare covers won't help with the cost of services that Medicare leaves out. Medicare, as we have heard, does not cover eyeglasses, hearing aids, and dental care, and even limits access to the medically necessary dental care the program actually includes.

Most risky for beneficiaries is Medicare's failure to cover long-term services and supports for which all Americans are essentially uninsured, publicly or privately, against the risk of needing extensive personal care, a risk affecting people of all ages. The result is not only impoverishment for people who need extensive personal care, a precondition for the receipt of Medicaid long-term services and support benefits, but gross inadequacies in care and such extensive reliance on family caregivers that their health and financial security is undermined.

Investing in all these now uncovered benefits is essential to adequately serving Medicare beneficiaries. Given the failure of the private insurance market for long-term services and supports, only a Medicare or other social insurance program can provide adequate protection. And I call your attention in that regard to Congressman Frank Pallone's 2008 [sic] discussion draft for such a bill, along with proposals in recently introduced coverage expansion legislation.

The third issue requiring investments relates to the administrative barriers and biases that impede access to care. Administrators' overzealous avoidance of anything resembling a long-term services and supports benefit has restricted beneficiaries' access to the home health benefit, especially Medicaid -- Medicare -- excuse me, especially aid services that Medicare covers for people who need skilled nursing or therapy.

Observation status aimed at preventing unnecessary hospital admissions exposes beneficiaries to cost sharing and denies them access to skilled nursing facilities.

Further, administrative action inappropriately steers Medicare beneficiaries away

from traditional Medicare and toward overpaid Medicare Advantage plans that may limit their care by narrowing their access to providers. Beneficiaries may be locked into these plans, since most states do not guarantee access to supplemental Medigap coverage without regard to pre-existing conditions when people want to switch.

Effective Medicare coverage requires administration that appropriately supports the delivery of covered services, fairly manages choice between MA and traditional Medicare, and federal law that assures that individuals who prefer traditional Medicare always have access to supplementary Medigap.

Last, but not least, is investment to assure the long-term sustainability of the Medicare program. Despite Medicare's extraordinarily low per-capita cost growth, Medicare spending will grow with the aging of the population. Keeping costs low rests on the continued and expanded exercise of Medicare's market power. Assurance of appropriate prices for drugs and other services must encourage policies to appropriate -- to promote appropriate service use.

But vigilance in payment will unlikely be sufficient to cover the costs of a growing Medicare-eligible population. More revenues are required. Despite claims to the contrary, projected GDP growth is more than sufficient to assure the long-term stability of the Medicare Trust Fund. Predictions are that GDP per adult will grow 23 percent between now and 2035, even after accounting for inflation and needed Medicare spending, just 2 percentage points lower than if Medicare spending grew at the same rate as the economy as a whole. Investment is, therefore, affordable, as well as required --

*Chairman Neal. Thank you.

*Ms. Feder. -- to strengthen and fully fund Medicare as the Baby Boom generation ages.

[The statement of Ms. Feder follows:]

*****INSERT 4*****

*Chairman Neal. Thank you, Dr. Feder.

*Ms. Feder. Thank you, Chairman Neal.

*Chairman Neal. Dr. Ippolito?

STATEMENT OF BENEDIC N. IPPOLITO, PHD, RESEARCH FELLOW, AMERICAN
ENTERPRISE INSTITUTE

*Mr. Ippolito. Thank you, Chairman Neal, Ranking Member Brady, and members of the committee. My name is Benedic Ippolito. I am an economist and research fellow at the American Enterprise Institute.

Now, I don't think any of us can disagree that recent developments in the drug market have provided some tremendous therapeutic benefits to patients. Yet I think we all look at this market and we see problems. We have seen stubbornly high prices, slow or, in many cases, non-existent generic drug entry, and we have seen public programs that simply aren't working for beneficiaries, nor are they working for taxpayers.

So I am -- there is a tremendous opportunity to improve these markets, and I am happy to see such an active policy discussion in Congress -- in both chambers of Congress, that is. Today I am going to focus on two key elements of recent proposals, namely redesigning Medicare Part D, as we have heard a little bit about, and tasking the HHS Secretary with negotiating drug prices.

Now, experts have long argued that Medicare's prescription drug benefit Part D needs reform. Its current structure encourages high list prices, inefficient plan design, and, importantly, it exposes seniors to exactly the kind of financial risk that insurance is supposed to prevent.

So I am encouraged to see proposals to reform incentives in Part D and couple them with a cap on the maximum amount enrollees can pay out of their pocket. This will fix a major problem in Medicare. I know there are some differences that remain across proposals that we have seen in the House and the Senate, but suffice it to say I think they all are moving in the right direction.

I am, however, more concerned about recent proposals to have the HHS Secretary set market-wide prices for drugs. And I say set prices because, frankly, with penalties climbing to 95 percent of a drug's gross revenue, not net revenue, H.R. 3, for example, would establish negotiations in name only. This is important because this kind of centralized rate regulation is highly consequential.

As is true in effectively all markets, the financial returns to successful products has a first order effect on investment decisions of firms. Indeed, the economics literature has shown us that the pharmaceutical market is no different in this way. We have talked a lot about Medicare Part D. The introduction of Medicare Part D itself was shown to reshift the investments in this whole market.

This is particularly important for the United States because we are the single most important market for drugs in the world. That is not necessarily something to celebrate, but that is something that must be acknowledged when making these kind of policy changes.

The importance of this tradeoff makes it odd, in my view, that U.S. prices would be constrained by the decisions of other nations. As Craig Garthwaite, an economist at Northwestern University and I wrote earlier this year, the simple fact that the U.S. pays more for drugs does not prove that our prices are too high, nor should we assume that international prices represent the appropriate balance of tradeoffs. Many of these countries have long had the luxury of enjoying innovations that are made possible by U.S. profits. In other words, they don't face the same tradeoff.

Moreover, H.R. 3's negotiation process would introduce some odd incentives. Any drug that does not have a competitor would be eligible to have its price regulated. By definition, most of these drugs will have been granted market exclusivity by Congress, typically through the Hatch Waxman Act, to spur innovation. Yet under H.R. 3 it is

exactly these drugs which would be targeted for rate regulation, especially as it is written in its current form, drugs that are -- have the highest value for the most number of beneficiaries. It is not obvious to me at all why those are the incentives that we would want.

However, many of my concerns with this policy are perhaps clearer if we instead imagine extending the exact same pricing authority to a different market, namely the market for physician services.

Suppose, just like H.R. 3, the Secretary of HHS could dictate the payments received by physicians from public and from private insurers. We could cap them based on low international rates. And, just like H.R. 3, physicians would absolutely be able to refuse the offer. If they did, they could work, they simply would face a 95 percent income tax. I suspect there would be less enthusiasm about my proposal than there is about H.R. 3, yet my proposal would also generate tremendous budgetary savings, possibly even more, given the size of the physician market. I suspect many would worry that it would dissuade some of our brightest students from investing the time and energy to become a medical doctor.

I suspect others would ask why are we asking France to decide what our physicians ought to be paid in this country? Similarly, physicians and their supporters would likely balk at the confiscation of 95 percent of their earnings for not accepting the Secretary's preferred price. Yet they would face exactly the same opportunity to walk away from the table that a drug company would. I don't understand why that sounds a little bit odd in the physician market but it doesn't sound odd in the drug market.

That said, I do want to re-emphasize there are many opportunities for real improvements in this market. Those included -- these include proposed changes to Medicare Part D, like what we see in H.R. 3, like what we have seen proposed in this committee, and like what we have seen proposed in the Senate Finance Committee. I hope

Congress doesn't lose sight of that.

And I thank you for your time.

[The statement of Mr. Ippolito follows:]

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*Chairman Neal. Thank you, Dr. Ippolito. And be assured we are open to ideas here, and we hope in the end, with -- we will have bipartisan support from -- in the final package.

So, Dr. Miller, a recent poll indicated that 97 percent of American people agree that American seniors and families should not have to pay more for their medicines than what the drug companies charge people in other countries for the same drugs. Today 40 percent of households don't have \$400 in the bank for an emergency, so it is unlikely that they can afford \$14,000 in out-of-pocket costs for specialty drugs.

The Ways and Means Committee recently put out a report that noted, on average, Americans are paying four times more than patients in other countries for the same drugs. In some cases, 67 times more. Why, Dr. Miller, are Americans paying so much more for these drugs?

*Mr. Miller. Well, I think there is a few reasons. The first that I talked about in my opening statement is that if a manufacturer is given a monopoly through its patent and its market exclusivity, you know, privileges that come through the FDA process, then they have the ability to set a price where they want just to set it. In European countries they often have to -- and the six in question, but others, as well -- they often have to negotiate or justify the price that they offer.

When a drug is a breakthrough drug and it has a first-in-class new effect, foreign countries often do pay high prices, not necessarily as high as the U.S., but they pay high prices. Where foreign countries are less likely to pay high prices is when a drug follows on and demands a high price. There they are less likely to pay. And so some of the difference lies there.

The other issues -- and I will stop and let you take back over, but there is also issues in the supply chain, the spread pricing between list prices and net prices that results from

the PBM process. And that also contributes to some of the higher prices in the U.S. that you see.

*Chairman Neal. Thank you. And Dr. Georges, AARP has long been an advocate of both reining in high costs and investing in Medicare. You noted in your testimony some suggestions as to how we might proceed. So what do your members tell you are the most important Medicare improvements that Congress ought to consider?

*Ms. Georges. One is making sure, Chairman Neal, that prices and costs to them for their drugs are lowered. Our members also are interested in some additional benefits through Medicare, such as dental, hearing, and vision that would allow them to age in place without all the concomitant injuries or problems that they would have at home.

*Chairman Neal. Thank you.

And Dr. Feder, by bringing prices in the U.S. more in line with those charged in other countries, H.R. 3 will leverage significant savings that could be reinvested in Medicare to improve the program for beneficiaries. You have worked for decades on improving the Medicare program. What areas would you recommend we target to make meaningful differences in lowering costs and improving health?

*Ms. Feder. You have heard several of them this morning, and I would highlight the -- addressing the excessive out-of-pocket spending with caps on out-of-pocket spending for Medicare beneficiaries equivalent to what are provided to pretty much everybody else in the U.S.

In addition we need improvements in protections for modest-income people who faced out-of-pocket burdens that are greater than are -- than people -- younger people face, given the protections in the ACA. So those are the out-of-pocket protections.

In addition, as has been said, we need to address some new benefits: the dental care, the vision care, the hearing care, and I would add it is past time that we address long-

term services and support costs for people of all ages.

*Chairman Neal. Thank you. And Ms. Reid, you put the word in your testimony about innovation. But medicines don't work if people can't afford them. So one of the defenses we frequently hear as to why we should not act on drug prices is that lowering drug prices in the U.S. will harm innovation. You are a patient that relies on innovation. What is your comment?

*Ms. Reid. Thank you. I depend on innovation completely. Without it I will not continue to be able to work and, you know, live my life.

That being said, I do think that the threat to innovation that pharmaceutical companies cite is just that, it is a threat. There are many other areas that pharmaceutical companies could pull from if their profits were to go down at all. I think right now their profits often fund high CEO salaries, corporate jets, things of that nature, marketing and advertising.

And so, when pharmaceutical companies say that if their -- if prices go down innovation will go down as a result, that is a choice they are making. There are many other areas they could pull funding from that they are simply refusing to do.

*Chairman Neal. Thank you. With that let me recognize the ranking member, Mr. Brady.

*Mr. Brady. Thank you, Mr. Chairman. Defending the status quo is unacceptable. Americans deserve lower drug prices, and they deserve more cures for the diseases they face.

The Congressional Budget Office points out my worry. There is a clear connection between payment and investments in research. The greater the cuts to scientists looking for new cures, the fewer drugs come to market. You can live in denial, but it is settled science, and all we need do is look around the world, where similar countries with similar

price-fixing schemes -- innovation is less, access to the new drugs is less.

Dr. Ippolito, I worry because in this bill they estimate it will reduce revenues to research companies by up to \$1 trillion. We know all that won't be spent on R&D. So just cut that conservatively. Even then, looking at the average cost of 2.7 billion to bring a new drug to market, and 15 years to do it, by my very conservative estimate we could see 100 lost cures or more, as a result of these significant cuts.

We don't have a crystal ball. But as you look at CBO's assumptions, do you think the magnitude of lost or delayed cures could be bigger than what we are talking -- than what CBO may have estimated?

*Mr. Ippolito. Well, sure. So, mechanically, the answer is yes, because the score that they have released is only a partial score. So it is only the part D part of this bill. So mechanically, we know the answer is going to be larger.

But more to the actual score itself, yes. So if you do work this out, it -- basically, what they are saying is that the market size for drugs needs to go up by about 65 or \$70 billion to get one more cure. And I have worked through exactly what they are doing, and I see exactly how they are getting there.

I am at a little bit of a loss on the final number, just because, I mean, if you look at the drug market, literally, there are 5 drugs that have ever made that much money in the U.S. in pure revenues, let alone -- I mean, if you scale up to the world, maybe 10 drugs have ever made that much money. So it seems to me a fairly large estimate.

With that said, CBO is also clear. This is not a final estimate. This was their first cut on this.

*Mr. Brady. Yes.

*Mr. Ippolito. And I think the wording was --

*Mr. Brady. By saying a larger estimate on costs what you mean is it could be --

there could be more lost cures if a more practical number were used?

*Mr. Ippolito. Yes, I think very easily the number could be larger than that. Yes.

*Mr. Brady. Yes, much larger. So this bill is a tradeoff, right?

*Mr. Ippolito. Mm-hmm.

*Mr. Brady. So lower drug prices now, fewer cures tomorrow.

I worry about slower cures, as well. It seems to me, the way this bill is written, it targets companies for being the first to market. So if you tackle a rare disease or the most stubborn cancers, the most cost, but you are the first to market, you pay a steep price for doing that. This bill appears to reward companies to delay that entry to the market to being the second or the third.

Do you worry that, beyond fewer cures, we might have slower cures as a result of the flaws in the bill?

*Mr. Ippolito. I would emphasize the composition of the cures, frankly. I mean I think that is one of the most important things to think about. Right?

So you say this is about tradeoffs. It is about tradeoffs, of course it is. Most policy is. And a lot of tradeoffs are worth making, and some aren't. And the question is what tradeoffs are we making here?

And so what we want to think through is what does H.R. 3 incentivize? And what H.R. 3 says is the more people that are treated by this drug, the higher the value, the more likely it is to trigger the rate setting at the HHS level. And if you are second to market, you are explicitly exempted from that procedure. If you are a smaller market, if you are less valuable, you are less likely to trigger that rate-setting system.

And so, as I look at it -- and I look at it in the context of what Congress has done in the past -- by establishing this regulated monopoly, then it seems a little odd that H.R. 3 takes such an explicit tact towards those drugs which seem to have the highest value.

*Mr. Brady. And so the final point there, you are saying the drugs with the bigger value, like tackling diabetes or Alzheimer's or some of those bigger -- those actually pay a steeper price than if you bring a drug to market that is cosmetic or --

*Mr. Ippolito. Right, the seventh treatment for gout is not going to trigger the rate-setting system, at least as H.R. 3 is written. The first treatment for Alzheimer's is.

*Mr. Brady. Okay. Thank you, Doctor.

*Chairman Neal. Thank you, Mr. Brady. Let me recognize the gentleman from Georgia, Mr. Lewis.

*Mr. Lewis. Thank you, Mr. Chairman. Mr. Chairman, I especially would like to thank Ms. Reid for being with us.

I thank each one of you, but especially you, Ms. Reid. It is not easy to speak openly about our struggles. But you did it. I think you are very, very brave. Thank you for sharing your truth.

Ms. Reid, in your testimony today you tell us to be brave. You tell us to be bold. You ask us to stand up for you and countless others who live in constant fear of economic ruin. You have more to lose than maybe anyone else in this room. What will you say to people who are worried that this bill goes too far, and maybe it costs too much?

*Ms. Reid. Sure. So something that I think is important to note about this bill is - I would like to push back a little bit on what Congressman Brady mentioned about cures.

I think that an important thing to note here is that the 8 to 15 drugs that the CBO suggests may not come to market in a reality where H.R. 3 is law is that the majority of drugs that come -- new drugs that come to market are not cures. They are treatments. And as someone with a chronic illness, I am acutely aware of the fact that it is much more beneficial for pharmaceutical companies to create treatments that I will take every month for the rest of my life than it is for them to bring a cure to market.

So I take -- I think it is important to remember that we are not talking about a world where 8 to 15 cures for diseases don't come to market. In reality, we are more likely talking about a world where a drug company takes an already existing drug, changes the mechanism slightly, and brings it to market as a new FDA approval.

So I think that this bill, if you think that this bill goes too far, you are not living in the reality that patients are living in every day. It is easy to say that, you know, these are potential tradeoffs, but I think no one is better equipped to make those tradeoffs than patients. And as the patient on this panel, I am willing to make some tradeoffs, because I think that if a cancer patient -- if 42 percent of cancer patients are financially depleted 2 years after treatment begins, what are we telling those patients, that you can have a medication that makes you better, but it will ruin the rest of your life? I don't think that is a fair calculation to make patients make.

*Mr. Lewis. Dr. Feder, Congress must constantly think about the future. The next 5 or 10 years, even the next century, it is harmful -- is it harmful to miss this opportunity to invest in Medicare?

*Ms. Feder. It is absolutely harmful to miss this opportunity. Medicare is one of our most valuable social programs. It is loved by all. It has done an enormous benefit for our citizens by supporting -- enabling older and disabled Americans to get adequate care. But it is a benefit design that is largely shaped on what insurance benefits looked like in the 1960s, and does not recognize all the other benefits or services that people need and that have become more expensive over time.

So I think it is absolutely critical to take advantage of this opportunity to strengthen this most valuable program.

*Mr. Lewis. Thank you. Mr. Chairman, I yield back.

*Chairman Neal. Thank you, Mr. Lewis. Let me recognize the gentleman from

Florida, Mr. Buchanan, to inquire.

*Mr. Buchanan. I want to thank the witnesses and thank you, Mr. Chairman. I want to just touch briefly on the idea of bipartisanship. As you mentioned, I am very hopeful -- this is too big to fail, in a sense. We have got to find a way to come together.

I had seen something that -- I was at a retreat -- stuck with me, anyway, that -- they said from 1985 to 2015, 9 bills that were partisan bills became law. So if we are serious about getting something done on this front, and I think everybody here on both sides of the aisle agreed to that -- in fact, AARP said in 2017 they found 270 brand-name drugs, it rose 4 times the higher cost than inflation in general [sic].

So it is a big issue, especially -- I am in Florida. I have more seniors, probably, than the top five counties. It is a very big deal.

So I would ask you, Dr. Ippolito, do you agree with my view that, if we want to reduce drug prices and get something done, it is imperative that Congress work together in a bipartisan fashion to craft legislation that the President can sign into law?

*Mr. Ippolito. Well, you certainly know more about the politics than I do. But what I will emphasize is that you do have an opportunity to do just that. So I would emphasize, since it is included in H.R. 3, the reforms to Medicare Part D. We heard Dr. Miller, in particular, talk about this.

There are some really weird incentives in that program. They encourage really high-list prices, high-list prices that directly impact patients' out-of-pocket spending. And Medicare has this crazy insurance design where it is supposed to be an insurance product, a.k.a. a financial risk mitigation tool, and there is no maximum on what you can spend out of your pocket. There is a whole bunch of problems with that program. And I think what we have seen is, yes, there are differences, but a number of proposals that are really close to really solving that and really improving a meaningful part of --

*Mr. Buchanan. Let me also add -- I want to get to a couple of other things.

There has been a lot of discussion on the panel about dental, vision, and hearing. I can tell you in our area, 200,000, 220,000 that are on Medicare, a third of them, all they have is Social Security and Medicare. These programs are so critical. I think I am on all these bills.

So I would like to get also, Doctor, your opinion on, you know, where that is at. You know, how do we pay for it? How do we make that happen, in your opinion?

*Mr. Ippolito. Well, I think we start with things like reforms to Medicare Part D, and then we start adding on.

If I were Congress, I would say there is a market out there for drugs. And I would look at the market as you wrote it down, as it was supposed to behave. And I would compare the two. And if I were to do that, I think I would find that what is actually happening in the real world isn't really what you wrote down. And so I would enact a bunch of laws, be it to address REMS abuse, patent thickets, and so on and so forth, anti-competitive behaviors, so that we actually can get to a market that looks like what this market was supposed to look like, and then say, "Do we want to go further?"

*Mr. Buchanan. And also, all the provisions in H.R. 3 apply only to brand-name drug products. The bill does not apply to generic drug products. As a matter of federal health policy, how do you feel about this?

*Mr. Ippolito. Well, I think getting generic drugs to market is one of the biggest challenges that we have right now in the regulatory framework that we have enacted. Right? We allow people to have short-term monopolies, but then there is supposed to be generic entry. And in some markets it is clear that we are not getting generic entry as fast as we ought to be.

And so I look to a whole bunch of policies like the CREATES Act and a variety of

other ways to address patent thickets and other sorts of anti-competitive contracting behavior to address exactly that point.

*Mr. Buchanan. Yes, I have seen different lists or sheets where we have more generics competing. It drives the price down substantially. That is what I have seen. Is that your --

*Mr. Ippolito. Yes, that is absolutely correct. Yes.

*Mr. Buchanan. With that I yield back.

*Chairman Neal. I thank the gentleman. With that let me recognize the gentleman from Texas, Mr. Doggett, to inquire.

*Mr. Doggett. Thank you, Mr. Chairman, and thanks to each of you for your testimony.

I believe that, as we consider this legislation, our guiding principle must remain seeking the most relief for the most patients. We shouldn't let the perfect get in the way of the good, but we should assure that the good we are promising is the good we deliver. Our job is not to rubber-stamp a staff-written proposal, but it is to scrutinize each section carefully to assure that it truly fulfills its purpose.

We are here today largely because of what happened in this very room 16 years ago. That is when the Republicans passed through this committee and ultimately, in the middle of the night, after hours of arm-twisting, forced through the House the Medicare prescription drug program. Inserted in that complex piece of legislation was one sentence -- one section that the pharmaceutical manufacturers spent millions of dollars to get in there, and it was to assure their monopoly power by denying Medicare any right to negotiate drug prices.

We have been stuck with it and millions more dollars of pharmaceutical lobbying to keep it there for all these intervening years. And Americans have paid billions of dollars

because of that.

I am concerned that the benefits of this legislation reach all Americans. And let me ask you, Ms. Georges. Does AARP support denying the uninsured any of -- the guarantee of any of the benefits of negotiated prices?

*Ms. Georges. No, we --

*Mr. Doggett. You believe all Americans should reach --

*Ms. Georges. That is true --

*Mr. Doggett. And --

*Ms. Georges. -- Congressman.

*Mr. Doggett. One of the improvements I think we need in H.R. 3 is to assure that. Because, as currently written, it does not guarantee any of its benefits of negotiated prices to the uninsured.

Let me ask you also with regard to that prohibition against banning the federal government from negotiating the price of drugs. Does AARP support the ban on the federal government negotiating drug prices?

*Ms. Georges. Sir, AARP has said that one of its priorities and -- is to lower costs to our members. And we did suggest in a previous hearing at another committee that the Secretary of Health and Human Services be given the right to negotiate prices for Medicare recipients.

*Mr. Doggett. Well, thank you. When I met with my AARP members in San Antonio last weekend, they were surprised to learn that AARP had so fully embraced legislation that maintains the prohibition on the federal government negotiating drug prices. Indeed, about two-thirds of Medicare-covered drugs, it would still be against the law to negotiate them if the bill passed without improvements. I believe it should be improved to cover more of those drugs.

And specifically, Ms. Reid, with your testimony -- which is very courageous -- in the committee, my concern with the bill as drafted is that if you are only -- you satisfy the requirements of the bill by only dealing with 25 drugs a year. With more than 25 drugs a year coming into the market each year, we don't know whether the -- any of the 3 drugs that you take will win the lottery and be in the 25 or 20 or 30 that get considered, or whether it takes decades before yours are ever reached.

So, trying to see that the bill is strengthened to assure that we deliver for you what you are here to talk about today -- and you make a very good point that many of these new drugs are nothing but reformulations, different colors, different mechanisms to preserve the monopoly power of prescription drugs.

Dr. Georges, I particularly agree with you and Dr. Feder on the importance of using any benefits from this bill to fund dental, hearing, and vision. I have introduced legislation on that. There are now many different bills to do that, as well as to address the Medigap problem on which I have introduced other bills.

While I want to see dollars also invested in new cures and treatments, one of the biggest challenges we have also failed to deal with is to assure that when taxpayers put the money in -- and every drug approved from 2010 to 2016 had taxpayer money in it -- that there is any restraint on the prices. And there is no restraint coming on that now, and that is also an important part of this bill, as well as addressing for the first time the launch prices, which need some attention.

Thank you very much for helping us as we move forward.

*Chairman Neal. With that let me recognize the gentleman from Nebraska, Mr. Smith, to inquire.

*Mr. Smith of Nebraska. Thank you, Mr. Chairman, and thank you to our witnesses for being here today. Obviously, this is a very important topic.

And as I talk to seniors across my district, a very rural district, it is interesting just hearing their input, their feedback, looking at the history of Medicare, hearing, you know, the very contemporary perspectives, perhaps, on what Medicare is, what it should be, according to some, and certainly a lot of rhetoric involved, and especially in this presidential campaign season.

I think that, as we do weigh issues, it is very important that we look at these tradeoffs. And, you know, many, many pieces of legislation, as it has been mentioned, they are tradeoffs. I worry greatly, because many, many, many occasions are proof that Congress intended to do one thing, and accomplished, I would say, sometimes the exact opposite outcome. And so that is why I think we should tread very, very carefully as we do weigh these options and these policies.

I am just curious. Are any of you on the panel here in support of Medicare for All? Any hands? Raise your hand if you are in support of Medicare for All. Okay, I just want to establish the context in which we are discussing these issues.

But as was mentioned earlier, regulation is highly consequential. And, Dr. Ippolito, I believe that you mentioned that, and I couldn't agree more. And when we talk about negotiation, I am not sure there is the most basic definition of a negotiation in play here. Dr. Ippolito, can you perhaps discuss more what this negotiation, as proposed in the bill, would actually be? Because it, the government, you know, the central government, HHS, supposedly having negotiation -- that is a pretty heavy hand in what I would consider a typical negotiation.

*Mr. Ippolito. Sure. So, mechanically, what would occur, at least as I understand it, is that each year the HHS Secretary would be able to choose drugs to enter into this negotiation. That number right now is a minimum of 25 -- there have been some suggestions to expand that to 35 or more drugs -- conditional on being selected into that

negotiation. Then the price that you would receive is going to be capped, as a function of what other countries pay. And then the Secretary and the manufacturer will ostensibly negotiate for a price somewhere below that or at that price.

The key, though, is that there are penalties for not coming to an agreement. So if you choose to sell the drug at a higher price, for example, then within a year or so you will be taxed at 95 percent of your gross revenues on the drug, which, of course, is higher than your net revenues on the drug.

So the choice, practically speaking, is conditional on being selected. Do you accept the HHS Secretary's price, or do you simply not sell the drug, period?

*Mr. Smith of Nebraska. Okay. And clearly, when we talk negotiation, as you point out, the bill does not include true negotiation. What is negotiation is what is -- has been taking place in a very successful format across so much of Medicare part D, and that is what has kept premiums down, and affordable access to so many drugs, especially for seniors. When we talk about economic feasibility, I think it is important to look at that.

Now, as I understand the bill, it would be less economically feasible for someone to cure diabetes than a disease felt by fewer Americans. Would that be accurate, Dr. Ippolito?

*Mr. Ippolito. I think it would be accurate to say that you are much less likely to trigger this rate-setting process if you are a lower-value drug than if you are a high-value drug that treats a lot of people.

*Mr. Smith of Nebraska. So there would be incentives to innovate for drugs that would impact fewer people. Would that be --

*Mr. Ippolito. That is entirely possible.

*Mr. Smith of Nebraska. -- accurate?

*Mr. Ippolito. Yes.

*Mr. Smith of Nebraska. Okay.

*Mr. Ippolito. That is entirely possible. I think one of the key things to keep in mind is what kind of drugs do you want to invest in under this system, especially because there is going to be a lot of uncertainty about who that HHS Secretary is, what the administrative preferences are during that administration some 10, 15 years in the future.

You may say, "Geez, that is a lot of uncertainty, that is a really low price. I may want to target an area where I think I know what I am getting with a little more certainty," and that may well be a smaller market.

*Mr. Smith of Nebraska. Thank you. Well, I appreciate the feedback here. This is an important topic. And if there is an opportunity to work together to address this, I hope we can do that by Tuesday. Thank you.

*Chairman Neal. I thank the gentleman. Let me recognize the gentleman from California, Mr. Thompson, to inquire.

*Mr. Thompson. Thank you, Mr. Chairman, and thank you for having this hearing today, and thank you to all the witnesses for being here.

You know, Mr. Chairman, every time I go home to my district I hear about prescription drug costs. And I don't think I am alone. I think we all hear the stories: constituents who have to ration their insulin, seniors cutting pills in half, folks skipping doses to make their meds last longer. It is absolutely critical that we use every tool at our disposal to bring down these prices for Americans.

As we have heard, one of the key components of this legislation is the ability for Medicare to negotiate drug prices. I want to say that I have seen firsthand how effective it can be when the government uses its leverage on behalf of our constituents. I know this from personal experience, because I am a customer of the VA.

Before I started using the VA to buy my cholesterol medicine, I paid out of pocket

every month \$120 and change. At the VA I pay \$18 a month. That is over \$1,300 in savings every year. And that is just for one cholesterol med, \$1,300. That is real money. That is more than a month's worth of groceries for a family in my district. That is two or three car payments, a month of child care. That is what happens when the government has leverage in negotiations.

I want to start my questions by asking one of the most innovative and -- asking about one of the most innovative and expensive drugs on the market today. Earlier this year the FDA approved a new gene therapy for children with a rare genetic disorder. This therapy is, quite literally, a lifesaver. It is also the most expensive drug in the world. It costs \$2.2 million per patient.

So, Dr. Miller, I would like to ask you. How do we verify that a \$2 million drug is priced fairly? Is there any mechanism in Medicare to make sure that new drugs, drugs without competition, are reasonably priced, and are not going to be used to gouge patients?

*Mr. Miller. So the choices you have -- but right now there isn't a mechanism -- the choices you have is you can look at cost-effective analysis. You can look at what other countries pay. Or you could look at the cost of what it brought -- what it took to bring that drug to market. But, of course, that is pretty opaque to anybody. That would require information, information we don't have.

The issue, I think -- and particularly as it relates to the last exchange on the negotiation -- is the PBMs negotiate. And I am speaking only for myself. I think that process in part D, where there are competitors, actually can work well. The problem is when a drug like this shows up and there is no other competitor. Then the manufacturer can set the price.

And I think the penalty is put in -- you know, I think the penalty is put into this law because the leverage that the PBM has is it will take the drug off of formulary. It will say

all your revenue is going to disappear if you don't agree to a price. And, as I understand H.R. 3, they are trying to say they don't want to take it off the formulary, they want to make it available, and they need some other leverage to bring the person to the table.

But either you can look at international prices, cost effectiveness, or the cost of the drug. Those are your three metrics. But they are not available to you now.

*Mr. Thompson. Thank you. We have heard from critics that this particular bill will hamper innovation. I want to point out that innovation isn't worth much if nobody can afford the product. But I agree that we should encourage the development of new medicines and new treatments, and innovation is important.

So, Dr. Miller, if this bill were to pass, how would the negotiating drug prices disrupt innovation?

*Mr. Miller. All right. So I do -- I want to be very clear. And I agree with Benedic and some of the other comments, that this is something that needs to be done carefully.

I also wouldn't blow past the notion that, with lower prices, there will be greater access, and with better coverage there will be greater access. So you will get health gains there, and we shouldn't just blow right past that.

But on the R&D front, I think the real key here is targeting and clarity. If in the legislation you say these are the criteria for these drugs -- and the idea being that they are expensive and no competition -- are the drugs that are subject to negotiation, then the industry will understand the lanes that they have to play in, and will know what to expect. That will mute some of the effect on -- that people are concerned about in R&D. I don't think it is the fact that you pull money out, because I think there is headroom on the revenues that are available to continue to go into R&D. I think uncertainty is the risk. And as long as it is clear in the legislation, you can adjust that.

But there are other places where money can go into R&D. People have mentioned marketing. The CBO estimates suggest that EU prices will go up, which will generate more revenue for R&D. And then, as I mentioned, you could take savings from the bill and also put that into R&D.

*Chairman Neal. Thank you. Thank you, Dr. Miller and thank you, Mr. Thompson. With that let me recognize the gentleman from Texas, Mr. Marchant.

*Mr. Marchant. Thank you, Mr. Chairman, and thank you for continuing to have these discussions about lowering drug prices. People in my district, this is a -- very high on their list of concerns. And I think that we are doing what they would like us to be doing: discussing how, even though we have strong disagreements, how we could lower drug prices. I think everybody here agrees that drug prices are too high. We need to find solutions that will provide real savings to our constituents.

I do not believe that H.R. 3, as it is now written, provides those solutions, and do not believe that it is a bill that the Senate will take up and consider. So I am looking forward to some serious changes to be made in the bill to make the bill more palatable. I support a bipartisan part D redesign that protects beneficiaries, lowers their out-of-pocket costs, and isn't attached to legislation that has no future.

Mr. Ippolito, some of the more progressive voices on the other side of the aisle have suggested that Americans are paying for drugs twice, once by investing in the National Institute of Health, and then again as part of the Medicare program. Can you shed some light on the relationship between public research and medicines coming to market?

*Mr. Ippolito. Sure. So it is -- I would start by just going back to square one and saying, "Just what the heck is NIH doing?"

And in many cases, the NIH is providing a very valuable resource. They are trying to solve what economists would call a public goods problem, which is you can learn a lot

of things that are really useful for drug development or other endeavors that are examples like how the body works. But you can't patent that. You can't get intellectual property protection about that -- or on that, excuse me.

And so you have this problem of, gee, I could spend all this money to discover these things that would help us down the road discover new drugs, but if Pfizer finds out, they can just take it from me. And so you have this problem of we worry about chronic under-investment in that kind of public good.

And so a lot of what the NIH is doing is funding research to try and get more of that basic research done, overcome that public good problem, so that then you solve that and then say, "Okay, we have learned something about the human body," say, "Now we can go ahead and make a drug to somehow treat that."

So I think there is a big difference between the sort of primary goal -- at least typically -- for the NIH and what a commercial drug maker is actually doing.

*Mr. Marchant. In a similar vein, can you discuss the inherent weakness of a -- the price-setting scheme that is put forward in this bill?

*Mr. Ippolito. Yes, sure. So one thing I will emphasize is something that Dr. Miller just emphasized that is really, really important, and I think is woefully under-appreciated. Uncertainty is extremely costly, especially when you talk about long-run investments.

And so there is two things going on. There is one that is sort of a just level shift, where we are going to lower drug prices. And then there is the second element, which is that we are going to have to try and measure international prices, which comes with some uncertainty itself, and then there is going to be the actual price that you come to is, in large part, going to be at the discretion of the HHS Secretary of a particular administration. That uncertainty element is really expensive, because you don't know what draw you are

going to get in 10 years.

And so, I think one of the first order issues that I would think about as I would -- if I were in Congress, kind of trying to tackle this issue, is I would think about certainty. I would think about setting up rules of the game that are clear, that convey clear incentives that allow us to think through the tradeoffs that we are going to make.

And so, if you really are worried about drug prices being too high, for example, you could think about, well, maybe we should shorten exclusivity lengths. That is a very clear signal, it is very easy to understand what we are talking about. We can have an open discussion about exactly what that would mean. I would prefer that much more strongly to something like this, where we kind of say, "Hey, HHS Secretary, in 15 years go get them."

*Mr. Marchant. And to the other panelists, just a short question. Do you support the language that is in the bill that fixes the drug pricing scheme, going forward?

*Mr. Miller. I think that, as mentioned by a number of people, the part D reform is -- you know, deals with one particular problem, the PBM issue. The inflation index deals with a different problem, and I think it is important to have.

And then I think the difficult conversation is how do you get at the drugs that have no competitor and are extremely expensive? And the government has granted them a monopoly to set that price, and the negotiation, as long as it is structured in a way that is relatively clear and targeted, consistent with, you know, the uncertainty concerns, I think is one way that you could get at that.

*Chairman Neal. I thank the gentleman. With that let me recognize the gentleman from Connecticut, Mr. Larson, to inquire.

*Mr. Larson. Thank you, Mr. Chairman. And I want to thank all the panelists, as well. And it is rare when you get nearly unanimity, in terms of agreement, especially as it relates to part D, in terms of what is need in reform.

And I would say to my colleagues on the other side of the aisle that there is a great opportunity here for bipartisanship. I noted with some crocodile tears that there was none over those eight years that you were in control. But nonetheless, I do think that there remains that great opportunity.

Mr. Thompson had a very interesting line of questioning, and that is clearly that the military side of this, they have been very successful with direct negotiations.

Dr. Ippolito, would you say that that -- they have been successful with regard to that, in determining the cost of drugs?

*Mr. Ippolito. Yes, through the negotiations and formulary use, they have achieved some of the lowest net prices in the U.S., yes.

*Mr. Larson. So why aren't we able to replicate that? Dr. Miller, do you think that that is a model that we ought to continue to pursue, and --

*Mr. Miller. I think that H.R. 3 is an attempt to replicate that for a certain set of drugs. I think Benedic just mentioned this, and this is something I have mentioned: most negotiation in this country in the commercial sector PBMs, they negotiate on the basis of taking a drug off of formulary.

What I think is the intent here is not to ever remove a drug from formulary, to make it available to the patient, but just at a lower price. And I think that is what has created the mechanisms and the discussions that are in play here, particularly around the penalty.

*Mr. Larson. Dr. Feder, do you agree with that?

*Ms. Feder. My expertise is primarily to talk about the extra benefits. But based on what I know about the pharmaceutical market, I would support whatever Mark says.

[Laughter.]

*Mr. Larson. I like your clarity with respect to that. I think this is an important aspect that Mr. Thompson raises, and primarily because, when you go back home and you

experience what veterans have gone through, and when you hear from people in the military they say, "Yes, why can't we do for Medicare what we do for our military?"

And it seems like a pretty straightforward answer, I would think, to any Member of Congress. What do you see as the complications, in terms of getting there?

Dr. Georges, what would you say?

*Ms. Georges. There has to be willingness to come to the table and do the discussion about having prices negotiated by the Secretary, as we had suggested, on behalf of Medicare beneficiaries.

And that also has to be extended to the -- to those who are -- who -- between 50 and 64, people who we also represent, who are our members, because they would not fall into the Medicare piece.

So we support -- and we don't have all the details, but we support that prices need to be negotiated on behalf of our older Americans in this country.

*Mr. Larson. And what would you say to Dr. Ippolito's call -- because he has been fairly articulate about saying what we need is greater competition, and within that competition we are going to get greater -- I think you used "certainty" as a term in -- where we will be, in terms of prices.

The quandary for most Americans is, well, that is the system we are in, but we don't see certainty. What we see is the continued escalation and rise in cost of prescription drugs.

*Mr. Miller. So --

*Mr. Larson. Dr. Miller?

*Mr. Miller. Yes. In our framework -- and I tried to touch on this quickly in the five minutes, and it is -- you know, it is hard to do -- we strongly agree that part of this legislation needs to be aimed at anti-competitive practices. It creates pay-for-delay, those

types of changes.

And I also think there are patent reforms that need to go beyond that that will make a more competitive market. More competitors can come, prices can be driven down.

But keep in mind, even if all of that was effective tomorrow, you don't see the benefits of that for many years. And there is a lot of people who are paying a lot for drugs right now, and -- that I think other components of the bill are aimed at other parts of the problem and at that problem, in particular.

But I want to be clear. We strongly support that.

*Mr. Larson. Thank you, and I yield back.

*Mr. Thompson. [Presiding] I thank the gentleman. Mr. Reed, you are recognized to inquire.

*Mr. Reed. Thank you, Mr. Chairman, I appreciate that. And maybe -- I am going to bring up a topic, but I want to address the elephant in the room.

In regards to -- now that -- I had a meeting this morning with a bunch of Senators. And I was flabbergasted to learn for the first time that, when impeachment goes over to the Senate, they are prohibited from discussing any legislation, other than those impeachment articles. By their own rules, they will be locked and prevented from having any discussions about legislation that they can process through the Senate.

So I am very concerned that if we are going to pursue H.R. 3, given the backstop of what is going to -- we are facing in the Senate, our window of opportunity here is going to be very short to get something done. And so I want to focus my time on maybe, from the panelists, the items that I see bipartisan support from, across the aisle, across the chambers in the Senate and the House that could get to the issue of drug prices. Because I think there has been a lot of bipartisan work already done. And if we have that small window of opportunity to get something passed and signed into law, I want to focus on what are the

legislative vehicles that will achieve success for Americans today.

And so, by show of hands -- and I have already had some testimony here, and I have got your written testimony -- how many of you on the panel today would support an out-of-pocket cap in part D that would benefit American people back home?

Let the record reflect everyone has supported that.

Let me ask you this. Again, by show of hands, how many of you would agree that simplifying the part D to put more of the responsibility of the cost of drugs on insurers and manufacturers would directly benefit consumers?

Let the record reflect everyone agrees with that.

How many of you would support a ban on the pay-for-delay contracts that Dr. Miller has been talking about that stop generic competition in the market? By show of hands.

Let the record reflect again all panelists are in agreement with that.

How about the issue of getting to the question of transparency? We have a proposal, bipartisan, Mr. Horsford and I, called the SPIKE Act that gets to transparency on drug prices as they go through the Medicare system. They would have to disclose what is the basis for their cost increases, and demonstrate why those increases are occurring. Do you believe that is legislation that would help the American people in regards to this issue? By show of hands.

Let the record reflect everyone agrees.

The transparency issue of how contracts are negotiated or drug prices are negotiated today, and that is the transaction that is between the -- a pharmacy benefit management companies and Pharma, having these disclosure pieces of legislation that get to what is the compensation, how are those transactions occurring.

By show of hands, would transparency in those negotiations to get the hard data as

to actually what is going on, would that benefit American people in regards to drug prices?
By show of hands.

*Mr. Miller. As long as it is protecting proprietary information, yes.

*Mr. Reed. Okay. So, by show of hands, does everyone agree with that?

*Mr. Miller. On all the others, as long as it is paid for, yes.

*Mr. Reed. Okay.

*Mr. Miller. You know, like the out-of-pocket cap, that kind of thing.

*Mr. Reed. Sure. So I am very encouraged by what I just saw there. And the American people should be encouraged.

So if my crystal ball is accurate, and given the small window of opportunity that we have here -- and also, I don't want to bust the bubble, but H.R. 3 is appearing to me to become a partisan type of exercise. It seems to become an issue that is going to divide Republicans and Democrats, and we are going to have to have lengthy conversations and negotiations to see if that can even get through the system and signed into law.

So if H.R. 3 is not going to pass and get signed into law in this small window of opportunity, does anyone on this panel recommend to me and go on record today to say we should do none of these other items in regards to the show of hands in support of the legislation I just addressed, because we should focus our continuation on H.R. 3 and getting that signed into law?

Should we stop all efforts to try to get that legislation that has been broadly supported by all panelists today? Anyone think we should do that?

Yes, Dr. Feder?

*Ms. Feder. Yes. I was asked earlier about -- I think by Mr. Lewis -- about whether it would be a mistake to ignore this opportunity not only to really control drug costs --

*Mr. Reed. Okay --

*Ms. Feder. -- which I think would go beyond --

*Mr. Reed. Dr. Feder, I --

*Ms. Feder. I am just answering.

*Mr. Reed. Yes.

*Ms. Feder. Is that if the -- it would be a mistake not to do -- to go for what we really need, and it would be a mistake not to invest in additional services --

*Mr. Reed. Okay, your --

*Ms. Feder. -- beyond the --

*Mr. Reed. Your testimony to me, then, to me, as a Member of Congress, is I should advocate stopping all bipartisan legislation, focus all my efforts on H.R. 3, in order to get --

*Ms. Feder. No, my recommendation to you as a Member of Congress is to work together to make this legislation as strong as it can be.

*Mr. Reed. Okay, but I -- the legislation that you all identified that you agree with, we should continue to work and get that signed into law and use this opportunity, if we can get it signed into law, to get that legislation --

*Ms. Feder. I am just saying -- what I am arguing with you is that I do not think you have to abandon many of the more valuable or equally valuable provisions of H.R. 3 in order to achieve your objectives.

*Mr. Thompson. The gentleman's time has expired.

*Mr. Reed. My time has expired. Thank you.

*Mr. Thompson. I recognize Mr. Blumenauer to inquire.

*Mr. Blumenauer. Thank you, Mr. Chairman. I appreciate the committee's working with us, particularly to incorporate into this legislation H.R. 4663, the Freedom

from Price Gouging, with Representatives Porter, Underwood, Crow, and myself, that would protect Medicare patients from drug price spikes by requiring the manufacturers to pay the government back when they increase the price of the drugs covered more than inflation. I think that is important, and I appreciate it happening.

I will say that I continue to have some concerns, as this moves through the process, that we do work to increase the number of drugs that are negotiated and eligible for negotiation. I am interested in protecting people from prescription drug price spikes by expanding the inflationary rebates to all drug sales, and address the issue of high-launch prices. We are not done with this as it goes through the process, and I hope we can continue to focus on that.

I would like to consider two additional improvements to the Medicare program.

We have been working, and the people on this committee helped deal with a concern we have under Medicare and Medicaid dealing with medical records, the part 2CFR that we had included in legislation last year that got stripped out in conference that would enable the records to show people who have substance abuse. Right now in emergency rooms that is not available. That is, I think, an important bipartisan piece of legislation that we ought to hook back in as it goes through the process.

I also hope that we can look at the program -- the PACE program, to have the necessary tools to provide care. Right now the lower-income, Medicare-only beneficiaries have an extraordinarily expensive part D premium cost for PACE, \$800 a month, a wildly strong disincentive for enrollment. I would hope that we might allow, just for Medicaid/Medicare-only beneficiaries, to have the choice of either using the PACE part D program or a stand-alone marketplace part D program. Congresswoman Murkowski and I have some legislation to provide options for seniors and individuals with disability, and I think it should find a home in this legislation before we are done.

I would like, first of all, Dr. Miller, to thank you for injecting a note of fiscal reality, as you qualified your answer. That is important. And it isn't necessarily included in a hand-wave. But I would hope that you might consider for a moment elaborating on your testimony on page six, when you talked about the array of anti-competitive tactics that are involved.

We are involved right now in trying to move NAFTA 2.0, and one of the things I hope comes out of that will be reining in some of those anti-competitive tactics.

You have an array that you list there. Could you elaborate on a few of those that you think are the top priority that we should be dealing with?

*Mr. Miller. I will do the best I can in the time.

So what I was saying, and what I was saying on page six of the testimony -- and this is consistent with other comments -- definitely there are changes in the -- to prevent anti-competitive behaviors, and to improve patent law. And a couple of the ideas that we are working on and thinking about is whether you, for example, allow FDA the authority to import generic drugs when there are fewer than three manufacturers of the drug. This kind of goes at generic shortage types of situations.

There are questions about when a drug -- this is more complicated, but it was also referenced, I believe, in somebody's testimony. I apologize forgetting. But when a drug converts, say, from a pill to a film, like, how much does that represent a patent?

There is a nasal decongestant. Advair, I think it is called, which is a combination of two drugs. They are basically 20 years old, patented, held the patent for 7 years. Is that innovation? Should a patent be held on that basis? There are things like that.

There are abuses of the citizens petitions process, where you can just file citizens petitions. Ninety percent of them are filed by brand-name manufacturers, which just slows the process down. And I believe there is pretty straightforward regulatory changes you

could do to clean that up.

And then also, on page six there is a whole set of -- or there is the idea in part B that if a manufacturer engages in a pay-for-delay tactic, then their part B reimbursements are reduced. That was actually something that came out of the Administration.

*Mr. Thompson. The gentleman's time has expired. Mr. Kelly, do you wish to inquire?

*Mr. Kelly. Yes, thank you, Mr. Chairman.

*Mr. Thompson. You are recognized.

*Mr. Kelly. First of all, thank you all for being here. And I don't think there is anybody that is on the dais today that doesn't agree that we have a major problem with this.

Dr. Ippolito, I was really interested, because I think that one of the things, when it comes to innovation, we are not talking about inventing something new, but taking something that is already out there, and then innovating and trying to find a better way to handle it.

One of the things I have been concerned about is the cost of insulin, and the fact that we have no generic substitute for it, although the three manufacturers of the product say, no, we do have a generic substitute, it is just very hard to find on the shelf anywhere.

This is a business we are talking about, right? And so, in order for a business to be successful, and to continue to have success, they have to have some type of a profit structure. Other than that, it just -- it doesn't work. I am concerned, Doctor. You talked about the penalties in H.R. 3 that would really stifle any type of innovation going forward, and people would start to pull back from it when it comes to the penalties that are imposed.

Go a little bit further on that, because you were using the terms "the tax would be based on" -- it actually would be based on sales.

*Mr. Ippolito. Yes.

*Mr. Kelly. And not on profits. And it is one of the weird things that we come up with. We also do the same thing with medical device tax, where we want to tax people on sales, and not on profits. That is an upside-down approach to keeping people active and moving in the right direction.

*Mr. Ippolito. Yes, at a --

*Mr. Kelly. Explain a little bit more.

*Mr. Ippolito. At a minimum, it is a -- I suppose if you want to call it an incentive, it is an extremely strong incentive. But basically, what you are saying is, look, you have two choices. Either you take the price or you don't sell the drug. Right? That is the option that you would have under H.R. 3.

And as Mark talked about, the goal here is to not do what the VA does. It is to not have a formulary. It is to not exclude anything. But, of course, the problem is, yes, that works today. We can absolutely -- today we could -- you know, the federal government has control of the military. You could say all drugs are zero, and go confiscate every patent, you know, in the country right now, if you really wanted to. And we could have some great short-run benefits, right?

The challenge is what does the access to the next set of drugs look like. And that is what we are debating right now. It is access today versus access tomorrow. And there is a balance there, right? Nobody looks around and says, boy, it is great that somebody happens to have rheumatoid arthritis, and that drug costs \$5,000 a year. Nobody likes that.

The question is at what point do we say that is too much, and at what point do we say that is too low. That is, it stifles the next thing that is coming down the pike, be it Alzheimer's or whatever. And so that is really the dimension that you want to be thinking about, the selection of drug and the availabilities of drugs.

*Mr. Kelly. So in H.R. 3, if we eliminate the opportunity for success, and the

financial risk, then, far outweighs the financial gain, I would think that most people looking at this purely as a business model would say, you know what? I am just not going to go down that path. I will stay away from that, because there is no upside to this.

And I think the great danger that we face -- we always think that somehow the government has an answer. I am very reluctant to look at an outfit that is \$22 trillion in debt and say, "I think I am going to go to him for business advice."

This is really troubling. And H.R. 3, while some of the things we agree with, I think the danger of what is being proposed, where the government negotiates prices and determines that, it will determine then what actually goes onto the shelves, what actually goes to market. And are we really serving the needs of the people that we represent? I just don't see -- and I am talking about just purely an economic model.

In Pennsylvania there is 254,000 jobs, by the way, that are involved in the pharmaceutical business. There is a lot at risk here. Financial risk that you talk about so clearly is one of those things I think we need to take into effect [sic].

Now, Mr. Kind and I sit on the -- an innovation -- medical innovation, not -- he and I, Dr. Bera, and Markwayne Mullin. But the whole idea is we want to encourage people to do innovation. We want to -- we don't want to discourage that, because look at what happens going forward.

And I am, again, talking about insulin. Thirty-plus -- more than thirty million Americans have diabetes. The seven million that have type one are in grave danger, because rationing their dosage would -- is a death sentence.

So again, the business model is critical for anything to go forward, and innovation is the key. Competition improves quality, lowers price. I don't think we want to go away from that --

*Mr. Ippolito. Yes, I don't think anybody disagrees that you need to have a reason

to make a drug, right? And we all look around and we see drugs that are fabulously successful in a clinical sense. And I don't think anybody wants to stop that. The question is simply at what point is it too much. And I think we all would say we don't want to spend the entire GDP on drugs, either.

And so, at some point we are haggling over, right, what the number is. And so I think what I would definitely agree with you on is I think you do want to be careful, because we know the direction of the tradeoffs, and so we want to tread fairly systematically, and fairly lightly as we move in this direction.

*Mr. Kelly. Okay. Thank you all for being here today.

Thank you, Mr. Chairman.

*Chairman Neal. [Presiding] I thank the gentleman. Let me recognize the gentleman from Wisconsin, Mr. Kind, to inquire.

*Mr. Kind. Thank you, Mr. Chairman. Mr. Chairman, I want to thank you for holding this very important hearing, and I want to thank the witnesses for your testimony today. It has been very, very helpful.

And I am also thankful to the chairman for agreeing to include in the underlying legislation a bill that I recently introduced with Ms. Davids and Mr. Butterfield called the Better Transparency and Information for Medicare Beneficiaries Act. It would direct the Secretary of HHS to provide notice comparing out-of-pocket costs for other lower-premium prescription drug plan options to individuals who are eligible for low-income subsidy program, better inform them of what choices, price choices that they have. It doesn't force them to have to take it, but just getting them more information. I appreciate the chair including it in the underlying bill.

You know, earlier this morning the ranking member kind of chastised some of us Democrats who did not support the part D prescription drug bill back in 2003. And as one

of the members that was around for the formulation of that bill, and for the debate, there were a couple of overriding considerations that led me to no.

That bill cost over \$400 billion. It was the largest expansion of Medicare spending since the creation of the Medicare program in 1965. Not a nickel of it was offset. Not a penny was paid for. And you are wondering why today we are running annual trillion-dollar budget deficits.

And the other consideration, too, was that language was inserted in the bill that specifically prohibited the federal government to even discuss price with the pharmaceutical industry. The drug companies are the only private company that does business with the federal government where we are specifically prohibited to talk price with them.

And I will tell you who this doesn't divide, H.R. 3. It doesn't divide the American people. Because when I bring this up back home, all of them are shaking their heads. And they may not be Nobel prize-winning economists, but they know when the gig is up, and that something isn't on the level here. And they think it is ridiculous that we have a prohibition on price negotiation with the pharmaceutical industry.

And then put this in the category of Call Me Cynical, but the chairman of the Commerce Committee that was instrumental in getting the non-negotiating language in the bill suddenly left Congress and became the head lobbyist for the pharmaceutical industry here in Washington. I mean you wonder why this place ain't on the level sometimes. H.R. 3 corrects that.

And I will tell you who else this doesn't divide: the President of the United States that campaigned on H.R. 3. He may not have known what the name was at the time, but back in 2016 he said he wanted to restore price negotiation for these drugs. And that is exactly what we are doing now.

But, listen, I am sympathetic to what Dr. Miller and what Dr. Ippolito have said about the need for providing clarity. No one up here wants to prohibit new drugs from entering the market, break-through drugs. No one wants to prohibit the important R&D investments that the drug companies have to make. We need them to stay on the cutting edge and doing this discovery and breakthrough research.

And I think, Dr. Miller, you addressed it earlier, but I want you to amplify a little bit about the importance of clarity in these negotiations so that the companies know what investment decisions make sense for them. And there are -- check me if I am wrong -- under the bill certain parameters that HHS must abide by in order to negotiate these prices. It is not just a gun to their heads to say take it or leave it, or you are going to get taxed to death.

But it is not just the 1.2 times -- the average international market price for the 6 most developed nations around the world, but other parameters like they have to take into consideration R&D costs, information on alternative treatments, and the value of the drug, domestic and international sales price information. So there are parameters that HHS has to abide by that could constrain these negotiations somewhat, too.

But are there other things that we ought to be considering to provide that type of clarity, which I think is important for the industry to have, as we move forward?

*Mr. Miller. Yes, there -- as I understand the legislation, in addition to what you said -- what you are talking about there is when the negotiation is occurring, this is what the Secretary needs to consider.

But in addition to that, and consistent with your point, and consistent with the point that I have been trying to make, is there are parameters about which drugs will enter into the negotiation space, and under, you know, what circumstances, and that is the clarity I am talking about for a manufacturer.

Right now we have investments, and those investments produce certain types of outcomes. Like nobody is investing in second-generation antibiotics. It is true that you will change the structure of the market. But as long as you do it clearly, the market will form around the new parameters. And that is what I am sort of reaching for in my comments.

Yes, there are other --

*Mr. Kind. I think we need to devote a little more information on that part, too, and I think we can also have a larger conversation on what the savings -- and right now preliminary savings in this bill is about 345 billion. Ironically, almost the cost of the prescription part D drug plan way back when. But it is going to be an important determination on how we use that additional savings, and for what.

I yield back, Mr. Chairman.

*Chairman Neal. I thank the gentleman. Let me recognize the gentleman from North Carolina, Mr. Holding, to inquire.

*Mr. Holding. Thank you, Mr. Chairman. I appreciate it.

H.R. 3 is a short-sighted proposal that will derail the strong legacy of innovation our nation enjoys. This bill is chock full of bad ideas, misaligned incentives, failed policy imported from socialized nations, and it will undermine the next generation of scientific research in America.

Government price controls will not only kill innovation, but will also fundamentally change the doctor-patient relationships in this country. It allows bureaucrats to make the most personal choices about course of treatment for our constituents. Horror stories abound of the health care systems of socialized nations. Patients are told they must wait years while living with a cancer diagnosis for a treatment that is readily available here in the United States. Doctors make professional treatment recommendations to their patients,

who can then be denied access to the drug of their doctor's choice by bureaucrats.

Only 53 percent of new medicines developed between 2011 and 2018 available now in the United States were available in France. Yet this committee will soon consider H.R. 3, which seeks to more closely align our health care system with France.

Make no mistake. Government price-setting is a bad idea for our constituents, and I take issue with the notion that government price-setting would allow for innovation. I don't believe it would.

Over two million seniors in North Carolina rely on Medicare for their health coverage. And they deserve access to the full array of treatment options that the brilliant minds in our nation are developing. My constituents deserve access to the next life-changing drug in the pipeline, and their children deserve access to the next one in the pipeline after that.

The Research Triangle Park, which is located in North Carolina, is home to many small and mid-sized biotech firms and start-ups taking immense risk to pursue breakthroughs. Government price controls would not only discourage these ventures, but would also punish them for their successes as the market for new cures crumbles.

In North Carolina government price controls would shatter the bio-pharmaceutical ecosystem that supports 45,000 jobs directly, 200,000 jobs indirectly, and generates \$13 billion in economic output annually. These statistics do not even begin to capture the cures such as Zolgensma, which my friend, Mr. Thompson, referenced earlier, the drug that costs \$2 million per dose, which would allow children with little chance of survival past age 2 to grow up, or the hope of curing Alzheimer's or ALS, both of which have drugs currently now in the clinical development phases. It would be a grave mistake to fundamentally change the market structure that makes America a viable market for cutting-edge innovation in biopharmaceuticals.

We live in an era of unprecedented progress in the biopharmaceutical industry. And in his testimony, Dr. Ippolito recalled the failure of hospital price-setting. We should remember the failure of hospital price-setting and the implications of government price-setting in the health care system, and reject it.

So a question to Dr. Ippolito. Your testimony also talks about the re-tilting of incentives, as a result of H.R. 3's part D benefit design. Can you explain in more detail what the impact of this tradeoff would be on the innovative -- on innovative products, and is there any other information you can share about which classes of medicine are more -- most likely to be impacted by the part D redesign proposal?

*Mr. Ippolito. Sure. So as you think through re-designing Medicare part D, probably the most important thing to keep -- to focus on is what are you requiring manufacturers to discount, and where, in the benefit structure?

And basically, what would happen under the new system is that manufacturers would have to, depending on the bill, either offer no or small discounts initially, and then, in the catastrophic phase -- which is very much what this is all about -- they would have to offer larger discounts in an indefinite manner.

That has an advantage, in the sense that the federal government is not just writing open-ended checks forever. That is good. But we also have to think through who are writing those checks, and how much is that going to differ from what they are paying today.

And so I have a piece with Scott Gotlieb and Abigail Keller, both at AEI, discussing these tradeoffs. I am happy to send it to your office, of course. But when we did this we emphasized that there are probably two groups: number one, drugs that tend to be higher net-price drugs; and number two, drugs that right now tend to be taken by lower-income-subsidy patients.

So think about things like Hepatitis C and AIDS medications. They tend to be the kinds of things that would see a very different world under the new part D re-design. And that is the kind of thing that is worth thinking through. Do you want to maybe smooth those rebates out a little bit more over the schedule, or keep it as-is? Either or, it is the kind of incentive to think through.

*Chairman Neal. Thank --

*Mr. Holding. Thank you very much.

Thank you, Mr. Chairman.

*Chairman Neal. I thank the gentleman. Let me recognize the gentleman from Illinois, Mr. Davis, to inquire.

*Mr. Davis. Thank you very much, Mr. Chairman, and I thank you for calling this very important hearing.

I think by now we know that the high cost of prescription drugs has put many Americans in a place where they decide whether to get their prescriptions filled, or whether to pay rent, send their children to school, or do other basic things that one has to do.

I am thinking of one of my constituents, a fellow named Thomas, who stated that he paid out of pocket \$7,000 a year for his prescription drugs. Then he said, "And I have insurance." But he also ended by saying, "This is insane." And I think it is insane for us to do business with pharmaceutical companies on behalf of Medicare, and not have the ability to negotiate. And so I agree with Thomas. That is kind of insane.

We know that, by lowering drug prices, H.R. 3 would yield significant savings that Congress could put back into health care by improving dental benefits under Medicare and promoting innovation of new treatments for diseases such as antibiotic-resistant infections, a many of the 162,000 people a year die from infections that are resistant to current medicines, making AMR the third leading cause of death in our country. And the

expectation is to rise as more and more bacteria become resistant to existing drugs.

It is clear that we need to do something. We need to do it now. We need to do it fast. We need to reverse this trend. And that is one of the reasons why Representative Marchant and I have introduced the DISARM Act, H.R. 4100. And I hope that our committee can find a way to address this problem as we continue the pursuit of lowering the price of prescription drugs.

My question is -- and I would like to ask Dr. Georges and Dr. Miller, if each one of you would respond to this -- how does the high cost of drugs negatively impact hospitals and other health care operations from providing other needed services that patients need to have?

Dr. Georges, why don't you --

*Ms. Georges. Congressman Davis, I will say to you that -- in speaking on behalf of older Americans, and looking at what has been happening to many of our members, the fact that they have not taken their drugs as prescribed by their physicians causes them to return via our emergency rooms in all our cities and towns in this country and/or have the outcomes of their disease be magnified because they have not followed through, or have not adhered to the treatment regimen that has been set by those who are the experts in managing those treatments.

*Mr. Davis. Dr. Miller?

*Mr. Miller. Part of your question was about the effect of costs and drugs on hospital care, for example. And, you know, the obvious -- I think the obvious -- one obvious response is that, to the extent it drives up the cost of the care, then you are going to see it in your premiums, you are going to see it in your out-of-pockets in the commercial sector. And Medicare, if there is restraints on the price, it is there. But it puts pressure on the hospital in their cost structure.

One thing we did at Arnold Ventures is we funded a not-for-profit generic company to bring to market some of the shortage drugs and the generic drugs that are actually the biggest -- some of the biggest problems in the hospitals right now. And that is one way we have gone after it.

*Mr. Davis. Thank you both.

And I yield back, Mr. Chairman.

*Chairman Neal. I thank the gentleman. Let me recognize the gentleman from Missouri, Mr. Smith, to inquire.

*Mr. Smith of Missouri. Thank you, Chairman. I hear from folks back home all the time in Missouri, and their message is clear: Congress needs to address the rising cost of prescription drugs and medical costs.

I have held numerous roundtables, public forums, met with constituents one-on-one to hear their concerns. And two things come up quite common. One is they are tired of the skyrocketing out-of-pocket expenses for prescription drugs that they are facing. And two, transparency in health care costs. Those are the two items that I continue to hear over and over.

A woman I represent -- I will call her Susan -- wrote me to ask for some help. She was 74 years old and on a fixed income. She has Medicare, a Medicare supplement, and a part D drug plan. Susan was doing everything in her power to ensure she could afford her medications. She did everything right. But our health care system was still failing her.

The out-of-pocket cost for those same generic drugs she was taking for the last 30 years suddenly increased by over 3,200 percent, 3,200 percent, not by double, not by triple. The generic drug increased 32 times of what she was paying in one month.

Again, just this summer while I was visited farms and agriculture businesses all over my district in August, I stopped at a farm in Carter County, Missouri and was

speaking to a rancher, thinking that he would talk about issues with his land, issues with his farm, raising livestock. He was talking to me about prescription drugs.

And he ended up taking me into his home to take a picture of this cancer drug that he was taking. He told me this one cancer drug that he was taking cost more than \$27,000 a month, \$27,000 a month.

This has to stop. It is time for Congress to act. We must inject more transparency into our health care system, increase access to lower cost generics in Part D and lower out-of-pocket costs for all seniors.

The Trump administration and Congress have been working to lower the cost of prescription medications for Americans. This administration has approved a record number of lower cost generics. In the last Congress, we passed multiple pieces of legislation to address the issue, including two pieces of legislation to ban gag clauses.

In Medicare and the individual market, this was an important step to ensure companies cannot conceal lower cost treatments for consumers.

But more must be done. I have been looking forward to engaging with my colleagues on both sides of the aisle, but I am truly disappointed of the bipartisan negotiations that the House has come to a halt.

I also share the concerns of many of my Republican colleagues that have spoken before me about H.R. 3 and the impact on innovation and access to future cures. But more than anything, I would like to see us work together to get a bill across the finish line and signed into law.

What Congressman Reed spoke of earlier, that is a great start. Something is always better than nothing is what my grandfather always taught me, and if we can help lower the cost of prescription drugs for the people that I serve in Southeast Missouri, that is a huge benefit.

But we can only do that if we work together and we put partisan politics aside. I do not care who gets a win in Congress. I care about who gets a win for the people that I serve, the folks that can barely make it by buying their prescription drugs.

And so let's get these fixes that we agree on, and let's take out these poison pills that we are all fighting about, and let's get something delivered for the people of America who we all call our bosses.

I yield back, Chairman.

*Chairman Neal. I thank the gentleman.

And I want to assure the gentleman that as this process proceeds, we still hope that there will be an opportunity for a bipartisan agreement on the legislation.

With that, we will now proceed to a ratio of two-to-one, and the gentlady from California, Ms. Sanchez, is recognized to inquire.

*Ms. Sanchez. Thank you, Mr. Chairman.

And I want to thank all of our witnesses for joining us. I am glad that we are here today to continue our action to try to address the high cost of prescription drugs.

Ms. Reid, I want to commend you for sharing your story. I know that it must be a difficult thing to live with.

I want to sort of home in on one of your remarks in your testimony, and I want to repeat it for everyone in the room. Part of your testimony is that drugs do not work if people cannot afford them.

Prescriptions are not recommendations. Doctors write them for a reason. Patients, our constituents, our friends, our family members, they need those medications, and they cannot afford to skip their medications or water down their medications or take half of the recommended dosage.

And whether it is the rapidly increasing prices of prescription drugs that have been

on the market for decades or the high entry list prices for new drugs, high costs of lifesaving medication make it harder for Americans to access the care that they need, and they put the lives of hardworking people in danger and also add to the increased cost of our health care system.

In my district, for example, and I hear from many, many constituents about the high cost of their medication, I have so many personal stories.

There is Alice who lives in Whittier. She went into the donut hole, and she could not afford her insulin anymore, and she had to make do by asking her doctor for samples. She had to make do with her insulin.

Paula in Montebello had her prescriptions go up to \$3,000 a month.

Natalia in Pico Rivera has to pay for her parents' medication because they cannot afford it.

Adrian in Norwalk takes eight different medications daily, but cannot afford to take them all on a fixed income.

And David in La Mirada has asthma and has even considered cutting his dosages, but he can't breathe when he cuts his dosages.

I have more stories and sadly there are simply too many to tell here today, but stories like these, I hear them all the time. I am sure my colleagues hear them all the time. They are not unique.

Today we are taking steps to ensure that Alice, Paula, Natalia, Adrian, and David and others like them will not need to tell their stories to Congress in order to get the help they need.

Dr. Miller, I want to start with you, and I want to ask you if you could talk a little bit more about how we must balance scientific discovery and innovation with affordability to patients.

Could you briefly talk about that balancing?

*Dr. Miller. I will do it as briefly as I can, and if it is too long, you can cut me off.

So you know, the way I think about it is this is a 6 or \$7 trillion market. These firms are profit seeking firms. R&D is the road to that profit. The United States will still be a major market. The prices even under this legislation will still be the highest in the world.

I still see this as a market that innovation is not going to dry up in. I will just reference the number of comments that have already passed in this hearing about being clear about what the paths are in order that the market understands what it is dealing with.

And then I will just mention a couple of other things. Right now, the amount of revenue that comes out of the United States relative to worldwide R&D exceeds that R&D by 70 percent. My point there is there is revenue that can be redeployed into R&D.

I think we care about jobs to some extent, but we mostly care about the R&D jobs here. That is the jobs that I think we most care about.

And then I will just say the EU prices in the CBO estimate are expected to rise. That would also generate additional revenue that can go into R&D.

*Ms. Sanchez. Thank you.

And I want to ask Ms. Reid in the limited time that I have left because I think you are incredibly courageous and well spoken.

How does it make you feel to know that the very companies that charge you so much for your therapies and your medications, who complain that they will not be able to innovate because of R&D; how does it make you feel to know that they received in 2017 a 14 percent permanent tax cut?

I mean, it would seem to me -- call me crazy -- that with the R&D tax credits they receive along with this hefty tax cut that they could somehow find the funds to continue to

innovate.

What are your thoughts on that?

*Ms. Reid. I do know a lot of that tax cut went into stock buybacks, not into R&D, and I would also just say that from a patient perspective, it is incredibly disheartening to hear that there is just no way to lower prices and that all of these complicated calculations have to be made, when it is very clear to me how much money the pharmaceutical companies have and are holding and are making.

*Ms. Sanchez. Thank you so much.

And I thank my witnesses, and I yield back to my chairman.

*Chairman Neal. I thank the gentlelady.

Let me recognize the gentleman from New York, Mr. Higgins, to inquire.

*Mr. Higgins. Thank you, Mr. Chairman.

There are 13 organ systems in the human body. There are 70,000 ways that those organ systems can fail. There are 4,000 medical procedures, and there are 6,000 FDA approved prescription drugs. Very complicated.

But it is also very expensive. The American health care system last year was \$3.5 trillion, 18 percent of the entire American economy.

The Federal Government alone spent more than a third of that at \$1.3 trillion, including \$333 billion on prescription drugs. CAR T-cell therapy is a form of immunotherapy, and that cancer treatment costs \$475,000 to \$1.5 million per patient. So 175,000 (sic) to 1.5 million per patient.

In the United States in the past 15 years, 42.5 percent of the 10 million cancer cases had lost all of their life savings within a little bit more than 2 years.

The Veterans Administration serves 18 million people, 9 million of whom are enrolled in the VA health care system. According to a study that was conducted between

2012 and 2017, five years, if Medicaid Part D paid for prescription drugs similar to what the Department of Veterans Affairs pays, there would be an annual savings of between 38 and 50 percent.

That was published in the Journal of the American Medical Association, Internal Medicine.

Dr. Miller, we hear from pharmaceutical companies all the time as to how if we try to lower the cost of prescription drugs to all of our constituents, but we are also at the Federal Government a huge purchaser of drugs. It is a lot of money, but it is a lot of leverage.

And it seems to me that if Medicaid and VA can achieve savings in the 38 to 50 percent range, you reduce that \$333 billion on prescription drugs that collectively the Federal Government finances to about \$166.5 billion.

So obviously, pharmaceutical companies would, you know, categorically reject this and make the argument that it somehow undermines their ability to do innovative research to bring new therapies to market.

What would your response to that be, sir?

*Dr. Miller. Well, this is some of what I walked through just a second ago. I think that there are still a lot of dollars here in the market. They will have a strong motivation to continue our R&D.

I think the prices under this legislation would still be attractive to them, and I think there are revenues in the industry itself that could be redeployed.

Keep in mind that some of the savings that you are extracting in Medicaid and the VA. In Medicaid there are legislated discounts, and in the VA there is the negotiation about whether a drug goes onto the formulary.

H.R. 3 proceeds differently, engages in negotiation, but tries to -- and does not try --

intends to keep the drug on the formulary. So it is a little different than what will go on in VA.

*Mr. Higgins. But, Doctor, the larger point is this. As we have a \$4.7 trillion annual budget, 1.3 of which Federal Government outlays for health care and \$333 billion for prescription drugs, you know, people always invoke the private sector and the need to allow them to innovate and everything else. That is nonsense.

The majority of basic research is done by the National Institutes of Health, and further, drug companies are moving away from the very expensive and less profitable basic research and into later stages of drug discovery where there are huge profits.

So when we spend 1.3 trillion, including 333 billion on prescription drugs, that does not take into consideration what taxpayers spend for the National Institutes of Health in drug development.

And I just think that, you know, we have got to, on behalf of the American taxpayer, use the enormous leverage that we have to drive down the cost of health care, to drive down the cost of prescription drugs, and demand a better outcome in terms of the product that we are paying for.

I yield back.

*Chairman Neal. I thank the gentleman.

Let me recognize the gentleman from South Carolina, Mr. Rice, to inquire.

*Mr. Rice. Thank you, Mr. Chairman.

We are really in a special time right now in this time of intense partisanship. We have this agreement between the parties that something has to be done, and the White House agrees, and the Senate has passed versions of this legislation, and different committees in the House have passed parts of this legislation.

You know, I see it in my district as everybody has brought up here before, you

know, not just for seniors, but for others. I have children with diabetes, their parents coming to see me, and they cannot afford the medications that they are being offered.

I have dentists calling me and saying for unknown reasons the generic drugs that they used to give their patients have gone up ten times in cost, drugs long out of patent.

And there are so many abuses, and we need to do something to take care of it. If we squander this by putting up this partisan legislation, I am just concerned that this moment will not last, and that we will not be able to get anything done, and we need to focus on the things that we agree with.

The thing that really bothers me about this legislation is the way that it attacks the problem. You see, the United States Government decided a long time ago that we wanted to be the biggest innovators in the world in the area of creating drugs that save people's lives and improve the quality of their lives. And so we put in intellectual property protections. And that has been pretty effective, has it not, Dr. Ippolito?

I mean, are we not a leader in innovation in drugs?

*Dr. Ippolito. Yes, we certainly encourage a lot of them.

*Mr. Rice. Dr. Miller, I think we are like the biggest innovator in pharmaceuticals in the world, are we not?

*Dr. Miller. I think the United States leads a lot of innovation.

*Mr. Rice. And is it not because of, largely because of this preference, this intellectual property protection that we have allowed these companies that spurs this innovation?

*Dr. Miller. The answer is yes, but the only point that I have been trying to make is that monopoly should also be managed at the other end. You want the innovation, but you would also like a fair price. And that is what I think we are --

*Mr. Rice. So what is the benefit of the intellectual property protection, Dr.

Ippolito? How does that benefit a company?

*Dr. Ippolito. Well, it means what you discover you know you can own, right? If you do all of this work to figure something out, you learn how to treat Disease X, then you know nobody can come in and steal it from you. You can sell it for whatever the market will --

*Mr. Rice. You can sell it at your terms basically, right?

*Dr. Ippolito. Yes.

*Mr. Rice. That is the benefit of that monopoly.

*Dr. Ippolito. For a certain amount of time. But you want that monopoly to eventually end, and that is what has not always happened.

*Mr. Rice. And so now what we do is now we are saying, well, we encourage you to innovate. So we give you this intellectual property protection, but because you take the very preference that we give you, this encouragement that we give you, well, that is bad and we are going to punish you for that.

*Dr. Ippolito. Yes. So I think maybe one way to bridge this with Mark's point is that, you know, without question, Congress wrote down a set of rules about how to govern this market, and one of them was we are going to give you a temporary monopoly, and then afterwards, we are going to end it.

*Mr. Rice. But I have something. And then to go on further to say you took this incentive and we are going to punish you for taking the incentive that we offered you, which is what this bill does, and we are going to set the price by looking at what you charge other countries, which the American government and the American people who take medication are subsidizing that medication. So these other countries get this medicine at a lower price, subsidized price, which is abhorrent to me.

But now not only are we going to punish the companies for doing what we asked

them to do, but we are going to force them to take a price that is subsidized based on this framework that we set up.

Can we not come up with a better mechanism?

I agree we have to do something. I agree that the price is out of control. But you know, Dr. Miller, earlier you said that there were three mechanisms to set the price. You said it was value. You said it was cost, and you said it was what other countries are charged.

*Dr. Miller. That is right.

*Mr. Rice. Is there not another way?

I mean, if the intellectual property protection we have given them is too broad and resulted in this system that is bad, should we not look at the underlying intellectual property protection rather than trying to set up this government price control that is going to lead to misallocations, is going to lead to less innovation, is going to lead to all kinds of unintended consequences?

It seems to me that this is just an illogical way to attack this.

*Dr. Miller. Keep in mind that one thing it does, and you said that you were concerned about this, it would push prices higher in Europe and create a more balanced system between the U.S. and European countries.

You could entertain other ways to look at it. One thing I would strongly recommend is you ask the drug companies to present information on the cost of actually delivering that drug to the market because the prices usually do not track to that cost.

*Chairman Neal. I thank the gentleman.

With that, let me recognize the gentlelady from Alabama, Ms. Sewell, to inquire.

*Ms. Sewell. Thank you, Mr. Chairman.

I want to thank all of our witnesses today. I want to especially acknowledge the

courage of sharing your experience that Samantha offered today.

You said in your testimony, Samantha, that good health is not a moral virtue, and bad health is not a moral failing. We are all one diagnosis away from a lifetime of reliance on expensive medications that threaten us with bankruptcy. Well said.

All of our constituents are going through the struggle of having high prescription drug costs. Our constituents are going without the medication they need, and taxpayers are paying for the economic costs that result from the sacrifices being made across the health care system because of the high cost of health care.

The lives of too many of our constituents are being put at risk, and I want to again thank you for your testimony.

I, like you, know we can reduce the cost of prescription drugs without harming innovation. We can get the highest quality therapies in the hands of all those who need them, and we can also make sure that we are investing in the Medicare program in a way that improves outcomes for beneficiaries and patients.

That is why I am optimistic about the many proposals that we are advancing in H.R. 3 to improve the Medicare program.

Dr. Feder, in your testimony, you highlighted a few areas in the Medicare program that you believe are ripe for reform. You mentioned excessive beneficiary exposure to out-of-pocket costs and administrative barriers and biases that limit access to guaranteed benefits.

You spoke a lot about the importance of the cap on beneficiaries' out-of-pocket spending in the Medicare program.

One of the provisions in H.R. 3 that will go probably the furthest in my district is the cap on out-of-pocket costs for seniors to \$2,000. I was proud to work with Congresswoman Anna Eshoo on a proposal to allow seniors to pay their out-of-pocket

costs in equal installments throughout the year rather than all at once. This proposal is being offered in Energy and Commerce today.

My question is: can you describe the financial barriers that seniors face affording their out-of-pocket costs in Part D and their deductibles in January and February?

Can you talk a little bit about that?

*Dr. Feder. We have heard earlier testimony about the issue of foregoing prescriptions and foregoing care because of high out-of-pocket costs, and so we know that most seniors are not wealthy. A large proportion live solely or largely on Social Security income, and health expenses, despite the presence and value of Medicare, eat up a large share of that income, and it is then insufficient to purchase.

*Ms. Sewell. Yes.

*Dr. Feder. So the fact that there is no limit, and it is not just Part D, in fact. It is also the expenses in Parts A and B that affect what they spend out-of-pocket. It actually serves as a barrier to access to affordable care.

*Ms. Sewell. And what are the long-term economic consequences of medication non-adherence, when people try to self-medicate because the cost is so high?

*Dr. Feder. Well, as somebody said earlier, I think it was one of the members that said that the prescription is not a recommendation, and consequently, not to follow the prescribed treatment is to lead either to insufficient action to address the condition or exacerbating that or other conditions that an individual may have.

*Ms. Sewell. Dr. Georges, I know that you sit on the board of AARP. Can you talk a little bit about the cost to seniors with respect to prescription drugs?

*Dr. Georges. Yes, Congresswoman. So one of the problems is because they do attempt to manipulate how they are taking their medications if they cannot afford it. What does happen, as Dr. Feder referred to, is they end up in our emergency rooms. They end

up with poor outcomes in the management of their disease.

They end up many times because they lose their balance in the home because they have not taken their medication that keeps them doing well; they end up with traumatic brain injuries, additional orthopedic injuries, and again, an additional cost to the system because they then have to be hospitalized in the most expensive units in our institutions.

*Ms. Sewell. Thank you all for your testimony today.

I have actually introduced a bill with John Hayes and Haley Stevens and Representative Custer. It is called the "Maximizing Drug Coverage for Low-income Seniors Act" earlier this week. Fortunately, our bill has been included in the bill being marked up today, as well, in Energy and Commerce.

And I just think it is really important that we do all that we can to lower the cost especially for those who can least afford it.

Thank you.

*Chairman Neal. I thank the gentlelady.

I recognize the gentlelady from Washington State, Ms. DelBene, to inquire.

*Ms. DelBene. Thank you, Mr. Chairman.

And thanks to all of you for being with us. And, Ms. Reid, thanks so much for your story and for sharing it with us.

I think every single one of us has our own personal story, a story of a family member or a friend, and that is why this issue is so critically important.

And I have heard from so many folks throughout my district with their concerns and the impacts that they are trying to live through with the high cost of prescription drugs.

Dr. Miller, I have a constituent. His name is John. He is from Arlington, Washington. He told me how his wife, who is on Medicare, pays \$210 every two weeks for her diabetes medications. That adds up to over \$5,000 at the end of the year, and that

is assuming that John's wife does not take any other medications or does not have any new illnesses that require other medications during the year.

So how would the out-of-pocket cap protect seniors like John and his wife?

*Dr. Miller. So I think there are a few things that are going on. I mean, obviously, an out-of-pocket cap, as you accumulate expenditures throughout the course of the year, you will hit the cap, and you will stop, and your out-of-pocket will end. So as you pay through the year, you will hit a point and then you will stop.

There are a couple of other things to track on in H.R. 3. The inflation index should also put downward pressure on what you are paying month by month because particularly in the insulin markets, this is where you have a net price issue and then a list price that is escalating 300 percent in a decade or whatever the right number is.

And so that should also have some effect on what is being paid out of pocket month by month.

*Ms. DelBene. Thank you.

I have another constituent, Nancy from Kirkland, who is on Medicare. She told me how her narcolepsy medication seems to jump in price every six months.

Also, Dr. Miller, how would the bill prevent price spikes?

*Dr. Miller. Well, once again, to the extent that that spike is a list price spike, which I expect it is, the inflation index should have some effect, and what is going on there is the government will take those dollars and, as I understand H.R. 3, will put those dollars into the catastrophic cap, and then your constituent will then eventually hit that cap, and the out-of-pocket will end.

*Ms. DelBene. So one more question. I have a nurse in my district who has a young son who has hemophilia. Her name is Genesis. She spends thousands of dollars on her son's medications every year. He would not survive without these medications he

takes every day.

But while the drugs that keep her son alive are very expensive, there is a smaller number of patients who need that particular medication. So how does H.R. 3's out-of-pocket cap and the inflation rebate that you are talking about in Medicare impact drug prices in private insurance like Genesis has?

*Dr. Miller. Okay. Two ways, if I am following your question, two ways. I will start off. There is an indirect effect. So net and list prices do have a relationship to one another. List is growing much more quickly than net, but they do grow together.

To the extent that the inflation cap puts downward pressure on prices, that should put downward pressure on prices more broadly into the commercial sector. But it is very indirect.

The other way that this bill would have some effect is, as I understand it, if the drug is part of the negotiation and you come to a negotiated price, that price is required in the commercial insurance market as well.

*Ms. DelBene. Thank you.

Dr. Georges, I have a quick question for you. You were talking about coverage for vision, and I helped introduce legislation with my colleague from Washington, Dr. Kim Schrier, to provide coverage in Medicare for routine vision care.

I wondered if you could talk briefly about the impacts on seniors today for not having routine vision care in terms of isolation or other health care issues that result, and both the human and the economic cost of that.

*Dr. Georges. Yes, Congresswoman. The problem with decreased vision is it places the person in jeopardy for increased risk for falls because they cannot see the obstacles.

The other piece that we are finding on the emerging evidence in science is that as

their vision decreases, their social isolation may increase. And also, we are seeing very rapid cognitive decline or as we will say dementia occurring with that population.

So it is critical that they are able to see, and it also has a sense of how they feel about who they are and their wellbeing.

*Ms. DelBene. Thank you so much.

And I yield back, Mr. Chairman.

*Chairman Neal. I thank the gentlelady. Let me recognize the gentleman from Arizona, Mr. Schweikert, to inquire.

*Mr. Schweikert. Thank you, Mr. Chairman. And as a favor to you, I did not bring any of my boards this time, though I had several I wanted.

*Chairman Neal. I am not surprised.

*Mr. Schweikert. Okay. I actually want us to engage a little bit in not a thought experiment, but expanding a little bit of our understanding.

On one of the boards we were just teasing about is, as I brought in multiple times, shows that over the next decade and the decade after that, 91 percent of the spending growth, 91 percent, is solely Social Security/Medicare. The fact of the matter is the demographic, those of us who are Baby Boomers, it is here.

And it is not a Republican or Democrat. It is just math. So how do we engage in the revolution?

Ms. DelBene just actually touched on one of my personal fixations. Let's use an example, and then I will try to get back to my actual checklist here.

Hemophilia, sometimes as much as \$600,000 a year. The cure is here. I think it finished its Phase 3. I think it is waiting for its final production, certifications, those things. But the single shot cure may be a million and a half, \$2 million.

We need to as a committee, if H.R. 3 is serious about wanting to do what is going to

make us healthier and crash the price of health care, we are going to actually have a discussion on how do you finance disruptive pharmaceuticals that cure people.

As you know, for inflammatory bowel disease there are now a couple of vaccines and other things in experiment, but their biologics are going to be really complex, really expensive.

We should work on also a financing mechanism saying cure today. We do not have the costs from the future. Can we take some of the future cost and use that to pay back a health care bond?

Let's have the discussion of the 5 percent of our brothers and sisters who have chronic conditions that are the majority of our health care spending. Let's build mechanisms to cure.

And my fear is that with the current design of H.R. 3, we do not go there. There is a disruption coming.

There is also another odd one, and I would love my experts on the panel here. I have some scholarly papers on morbidity and those things about drug adherence, and one of the things I am finding in here is saying 50 percent of the pharmaceuticals that will be delivered today will either not be used at all or will not be used properly.

Does that number seem familiar for all of your research?

I have some heads going up, some heads going no.

*Dr. Georges. In our poll for AARP, we found that 40 percent, a little over 40 percent of our members reported that they did not take their medications, could not afford it.

*Mr. Schweikert. Well, this is actually pharmaceuticals that have been delivered, and look. These are peer reviewed articles going over.

So let's just use that in the back of our head. If 50 percent of the pharmaceuticals

that we sold today are not used at all, how many of you have gone to the dentist and gotten one, and it sits on the shelf because you needed one and then you were fine, or they are not used properly, and therefore, that person, as there was a previous discussion, ends up in the emergency room with those things.

Should we also be considering the technology that does the proper dispensing? You know, the little machine that says you get the blue pill at 8:00 a.m. You need this at this time, and this.

It turns out there is technology to do that. Should we for higher value pharmaceuticals have a more complex conversation of should they be in sterile packaging so if they are not used they can be returned?

I know these do not fit the normal discussion we have here, but if we are going to have the core conversation about the financing or reference pricing and the cascade events that come from that, are we willing also to be creative and deal with all the other side issues?

I can give you one example is in our tables we see that diabetes may ultimately be 30 percent of the cost in Medicare over the next 30 years. Should we be doing everything we can for diabetes treatment? The ability to grow pancreatic cells again, these sorts of things?

So I am hunting for those things that will also be price disrupters, and either whether it is providing cures or proper adherence, as some of these articles talk about, to crazy things.

You know, you are all freaky smart. You are all familiar with CAR T and the individualized treatments that are coming out. How do we as a committee incentivize the concept of a production line so we can crash?

Because even my university in Arizona, Arizona State University, believes they are

on the path to vaccines for cancer using the basic principles of what we now know as CAR T therapy.

We need to crash the price, but part of crashing the price is cures.

*Chairman Neal. I thank the gentleman.

Let me recognize the gentlelady from California, Ms. Chu, to inquire.

*Ms. Chu. First, let me say that I am glad to see Dr. Miller here, the former Executive Director of MedPak. It was a MedPak recommendation that Congress collect information on the value of drug samples that Pharma gives away to provide as marketing tools.

A concern is that such samples are given as a way to incentivize physicians to prescribe the most expensive drug to patients, thus increasing the cost of prescription drugs.

My bill, the "Sunshine for Samples Act," shines a light on this by mandating the public posting of the cost and quantity of these samples. This bill was folded into the STAR Act, which passed this committee unanimously, and I would encourage this committee to consider including the "Sunshine for Samples Act" as we move H.R. 3 through our process.

Ms. Reid, I was very moved by your story, and I would like to address one issue that is a particular concern for me. That is the increasingly high launch prices for new drugs.

As we make further advancements in fields like gene therapy, we are seeing more and more drugs launching with astronomically higher prices. Take cycle cell disease, for example. The NIH has invested billions of taxpayer dollars into finding a cure for this disease, and thankfully, in March of this year, NIH Director, Francis Collins, indicated that we are very close.

However, patient advocates are concerned that this cure, like other gene therapy

cures that have recently come to market, will be priced well out of reach for patients. And certainly we saw that with a drug therapy that would cure degenerative muscular disease in children but cost \$2 million.

I was happy to see that our colleagues in the Energy and Commerce Committee are taking steps to address this issue of high launch prices in their markup of H.R. 3 today. They are considering updated language that would bring newly launched drugs into eligibility for negotiation immediately rather than the 4-year delay that is in the introduced text.

So, Ms. Reid, could you discuss the impact it would have on patients like you to have new therapies included in the list of negotiated drugs immediately upon launch?

*Ms. Reid. Absolutely. I think that something that I often hear in the drug pricing debate is, you know, how much are patients willing to pay, and I think that is not the correct question to ask because obviously, if you are sick and suffering or if your child is sick and suffering, you will pay whatever you have to or you will try to pay whatever you have to to make yourself or your child or your family member healthy again.

And I think that often with these conversations of gene therapy, specifically someone earlier had mentioned zolgensma for kids with SMA. If it's the choice between living or dying, you will pay whatever. You know, no price seems too high.

But I think that is a false question to be asking, and I think that what we should instead be asking is what can average Americans reasonably pay.

And from my experience myself and from my experience in talking to other patients, what we can reasonably pay and what we are being asked to pay, there is a huge gap there.

And so for me having new therapies available, the way that Crohn's drugs work, biologic specifically, is that I will eventually build up antibodies to Entyvio, the drug that I

am currently on, and I will have to switch to a new drug.

So like I said, innovation is hugely important to me. However, with these launch prices being as high as they are, there is a chance that a new drug could come out that could change the course of my life and I would not be able to access it.

So I think that, you know, I support the idea of having launch prices included.

*Ms. Chu. And, Dr. Miller, I had a press conference about the high cost of insulin for patients in my district, and that is when a man in my district told me about getting stuck in Canada without his insulin and went to a pharmacy to pick some up. So the same bottle of insulin that he buys here in the U.S. for \$200 costs only \$25 in Canada.

That is why I am pleased to see H.R. 3, which would use the price of prescription drugs in other countries as a benchmark for negotiation.

So, Dr. Miller, how would using this model help contain the prices of drugs for American consumers as the average international market price?

*Dr. Miller. The experience of your constituent is not uncommon. I have heard people who travel abroad and say, "How is this 35 bucks and I am paying 350," in insulin in particular.

I think a couple things in this bill could come into play, the inflation cap and then the limit on out-of-pocket should help the insulin patient because their out-of-pocket in Medicare is being driven by the list price.

And then I believe the legislation also reaches for insulin as one of the negotiated drugs and then ties to, you know, ultimately between the 120 and the lowest price of the six countries, the negotiated price falls in there. That should result in a lower price.

*Ms. Chu. Thank you. I yield back.

*Chairman Neal. I thank the gentlelady.

Let me recognize the gentleman from Michigan, Mr. Kildee, to inquire.

*Mr. Kildee. Thank you, Mr. Chairman, for recognizing me, and thank you for your leadership on this issue.

This is obviously something that we all hear about, and this may seem a little redundant, but maybe in this case redundancy is not a bad thing.

When we go home, this is the subject we hear about from everybody all the time, continuously, for good reason. Because people are making decisions every single day about whether they can afford their medication or if they pay their rent or buy groceries and do the things that people do just in order to survive.

And the idea that in this country at this moment the wealthiest Nation in the world at the wealthiest moment in its history we cannot figure this thing out in a bipartisan fashion, I think, is a real shame. So I am hoping that we can come together on this.

And we are open to suggestions. Unlike some other pieces of legislation, like the tax cut bill that went through a couple of years ago, you have got the bill in front of you. You can spend the time you want to on it. You can offer suggestions.

We read that tax bill less than 24 hours before the entire House of Representatives voted on it. So I do not want to be preached to about bipartisanship and inclusion. You have got the bill in front of you. Let's see if we can do something with it.

Okay. With that throat clearing out of the way, I want to zero in on this insulin issue because for me this is, like almost everybody, it is personal. My daughter, 27-year-old daughter, Katie, for 20 years has been diabetic and was, you know, Type 1 diabetic like a lot of people in this country.

We have seen all sorts of innovation mostly around continuous glucose monitoring, the development of the insulin pump, but really not a tremendous change in the core medicine that keeps her alive.

So, Dr. Miller or anyone, just quickly a couple of quick questions. How much do

you think it costs to produce a vial of insulin? What does it actually cost to manufacture and to produce a vial of insulin?

*Dr. Miller. At this point, I mean, down to the marginal cost, I mean, you are probably talking about prices that are in the \$20 range.

*Mr. Kildee. To actually produce it or --

*Dr. Miller. I mean, yes, but keep in mind we are just talking about the production at this point.

*Mr. Kildee. I agree with that, but actually I have seen numbers that are significantly lower than that, in the few dollars, less than \$10 a vial.

*Dr. Miller. I would stipulate to that. It is not expensive at this point.

*Ms. Reid. I believe it is \$6 a vial.

*Mr. Kildee. Six. So let's say it is ten, whatever, six, ten bucks. And what is the retail price of a vial of insulin right now in the United States of America? A couple of hundred bucks?

*Dr. Miller. I think the list prices are in the two and three and --

*Mr. Kildee. Right.

*Dr. Miller. -- 300, right.

*Mr. Kildee. And I see Mr. Kelly is here, and I know he knows a lot about the auto sector on the sales side. I know a lot about it on the production side. The highly productive U.S. auto industry for production vehicles, for manufacturers, their margin is maybe 10 to 15 percent on luxury vehicles, 8 to 10 percent on standard vehicles.

And I would suspect for an auto dealer your margin is probably 1 to 2 percent on new sales, new car sales, maybe a little bit more, but not much.

So how in the world can we have a lifesaving drug that literally keeps my daughter alive being priced not at ten times its cost but 20 and 30 times the cost of actually

producing it and think that that is an okay thing?

It just simply is not. I mean, at long last I am just like done talking about this, and I know that none of these solutions are ever perfect, but for God's sake, let's not put people in the position like my own daughter is often in the position of having to choose between whether she goes to the grocery store or pays her health care bill.

My daughter is a journalist. She gets paid twice a month. She tells me one of her paychecks, one of her paychecks is for the medicine that keeps her alive every month, and the other one is for her rent and all the other things that a 27-year-old young person in this country wants to do.

Now, she has use to back her up. Not everybody has parents that are capable of doing that.

So my question is: what would it mean; what would this legislation mean -- and I know you only have a few seconds for people who are living day to day, week to week and depending on insulin to have a price negotiated that is somehow based on its cost?

*Dr. Miller. Again, there are a couple of components that I think matter here, the out-of-pocket cap, the inflation index, and then if I understand the legislation correctly, if it is pulled into the negotiation process, all of that would have the effect of making it more affordable for your daughter, in this instance.

*Mr. Kildee. But not marginally more affordable. Dramatically more affordable.

*Dr. Miller. Agreed.

*Mr. Kildee. Thank you. I yield back.

*Chairman Neal. I thank the gentleman.

With that let me recognize the gentelady from Indiana, Ms. Walorski, to inquire.

*Ms. Walorski. Thank you, Mr. Chairman.

And thank you, all of our witnesses here today. Thanks for your expertise. I very

much appreciate it.

Prescription drugs do play a vital role in treating and curing illnesses and providing patients a better quality of life. They can also help reduce health care costs by decreasing the number of emergency room visits and invasive health procedures.

However, prescription drug affordability has become a huge issue in my district as well in recent years as consumer spending on these drugs at the pharmacy counter has risen at an incredibly fast rate over the decade. I do want to find solutions that improve transparency in drug pricing, deliver lower prices and more choice to consumers to continue to advance medical innovation.

These goals could have been achieved through a bipartisan cooperation, but instead we are still here today discussing a one-sided bill written by and in Speaker Pelosi's office. The proposed changes within H.R. 3 would significantly hamper research and development, impose government price controls, and institute a retroactive tax of up to 95 percent on the total sales of drugs.

It would also destroy jobs in my home States of Indiana, where the biopharmaceutical sector supports more than 165,000 jobs with an economic impact of more than \$65 billion. In total, H.R. 3 would threaten good American jobs, eliminate future cures, restrict access for seniors, and worsen health outcomes for patients.

The public concern over prescription drug costs reflects the changing health needs of an aging population. We are living longer, but we are living longer with chronic disease. In many cases, pharmaceutical innovation is the best hope to manage chronic conditions.

According to the Kaiser Family Foundation, prescription drugs accounted for one in every \$5 that Medicare beneficiaries spent out of pocket on health care services in 2016.

Mr. Ippolito, what can we do to focus on reducing out-of-pocket costs for seniors?

And what are the guiding principles we ought to adhere to to be successful in reducing the cost without sacrificing the critical innovation to combat cancer and to treat chronic conditions?

*Dr. Ippolito. Well, I think we have a number of examples to look to. We have seen bills introduced in this committee. We have seen parts of H.R. 3 that are in a similar vein. We have seen bills in Senate Finance, all that work in the same direction. They attack a few key things.

Number one, they stop with open-ended incentives that encourage really high prices.

They, two, pair that with stronger incentives on insurers to actually control costs.

And then critically, three, they just explicitly cap the amount that consumers can actually pay out of their own pocket.

Those three things together, I think, are a great example of how you can use better planned designs or, excuse me, better benefit designs to both improve the efficiency of programs and the experience of beneficiaries on them.

*Ms. Walorski. I appreciate that. And if I could ask just one additional question.

An FDA analysis concluded that it takes five generics on the market to drive prices down to 33 percent of the original brand name. The FDA under this administration has made a concerted effort to speed up generic drug approval.

How does this increase in generics help to improve the market and reduce drug prices for seniors?

And then how might H.R. 3 affect that development of generics?

*Dr. Ippolito. The way our system is supposed to work is that you get a monopoly for a certain amount of time and then we allow robust generic competition. If robust generic competition does not happen, then the system is not really working as designed.

And so one of the things that I know Dr. Gottlieb at FDA worked on, but we have also seen other agencies work on, is how do we clear out all of these hurdles that we have that have been erected by branded companies to resist generic entry.

And I think the work is not nearly done. I would not suggest that we are necessarily even that close, but we know exactly what we need to do generally speaking. And so there are a lot of options on the table where if the goal is to get more generic drugs to market faster, there are options for Congress to do that.

*Ms. Walorski. I appreciate that.

And I yield back, Mr. Chairman.

*Chairman Neal. I thank the gentlelady.

Let me recognize the gentleman from Pennsylvania, Mr. Boyle, to inquire.

*Mr. Boyle. Well, thank you, Mr. Chairman.

I would like to thank all of the witnesses for their testimony, but especially to you, Mr. Reid, and I hope you take some comfort knowing that you are not alone in this fight.

When I go around to my district and I think that this is probably the case in probably all 435 districts, I have a ton of constituents who either talk to me at community events or send emails or phone calls or visit our district offices and talk about their struggle with prescription drug pricing.

I have heard from one cancer patient who has a monthly copay of \$3,000. I have heard from constituents who need to ration their medications or cut pills in half or even ask for samples just to get their care with some level of consistency.

It is now our turn in government. A majority means leading. H.R. 3 is an example of leading on what the public has said is the number one overriding concern.

We have thus far in H.R. 3 a bill that makes remarkable improvements while at the same time actually bringing down cost and bringing down the cost to government.

CBO score confirms that not only will the prices of drugs go down. Premiums and cost sharing will, too. Just Title 1 of the bill will save \$345 billion for Medicare over a 10-year period and \$61 billion in savings for new drugs.

Now with those savings, we want to reinvest in the wellbeing of the American people. I want to focus on one specific aspect of that.

That means expanding the low-income subsidy, LIS, also known as Extra Help, which provides prescription drug financial assistance for vulnerable families on a fixed income below certain levels.

When constituents come into our office looking for help or guidance as they grapple with how to afford their medicine, we often direct them to LIS. While the income thresholds to qualify are relatively straightforward, the resource test, however, which looks to verify the value of an applicant's assets, is a considerable barrier preventing families from participating.

So I am proud to lead a bill that would remove a major barrier for low income families to access this vital program. Along with my fellow Pennsylvanian, Mary Gay Scanlon, and my colleague Peter Welch, our "Better Tools to Lower Cost Act" will expand access to affordable prescription drugs by removing the resource test from LIS qualification.

If enacted, low income families and seniors who have small amounts of retirement savings can qualify for LIS to get the prescription drugs they need at a more accessible price.

So I would like to ask you now, Dr. Feder, can you please describe how the LIS program provides relief for low-income families and how some of the proposed reforms, such as my bill, whether it be eliminating the resource test altogether or changing the Federal poverty threshold, how these would help families and improve the program?

*Dr. Feder. I want to applaud the legislation you are proposing because it is exactly what is needed to assure affordability for low- and modest-income Medicare beneficiaries. It is not present in the current system.

The way in which those subsidies work is that individuals who do qualify according to the income threshold, the patients that they have to make in cost sharing are limited or offset by the value of the subsidy, and the challenge that you have noted, you are talking about the asset test as a barrier, and I was remiss in not including that in my testimony, and you are absolutely right. That is a barrier to people getting these subsidies.

The income level threshold in Part D, I believe, is at 150 percent of the Federal poverty level, about 14, 15, maybe a little higher, 17, \$18,000. That, too, is lower than the level that qualifies younger Americans for cost sharing protections in the Affordable Care Act.

So the inadequacy of subsidies prevents access to care, and we know that people are not taking advantage of these subsidies in the way they should, which I would argue was not just a problem of the rules for achieving them, but the way in which they are encouraged or enabled to participate.

So I applaud your efforts, and I think you are moving in exactly the right direction.

*Mr. Boyle. Thank you.

And I yield back.

*Chairman Neal. With that let me recognize the gentleman from Virginia, Mr. Beyer.

*Mr. Beyer. Thank you, Mr. Chairman.

And thank all of you for sitting here with us for hours and answering our questions.

Dr. Feder, let me quote Dr. Ippolito for one quick minute. He said that "the simple fact that the U.S. pays more for drugs than other countries does not prove that our prices

are too high," dot, dot, dot. "Many of these countries have long had luxury of enjoying innovations made possible by U.S. profits."

Just a simple existential question. Why should the U.S. with 5 percent of the world's population be funding all of the research and development for the rest of the world?

*Dr. Feder. I think that is a decidedly reasonable question, Congressman Beyer, and what we have heard and several people have referenced the CBO testimony, is that if we pay less, other countries will somewhat increase the level of their expenditures.

But no one, no one should be paying what we are paying in pharmaceutical prices because that money is not, contrary to lots of statements, necessary to support the level of innovation required. It is going to profits that are excessive.

*Mr. Beyer. Dr. Miller, we have heard again and again this morning and early afternoon that if somehow we manage these drug prices, that innovation will suffer. Let me toss out just three quick factoids.

In 2018, the nine largest pharmaceutical companies in the U.S. did \$50 billion in buybacks, far more than their R&D; that the dramatic rises in TV advertising and magazine advertising, once again, we are seeing increases in the 100s of percent, while R&D has been virtually flat the entire time.

And then finally, the fascinating Sovaldi story, the Hepatitis C drug, that all the early stages of research were \$315 million, but when Gilead bought it, they paid \$11 billion for it. So with 315 million in research, but 11 billion to actually bring it to market.

So I want to know is there any statistical correlation between pharmaceutical profits and their investment research and development?

*Dr. Miller. I mean, no, I'm not aware of a direct relationship.

*Mr. Beyer. And yet we find that that is the primary pushback, is because there is no direct relation.

*Mr. Beyer. And as I have tried to point out, I think the revenue that is being extracted from the United States, according to Peter Bach, exceeds the amount invested in R&D worldwide by more than 70 percent.

*Mr. Beyer. And then one of the things this bill is trying to address, too, is make sure that if innovation is occurring, that it is occurring where we need it, where it has high value.

So does the world really need another erectile dysfunction drug?

*Dr. Miller. I do not know the answer to that question.

[Laughter.]

*Mr. Beyer. It is a tongue-in-cheek question.

*Dr. Miller. I see your point, however.

*Mr. Beyer. They are so often, as you broke out the advertising, is what are the drugs that can make the most money, not the drugs that can help the most people.

*Dr. Miller. You might have warned me for that question.

*Mr. Beyer. Yes, sorry.

I want to push back a little bit, too, on Dr. Ippolito. I think it was my friend George Holding who said we cannot base the prices on these six countries because like France does not even offer some of the drugs that we are talking about in the Medicare non-formulary.

And yet God bless Wikipedia. The lifespan of the six countries that we are looking at rank first, fourth, ninth, 12th, 20th, and 24th in the world. We are 37th. So all the six countries that we are looking at have far better health outcomes and lifespan outcomes than what we have.

And, Dr. Ippolito, you said, "Determining a true transaction price in foreign countries could prove to be extremely challenging."

And later on, "Drug list prices do not represent the typical transaction price for many domestic purchasers."

I had the great honor of living in Switzerland for four years where the only thing that was cheaper was drug pricing. You would go to the pharmacy, and we were stunned how inexpensive it was.

Could you not find the right drug price by simply measuring it at the cash register rather than going upstream to pre-discount wholesale prices and list prices?

*Dr. Ippolito. Yes, so you could do things like that. So we try to do that domestically in the Medicaid program. We have tremendous difficulty doing it there. So I would imagine that it is going to be a bit challenging nationally.

*Mr. Beyer. I would suggest that we talk to Taco Bell because they measure the list price in real time and adjust prices in real time at the drive-through. It is not as a car dealer with our zero percent profits. I am very aware how this works.

Dr. Georges, I believe it was Dr. Miller's written testimony. He talked about how between 2006 and 2017, list prices of more than 100 brand named drugs increased cumulatively by 214 percent relative to inflation, whereas the overall economy was 25 percent.

How do you morally justify long-term drugs that have been in the market for a long time?

My time is up.

*Ms. Sewell. [Presiding.] I will let him answer.

*Mr. Beyer. Okay.

*Dr. Georges. We cannot. We cannot justify it because it is unsustainable for our older Americans and all Americans to be able to afford the drugs at those high inflation rates.

*Ms. Sewell. The chair now recognizes Dr. Wenstrup.

*Mr. Wenstrup. Thank you, Madam Chair. I appreciate it.

Thank you all for being here today.

You know, I would be interested in this panel. Maybe I will just try to take this role a little bit to share some of the concerns of those that actually treat patients.

You know, we have these panels of experts, but we do not always have the people that are there taking care of patients. We have a patient here. I am grateful for that, but cause and effect of things is what I think we need to be careful we are considering.

And just as we look at a lot of things, we look at this process. We want to make sure that we are looking at it as are we increasing cost. Is that the problem, or is it an increase in out-of-pocket expenses for people? You know, is it actually the drug or the insurance that they have?

You know, all of these things come into play, and for example, you know, compared to Medicare Part D, the VA formulary is restricted, and so that may be great that your medicine costs less at the VA, but you also may not be able to get the drug that your doctor thinks is best for you, at least on formulary.

And one of the things that I do want to talk about because somewhere it was mentioned today that, you know, drug companies want to have treatments that you have to keep paying for as opposed to cures, and as a doctor, I take offense to that because I do not see that. I do not see that amongst our researchers. I do not see that out there.

And let me give you an example. My sister 26 years ago had two forms of leukemia that most people die from, but because of people before her that went through testing of different trials of treatments, you know, they now had a way to get people in remission. It did not cure them, but got them in remission and always the hopes of a cure.

But led to that, she got remission, and then they developed bone marrow

transplants. I matched her for that. We matched perfectly. We were lucky. Okay. Five years later, they call it a cure.

Today we have treatments for leukemia that lead to a cure without a bone marrow transplant. So I would argue that coming up with treatments is just one step towards finding cures, and I think that research, people that treat, people that I know ultimately want cures. They do not just want treatment for people.

I look at Hepatitis C that we can cure today. Yes, it is expensive on the front, but what do you save on the other end of all the care and potential liver transplants that we are now avoiding in America?

We do not want this to stop. Go back to the polio vaccine eradicating a disease in our country that was debilitating and required that people have care their entire life.

And I look at biologics for so many of my patients. I specialize in foot and ankle. I would take the patients with rheumatoid arthritis and have to do reconstruction of their feet, and I will tell you with the biologics it went away. Procedures I used to lecture on I do not do anymore. They were not cured. They were treated, but we saved so much on the other end.

This is what we have to do, and we walk this fine line of being able to innovate and also be able to take a look at what we save on the other end when we have innovations.

You know, I have some problems, I think, with some of the marketing techniques and all the commercials and everything else. But I ran a business with my own practice and then joined a large orthopedic group. I ran a business. You did not do marketing to have less revenue. You did marketing to increase your revenue.

And we all would agree that it takes some revenue to be able to continue to research and innovate. So we have to be a little careful about that, but you know, I do not love it all. You know, I would much rather see some other kind of commercial most of the time.

But at the same time, the idea is to increase revenue from a business standpoint. Just ask the car dealer who was just there. Do you think they do not advertise? They are advertising day and night in every paper you pick up. There is a reason for that.

So I do not want our research and development to go by the wayside.

But one of the other concerns I have is I do not want this United States of America to be controlled or possibly manipulated by an arrangement some other country makes on what their cost is. We are the United States of America. Ideally, they should be paying more. We are innovating. They can pay more for the cost of that innovation than us.

We should probably talk and get in the weeds of how we can get to that, and you know, other countries have different values. Other countries do not have the same priorities that we do as far as caring for our people.

Therein lies a difference when it comes to innovation and research and why it is valuable to us.

My time is up so I really do not have time for a question, but I really wish we would all consider all those things as we move forward in trying to come up with solutions so that we can see more care more affordable, more timely to the American people.

With that I yield back.

*Ms. Sewell. The chair now recognizes the gentleman from Pennsylvania, Mr. Evans.

*Mr. Evans. Thank you, Madam Chair.

And I thank all of the panel for you being here today and this morning.

Ms. Reid, we have been talking a lot about financial costs today, but can you please explain to the committee the toll this experience has taken in terms of your health and wellbeing?

*Ms. Reid. Yes, absolutely. Congressman Wenstrup mentioned rheumatoid

arthritis patients who are undergoing these regular treatments, and you know, while it is not a cure, it does vastly improve quality of life, and I would not argue that.

However, I do not necessarily know that healthy folks or providers or insurers or anyone really understands the mental toll that it takes on patients to be dependent on a drug for the rest of your life and not know how you will finance those drugs for the rest of your life.

Patient assistance programs exist. Insurance exists. All of those things are precarious and not guaranteed. And I live with a constant anxiety about whether or not I will be able to afford my drugs. It is top of mind how much pain I was in and how difficult my life was when I was untreated, and I live my life knowing that I could go back to that at any time.

And because of that and because of these costs, like I said, I would love to have kids someday, but I just do not see how that is financially feasible based on my health care costs.

I would love to own a home, and I do not think that that is feasible. I am trying to pay back student loans, and it is an uphill battle.

So I think that, you know, it is easier to say when you are coming from an outside perspective how you think patients might feel, but I think there is a lot of mental anguish that all of us are experiencing.

*Mr. Evans. Can you please explain how you are taking the extreme cost of your medication into account as impacted on some of your decisions made in your everyday life and your career?

*Ms. Reid. Absolutely. So I am originally from Illinois. I recently moved to Washington, D.C. for a job, and the first thing that happened after I was, you know, in the interview process, very excited about a new job that I had worked very hard to be qualified

for, but the question that you always have to ask yourself is: what is the insurance? Is the coverage adequate? Will I be able to afford my drugs with this insurance?

And if list prices were lowered, that would be less of an issue. I do think there is a lot of rhetoric out there along the lines of, and I think that Congressman Kildee hit it right on the head, you know, his daughter has the fallback of, you know, parents who can help and family and a community who can help. Not everyone has that, and you know, I love my family very much, but they would not be able to pay for the \$12,000 that I am billed each month for the drug and the administration of my drug.

So I know that I could be offered my dream job tomorrow, and I would not be able to take it if the coverage was not adequate.

*Mr. Evans. As someone who relies on innovation to manage your condition, what would you like to say to those who continue to make this argument?

*Ms. Reid. I understand that it is a buzzy argument to make. However, I think that it is very clear if you look at the structure of pharmaceutical companies that, you know, no one is arguing that companies should not make a profit. No one is arguing that businesses should not make a profit.

The question is how much profit should they be able to make. I spoke in my testimony that I work with a lot of young people who also have Crohn's Disease and ulcerative colitis, another inflammatory bowel disease, and a lot of those kids are on Humira. AbbVie, the company that makes Humira has made more in revenue on Humira alone than if you took every NFL team's revenue and combined it.

So I think the question we really have to ask ourselves is how much is a fair amount of profit.

*Mr. Evans. Dr. Miller, how would H.R. 3 help increase the affordability of insulin?

*Dr. Miller. I think in a couple of ways. As I understand the legislation, there is an intent to put savings into an out-of-pocket cap for the beneficiary. So as you rack your monthly payment, eventually you would hit that cap and it would end. Your out-of-pocket would end.

Number two, the inflation index, insulin is very much characterized by a rapidly increasing list price. The inflation index would either extract revenue back to put into the Federal Government or put downward pressure on that price as the manufacturer chose.

And then as I understand the legislation, I believe insulin is included in one of the first-round negotiations. In theory, it should produce a much lower price.

*Mr. Evans. Thank you.

I yield back the balance of my time.

*Ms. Sewell. The chair now recognizes the gentleman from Illinois, Mr. Schneider.

*Mr. Schneider. Thank you, Madam Chair.

And I want to thank all of the witnesses for your patience in staying here this morning now well into the afternoon.

Ms. Reid, I want to first thank you for your courage in sharing your personal experience, also for cheering the Sox, as one from Chicago.

So I am glad to have you all here.

I want to share a story of one of my constituents, and it is consistent with the last question on insulin. Ms. Judy Nefstead from Zion in my district, she has insurance coverage. She is 62. She has Social Security disability benefit, and she has coverage through the Medicare Advantage Plan.

She is also a Type 2 diabetic and relies on a daily supply of insulin to survive. On her Medicare Advantage Plan she was paying \$320 per month, up from just \$47 per month

on her previous employer plan.

Then in August she hit her donut hole. Her insurer told her that she would be responsible for \$5,400 until she could make it to the catastrophic phase and lower her liability.

Ms. Nefstead is disabled and living on a fixed income. There is no way she can afford \$5,400 in out-of-pocket costs. As we speak, as we heard other stories today, she is rationing her current supply of insulin and waiting until her next disability check so she can go buy another month's supply.

She is risking her life each and every day because she cannot afford her life-giving insulin. This is sadly business as usual, which is wholly unacceptable. These are kitchen table issues, the cost of drugs, unaffordable premiums, skyrocketing deductibles, and H.R. 3 will help every single one of these growing crises.

But I also want to highlight one other way that H.R. 3 will help Jody. The ACA took a huge step towards eliminating preexisting condition exclusions for many patients. But Medicare beneficiaries are one of the last groups that do not have the same protection.

Until Jody turns 65 -- remember she is 62 and disabled -- she cannot purchase a Medigap plan without underwriting for her preexisting conditions. That means she can be denied a policy altogether.

If she wants to keep her Medicare Advantage Plan after she turns 65 and later switch to traditional Medicare, she would face underwriting that could be rejected because of her diabetes or her disability.

Not having guaranteed issue for Medigap is a serious barrier to care.

Dr. Feder, could you please discuss how Medigap protections for preexisting conditions currently function and how we might improve them going forward?

*Dr. Feder. I think you have highlighted the problem, and it is particularly severe

for people with disabilities. The access to guaranteed issue and community rating in Medigap plan is not a function of Federal legislation. It is a function of State legislation, and the majority of States do not provide the protections that would enable, assure people with preexisting conditions that they can always have access to the supplementary insurance they need because of the holes in Medicare coverage.

That, as I indicated in my testimony and you have made clear, is unacceptable if we are trying to provide people adequate protection. It locks somebody by your constituent into a Medicare Advantage Plan that may not be serving her well, and we do have plenty of evidence that MA plans favor less sick patients, and I would like others to disenroll.

She is stuck unless we fix this.

*Mr. Schneider. And I have a plan for that. My bill, H.R. 4676, the "Protecting Medicare Beneficiaries with Preexisting Conditions Act," would extend preexisting condition protections to Medicare enrollees under age 65, as well as allow Medicare Advantage enrollees switching to traditional Medicare to enroll in Medigap plans without the fear of underwriting.

I look forward to including this critical protection in H.R. 3, and I also appreciate that H.R. 3 will use a substantial portion of the savings to increase subsidies for low income Medicare beneficiaries purchasing their drugs.

I have another bill, the "Medicare Extra Prescription Help Act," that I introduced with my colleagues Robin Kelly and Senator Bob Casey that would substantially increase the low-income subsidy benefit to ensure that our seniors can get their needed prescriptions and adhere to their drug regimen.

With that, Madam Chairman, I am happy to yield back.

*Ms. Sewell. Thank you.

The chair now recognizes the gentleman from Texas, Mr. Arrington.

*Mr. Arrington. Thank you, Madam Chair.

Thank you to the witnesses and our thoughts and prayers are with the Cummings family.

I want to say from the outset that no matter how sincere my colleagues are and no matter how impassioned they are about solving this prescription drug price problem, it does not matter if we do not have some bipartisan legislation that comes out of this committee.

We all know that up here. So as one of my good friends said, after all is said and done in Washington, more is said than done unfortunately.

So, Ms. Georges, to your point that Congress needs to act now, I agree. The only way we are going to act and achieve the desired outcome for our seniors and all Americans in this regard is to actually continue to have what we were working on, which was a very constructive bipartisan path to a real solution that had real impact on your colleagues and my constituents. That is the reality.

So I hate to say it, but a lot of this really becomes academic if you cannot get there, and my biggest fear -- let me back up -- my biggest fear is that the impeachment charade and circus would damage the presidency and our democracy.

But another concern of mine is that we would be so distracted with the top priority of Speaker Pelosi, which is presidential harassment, that we would never get to solving real problems and doing the people's business. That is the reality.

So I have aired that out on my concerns with the process. Now, this is a real problem. Drug prices are out of control. They are unsustainable. They are unaffordable. I think we all agree with that.

How do we get to solving this problem? The current Medicare system shortchanges no doubt the two key stakeholders that I have in my mind every time I go to work: seniors and taxpayers. And while I hear a lot of talk about market failures, I do not

think the market has failed. I think that we have put government policies in place that have been very distortionary on the markets.

I agree with you, Dr. Ippolito. We should do our best to repair the damage to markets. It is competition that will give Ms. Reid the best choices and the best value proposition, best cost, best quality, and striking that equilibrium.

That is something, Ms. Reid, that just philosophically I can tell you government has tried and tried again, and they fail. You cannot divine profit from Washington. You cannot balance the cost and quality effectively. Market is the best way to get there.

And I am not suggesting that government does not have a limited role. They do. We do, but we need to first repair the market failures, whether it is the catastrophic piece of the benefit design where folks are being pulled into that catastrophic area where the taxpayers pick up the full freight. That is why we have seen that part of the cost increase from 14 to 40 percent. That is just one example.

And I agree with Dr. Miller's observation that there are anticompetitive forces at play, and we need to address those. I think rather than more government mandates, more government taxes, more government control, we need to bring into play more competitive forces.

I agree with you, Dr. Miller, in the way that you describe evidence-based intervention, but the evidence of our intervening in Obamacare with taxes, mandates, and government control had the opposite effect, and costs went up, and access was more limited.

And I believe it is grossly understated what fixed prices will do to the quality of our technologies and health care innovations and our therapies that save lives and improve the quality of life.

So here is my big question because I think this is the fundamental question. How

do we balance innovation and competition?

How do we balance quality and cost because we have to do it?

It is not just all about innovation, innovation. We have got to recognize cost plays a role.

So my question to everybody, starting with you, Mr. Ippolito, is: how do we get at that? How do we look at the real core problem, not the symptom of profit, but the root problems on the IP issues and on the anticompetitive forces like barriers to competition with other products?

Those are my observations for your comments, if the Chairman would indulge you to answer that.

*Dr. Ippolito. I will give a brief answer perhaps, and I would encourage you to focus on a number of things that Dr. Miller pointed to, a number of things that I pointed to that are included in my written testimony as well.

There are a number of things you can do. To the extent Congress is happy with the balance they have struck on paper, there are a lot of things you all can do to make it so that the actual reality of what is going on in the real world looks a lot more like what you actually wrote down, and you can look to certainly what Dr. Miller said and some of what I have said for examples of that.

*Mr. Arrington. Mr. Chairman, I have run over my time, and I yield back.

*Chairman Neal. [Presiding.] I thank the gentleman.

And with that let me recognize Mr. Pascrell.

*Mr. Pascrell. Thank you, Mr. Chairman.

Dr. Feder, you discussed the growing population of seniors, obviously, and the sustainability of Medicare benefits. Can you speak to how some of the reforms in the bill we are looking at today, H.R. 3, like capping out-of-pocket expenses and restructuring the

benefit design, will address the long-term sustainability of Medicare programs?

Would you address that please?

*Dr. Feder. I would be glad to. I think that the improvements in benefits we are talking about improve the value of Medicare to beneficiaries who otherwise, as we have heard from multiple people this morning, are suffering because of the insufficiency of Medicare benefits.

But I think that is different from the long-run financing problem for Medicare, which is a function of the aging population, and although older people, too, contribute to the cost of Medicare, the funding particularly in Part A is largely dependent upon the payroll taxes that we get from wage earners, and there are fewer wage earners supporting a larger number of elderly beneficiaries.

As one of those beneficiaries, I firmly believe that the value of this program makes it worth the investment from all of us, and it is possible through a number of revenue sources to sustain the funding of Medicare well into the future.

And what is often ignored when people say that we cannot afford Medicare, and I believe I even heard a little of that this morning, it is often ignored that our economy is growing and continues to grow, and as I said in my testimony, estimates that our GDP per adult will grow in the coming years by about 25 percent even if we pay for all of the gaps in Medicare funding that the Trust Fund report generally shows.

So we have the capacity to do this and all be better off, and it is essential.

*Mr. Pascrell. Thank you for the expertise of all the panelists today. I think it is very, very helpful.

We have work to do. H.R. 3 accomplishes, I think, two goals I have long supported: negotiating Medicare drug prices. That is better than price controls by far. Negotiations are never a negative thing, ever, and capping Medicare Part D out-of-pocket

costs, two very important things in this legislation.

I think much of our problem is it is like changing immigration. You do not even know what the present immigration laws are. You test the members of Congress, and they will fail on the majority of what is in our immigration bills.

I would say a good number of us who control the law, the legislation, do not know what is in the Medicare bills, do not the eligibility. It was not until recently that we got a handle on SSI and Social Security.

The point of the matter is we have got to know before we change something. We had better know what we are changing. That is not a simplicity. I think that is an actuality.

The core savings associated with negotiation create endless possibilities to improve Medicare. That is how I look at it. In fact, Medicare's actuaries estimate that negotiation in inflation rebates will save households \$158 billion over the next 10 years, nothing to sneeze at.

So the science and innovation behind lifesaving drugs is the best it has ever been, and we must preserve that as we tackle high cost of drugs and exploding costs in the health system as a whole.

We have a runaway train right now, and we have fallen right into the trap, all of us, both sides of the aisle. Americans with Hepatitis C have access to cures now, not only treatment. That has changed for the better.

When I go home to my district, I hear about the struggle to afford the prescriptions people need. You have heard that many times today. This is what I hear about more consistently than anything else, in fact.

Our committee has jurisdiction over the drug pricing crisis, and so it is our burden more than most to solve. We have acted on that mandate. I want to commend the

chairman before bringing this up before all of us, having a great hearing, and we are going to mark up a bill soon. How about that?

Thank you.

*Chairman Neal. I thank the gentleman.

Let me recognize the gentleman from California, Mr. Panetta, to inquire.

*Mr. Panetta. Thank you, Mr. Chairman.

I, too, commend you as well as Ranking Member Brady for having this hearing on the "Lower Drug Costs Now Act of 2019."

I do believe that this is important legislation that really is critical to making prescription drugs more affordable for millions, millions of Americans, and aligning the amount we pay for drugs with the rest of the industrialized world.

That is a question I often get when I am back home. People ask me, "Why the hell are we paying a heck of a lot more than other countries for these types of drugs?"

Now, as my colleagues have mentioned in their questions and as the five of you have mentioned in your testimony, we do pay a lot more, anywhere from 1.8 to four times more than other industrialized nations for the same drugs because government does lack a meaningful way to directly negotiate over the price of prescription drugs.

And there is not a ceiling on how much of the price of a drug can increase year to year. I think just last week it was the Institute for Clinical and Economic Review that found that drug companies hiked prices on seven popular drugs over 2017 to 2018 with absolutely no evidence that the drugs had improved and which collectively added, I think, \$5.1 billion to the U.S. drug spending.

And these types of price hikes and insurance premium increases really have put the undue burden on all Americans, especially minority communities, low income families and, yes, senior citizens.

Senior citizens like Nancy Salinas, which is in my district on the central coast of California, who wrote to my office about her experience in going to a drug store trying to pick up a prescription that was filled, but then realizing that it was going to cost her \$100 out of pocket. She literally had to walk away with that bottle of drugs just sitting there on the counter.

It is this type of legislation I do believe which is a bold step in the right direction to prevent instances like that, which Nancy had to face and which we shall be able to at least afford those types of drugs.

This legislation will save \$158 billion in lower premiums and out-of-pocket costs, and it will be reinvested, yes, in research and development, but also in key policies that will cover basic needs like eyeglasses, dentures, and hearing aids.

Now, Ms. Georges, on that note, as you testified, the limiting of patient out-of-pocket cost is clearly a necessary step in relieving the financial pressures facing patients and their associated medical conditions.

Generally, how would seniors' lives improve if they actually had full access to vision, dental, and hearing benefits?

*Dr. Georges. The quality of life would improve markedly because it would decrease the risk factors that exist currently for those who have limited eyesight and limited hearing, and for those who have lost teeth and cannot replace them and, therefore, have negative outcomes on their whole dietary behavior and their physical health.

It will also help to decrease the social isolation and what we know from research, which is the increase in dementia from those who are socially isolated because now they will be able to talk to people. They will be able to smile, which is also very effective for that population.

*Mr. Panetta. And based on those actions by them, I mean, ultimately will that

reduce the overall health costs by providing these types of benefits?

*Dr. Georges. Yes. Yes, sir, because one of the things that we do know and the science is very clear, that those persons who have infections of the mouth, they have subsequent kinds of infectious diseases that may occur in other organs in the body.

We do know the fact that if one falls and orthopedic injuries may occur or the traumatic brain injury, and then the system has to pay for that, and Medicare will then have to pay for that expensive care.

*Mr. Panetta. Exactly, exactly. Dr. Feder, just quickly if you could, explain how a cap on Medicare out-of-pocket spending on prescription drugs would help relieve some of the financial pressures put on many Americans.

*Dr. Feder. Well, without a cap and even when you get past the donut hole where you already may be bankrupted, even beyond that, you still have to keep spending unlimited amounts.

Now, when you are at this cap, individuals will not experience bankruptcy in the donut hold. They will not have such a hole. It will be that when they reach a certain level, the level of the cap, their out-of-pocket expenses are done.

*Mr. Panetta. Great. Thank you, and thanks to all of the witnesses that are here.

*Chairman Neal. I thank the gentleman.

With that let me recognize the gentleman from Kansas, Mr. Estes, to inquire.

*Mr. Estes. Thank you, Mr. Chairman.

And I want to thank our witnesses for being here today.

It seems like there is not always a lot that Republicans and Democrats can work together on right now, but I think lowering the price of prescription drugs is one priority that we all agree on.

I happen to believe we can develop a successful bipartisan solution that also

protects innovation and ensures future medical breakthroughs. To accomplish this goal, Congress needs to work together to lower out-of-pocket drug costs by cracking down on overpriced drugs, empowering patients to choose the most affordable medicines for them, and eliminating incentives in Medicare that reward bad actors and lead to those higher prices.

Unfortunately, the bill put forth today is not negotiation. It is really nothing more than government run price controls that truly amounts to extortion on the manufacturers and private industry.

You do not have to take my word for it. I mean, the bipartisan Congressional Budget Office, they have only been able to partially review the bill, but they have already listed the following outcomes that would occur if this bill would be signed into law.

Manufacturers will possibly pull their drugs entirely out of U.S. market if the government's take it or leave it amount is insufficient.

Manufacturers will potentially set list prices higher to start, and manufacturers will likely see a reduction of revenue up to \$1 trillion, resulting in a direct impact on their ability to reinvest in research and development.

The negative implications of this bill on innovation cannot be overstated. Consider that in 2017 alone the private biopharmaceutical industry invested \$97 billion in R&D. That is roughly three times what the entire NIH budget was for that same year, which was \$32 billion.

Clearly, a potential cut in R&D investment by an amount greater than the current spending would be a massive blow to medical research and innovation, which we take for granted every day.

Our country has been really blessed and benefitted from so much medical innovation over such a relatively short period of time, considering that between 2011 and

2018 there were 270 new medicines launched globally. American patients had access to 100 percent of those new drugs, while patients in the next closest country, Germany, had access to only 67 percent of those.

To put it in more relatable terms, when the innovative drug Imatinib was launched in 2001 as the first drug in its class to treat chronic myeloid leukemia, or CML, the 5-year survival rate skyrocketed from 31 percent to 89 percent.

Now, imagine if H.R. 3 had been law and prevented the development of this lifesaving drug. Sadly, those 9,000 people expected to be diagnosed with CML this year would have faced a very different diagnosis with little hope.

But this is the kind of innovation we should be encouraging, not stifling through price controls and bigger government. So I hope we can come together and come up with some free market solutions that will help lower these drug prices without jeopardizing that innovation.

I do have a question that I want to ask Dr. Ippolito. You know, as I previously mentioned, the figures are out. Private investments in R&D compared to the NIH are staggering, and more staggering is the cut that could occur if the bill becomes law.

Can you discuss the connection between investment amount and the time and rate of successes for new drugs that are being developed?

*Dr. Ippolito. Sure. So we certainly heard today some differing views on the importance of returns for investment. I would emphasize perhaps in simpler examples to make the point.

Half a million people a year die from malaria. Gout is a disease that you get if you eat a lot of fatty foods and drink too much alcohol. It is literally called the "disease of kings." In the last two decades, we have seen nine clinical trials publicly registered for gout or -- excuse me -- for malaria. We have seen 240 for gout.

That is not by accident. That is not manufacturers randomly responding to incentives. That is manufacturers clearly responding to the returns they think they will get for a successful product.

Whether that is great or moral or whatever you want to classify it, you cannot assume that away. That is a piece of reality that we have to contend with, and so when we go for these kinds of H.R. 3 style programs where, yes, you get benefits of lower cost today; yes, you get more access today, but the question is: what about access tomorrow?

And I simply do not think that it is credible to argue that there is no relationship between the returns you get for making a drug and the behavior of these firms. We have seen it in academic papers. We see it in common sense. We see it in data. We see it in half a millions people dying from malaria every year because they are not worth investing in.

You know, it is not something that is being made up.

*Mr. Estes. Thank you.

Mr. Chairman, I yield back.

*Chairman Neal. Thank you for that.

Let me recognize the gentleman from Nevada, Mr. Horsford.

*Mr. Horsford. Thank you very much, Mr. Chairman.

This is truly an historic hearing on H.R. 3, the "Lower Drug Costs Now Act," and as a cosponsor of this bill, I know that it takes bold action to level the playing field for patients and taxpayers, especially against Big Pharma.

As we started this hearing today the chairman recognized the work of Chairman Elijah Cummings, who in his 23 years in Congress tirelessly led the fight to investigate escalating prescription drug prices in his role as the Oversight chairman. We would not be here today without his leadership, and we will carry on his legacy to hold Big Pharma

accountable to the American people.

My top priority in Congress is to ensure Nevadans and all Americans can afford their prescription drugs. That is why earlier this year I introduced the SPIKE Act, along with my colleague, Representative Reed, a bill that would require transparency from drug manufacturers by making them publicly justify why they price gouge American families every day.

Additionally, just last week, I introduced the "Capping Drug Costs for Seniors Act," which would ensure that Medicare Part D beneficiaries would never have to pay more than \$2,000 out of their own pocket, saving seniors an average of \$3,100 every year.

So as we advance these proposals, all Americans will save considerably. As discussed earlier in this hearing, the partial estimate provided by the CBO shows H.R. 3 would produce \$345 billion in savings and an additional \$158 billion in lower premiums.

That means that we will not only tackle exorbitant and growing drug prices and invest in new cures and innovation, but we will also use the savings to make investments for the Medicare program.

While Medicare helps millions of seniors access health care, it has never covered routine dental services, leaving many of the most vulnerable Americans without regular dental care, as Dr. Georges indicated in her opening testimony. Nearly two-thirds of Americans with Medicare have no dental coverage at all, and nearly half of older adults reported skipping dental exams due to cost, and we know that foregoing necessary dental care can result in poor oral health, which can increase the risk of heart attack, stroke or diabetes.

That is why I joined my colleague, Congresswoman Robin Kelly, in introducing the "Medicare Dental Act," which will allow Medicare to invest H.R. 3 savings on preventative dental and screening services, such as tooth extractions, oral disease management, root

canals, and even coverage for dentures.

In my district in Nevada, there are 87,000 people enrolled in Medicare Part D, and 471,000 people enrolled in private health insurance, all of whom stand to benefit from the proposals we have discussed in this committee today. I speak for them, not Big Pharma that last year made an estimated \$400 billion in profit.

Drug manufacturers are granted a license to sell prescriptions by the Federal Government, us, the American people. That license should not be a death sentence for patients who cannot afford to buy lifesaving medications like Ms. Reid.

For Nevadans and all Americans, I urge this committee and this Congress to act swiftly to pass this legislation.

Dr. Miller, there are consequences of not acting and not altering how we pay for and reward drugs in this country. Do you concur with experts who believe that the future of health care delivery will become more reliant on pharmacological interventions to treat the conditions facing our aging society? Yes or no?

*Dr. Miller. Yes.

*Mr. Horsford. And do you agree that the types of products that are being developed now and are likely to be developed in the future will tilt towards expensive, specialty drug products rather than traditional chemical products?

*Dr. Miller. That is clear in the data, yes.

*Mr. Horsford. Can we count on these specialty drugs to attract the same level of generic competitors to the marketplace that we have seen for traditional chemical-based drugs?

*Dr. Miller. A lot of the researchers think that the competition is less likely in that scenario.

*Mr. Horsford. So would you agree that the cost of not implementing an

intervention is a policy choice that would have an increasingly negative consequence the longer that we delay this legislation?

*Dr. Miller. The longer you do not deal with the specialty drug pricing, the more of a drag it will be on the Federal programs and on commercial insurers, yes.

*Mr. Horsford. You have made our point. The case has been made. It is time for this Congress to act.

Thank you, Mr. Chairman.

*Chairman Neal. Thank you.

Let me recognize the gentleman from New York, Mr. Suozzi, to inquire.

*Mr. Suozzi. Thank you, Mr. Chairman.

Thank you to the witnesses for spending all of this time here. I have been out to five different things during the course of the time. You have been sitting here the whole time. So we are so grateful to you for all of the time that you have spent here. You are experts in this area, and we are very grateful to you for the time that you are spending.

You know, in January of 2017, a public official in this country when talking about the pharmaceutical company said, "These guys are getting away with murder." That was President Trump. He said that back in January of 2017.

And people will recall that President Trump said during his campaign we need to negotiate with the pharmaceutical drug companies to lower the cost of prescription drugs, and I actually wrote a list of things when he was first elected of the things that he said that I agreed with and things I disagreed with, and this is something that I certainly agree with.

And I am hoping that in the midst of all of this disfunction that is happening in Washington, D.C. these days that we can do something that will actually help real people, Ms. Reid, will help real people who are facing real problems.

This is one of the biggest problems that cuts across all different demographics, all

different geographic areas, all different age groups. Everybody is affected by these high prescription drug costs.

And as the President said in January of 2017, these guys are getting away with murder. It is a life and death issue for many families.

And so I just want to ask you, Dr. Miller. I think I may have asked you a question like this before in the past. Is it accurate to say that most large drug companies spend more money on advertising and marketing than they do on research and development?

*Dr. Miller. The analyses that I have seen suggest that that is true.

*Mr. Suozzi. And Mr. Ippolito, do you know that there are only two countries in the world that can advertise their drugs on television?

*Dr. Ippolito. I believe I have heard that said before, yes.

*Mr. Suozzi. Which two are they? Do you know?

*Dr. Ippolito. I believe it is New Zealand; is that correct?

*Mr. Suozzi. New Zealand and?

*Dr. Ippolito. The U.S.

*Mr. Suozzi. The United States of America. So think of all the money that is spent on advertising.

And what do they say in all of those drug commercials? They say you are going to have this problem, this possible side effect, this possible side effect. Call your doctor.

What happens? A lot of money is spent on doctors, marketing drugs to them to persuade them that they should sell this particular drug to their clients or to their patients.

You know, I was with somebody who was a very high official in the government who also worked for prescription drug companies, and he said regarding this argument that if we were to negotiate these drug prices down that it would affect innovation, the pharmaceutical companies are overplaying their hand.

Now, I could understand if we bashed them, if we drove them into the ground and they lost all of their profits. They would not have the money to spend on research and development. But to say that what we are trying to do here, which is try and align us with 120 percent of the international marketplace of our peers is going to ruin their profits does not make any sense.

So do you think that they are overplaying their hand by saying that innovation will go away if we reduce these drug prices? Dr. Miller what do you think about that?

*Dr. Miller. Yes, this has come up, and I have said a couple times there are 6 to \$7 trillion to spend here. They are profit seeking organization. R&D leads to profits.

The U.S. will be a large market in any case. Even under this bill, the prices will still be the highest anywhere in the country. It will continue to be a market that is going to be attractive, and I do believe that there is enough revenue that can be redeployed into innovation.

And then the other thing is that if the European prices rise, then that is more dollars that fill in anything that might be taken out.

*Mr. Suozzi. Well, Dr. Ippolito, the pharmaceutical companies make profits in other countries now, do they not?

*Dr. Ippolito. So they certainly sell their products.

*Mr. Suozzi. I want to know do you think they make profits in the other countries. Do you think the pharmaceutical companies make profits in other countries?

*Dr. Ippolito. I do not know if they sell at above average cost, but they do sell above marginal cost of the product.

*Mr. Suozzi. They make a profit? I mean, why would they be selling in these other markets if they did not make a profit? They are making a profit in other countries.

*Dr. Ippolito. That does not mean they would make a profit if they sold --

*Mr. Suozzi. Have you heard the expression by the President where he says that these are "foreign freeloaders"?

*Dr. Ippolito. I have heard him say that, yes.

*Mr. Suozzi. What do you think about that expression? Do you think the President is wrong to say that?

*Dr. Ippolito. I think we subsidize a lot of the world's development of drugs.

*Mr. Suozzi. We subsidize a lot of the world's development of drugs by paying my statistics say here, and I apologize if you have already talked about this in your testimony with the witnesses, four times what those peer countries pay for their prescription drugs.

Have you heard that before, witnesses?

*Dr. Miller. Yes. There is Hopkins research that suggests that, and there is an ASPE report on Part B drugs that suggests it is two, and so I walk around saying two to four times.

*Mr. Suozzi. Okay. Somebody was nodding their heads in answer to my question, and I have run out of time.

So I just want to thank you all for your testimony here today.

*Chairman Neal. I thank the gentleman.

Dr. Ferguson from Georgia is recognized.

*Mr. Ferguson. Thank you, Mr. Chairman.

And thank each of you for being here.

I am going to jump right into this since we have had a long afternoon or long morning.

Dr. Ippolito, excuse me. I am from the South. We take a little bit longer to get those many syllables out.

In your opinion, you know, if H.R. 3 goes into effect, are you going to see higher or lower revenues coming into those companies that are doing R&D and development of drugs?

*Dr. Ippolito. Clearly lower.

*Mr. Ferguson. Okay. If you have lower revenues, do you expect there to be fewer people that are hired and working in R&D, manufacturing and sales?

*Dr. Ippolito. Yes.

*Mr. Ferguson. Okay. If that is the case, do you see a lower output or do you think that potentially as a result of this to be shortages of drugs or harder access to drugs, particularly in rural areas of America?

*Dr. Ippolito. The access question in the short term, I would not worry as much about. The access question that is the one that really matters, I think, is the longer term access question, which is --

*Mr. Ferguson. The real concern that we have that we have seen time again that access of rural America when we see these larger programs gets hurt, and I am saying this as a practitioner. It really does.

And, Dr. Miller, I see you shaking your head, but I am the one that has been working in the rural areas, and I see how these programs negatively impact it.

Now, with that being said, do you think, Doc, that you could get less dollars invested in critical drugs and cures, such as those with Alzheimer's, those patients suffering Alzheimer's?

*Dr. Miller. Yes, I mean, directionally I think the answer is clear. If you invent a cure for Alzheimer's, you are going to be good.

*Mr. Ferguson. If we do not find a cure for Alzheimer's or treatment for it, what is the financial impact on the family?

*Dr. Miller. Well, it is quite considerable. We have discussed this to some extent in both directions, that there is a substitution or complementarity often between pharmaceuticals and all sort of other health care that we receive, and sometimes you can really save a lot of money by going the pharmaceutical route and sometimes it is vice versa.

But, yes, absolutely.

*Mr. Ferguson. So one other thing. You know, there has been a lot of discussion here today about having the ability to negotiate drug prices, and I think the distinguished gentleman from California, Mr. Thompson, talked about the VA having negotiating power and having a lower drug cost.

Listen. I think we could all say as long as we are getting into a fair marketplace, we would like to have the Federal Government or Medicare be able to negotiate drug prices. Okay? I mean, I think that is something that is solid.

But this, H.R. 3, is not a negotiation. This is a drug fixing bill. It is price fixing bill.

So this is based on the premise that we are going to price our drugs on the drug prices from six other foreign countries. Okay? And those six other foreign countries truly are more socialist leaning than we are, correct?

How would you determine that going forward?

Is this metric set? Does it evolve?

I mean, listen. The U.S. is a very different marketplace than, say, a country maybe in Asia or Europe. I mean, do you think that pricing it off of six other countries that do not have the same advantages or issues that the U.S. does is the right way to get to a drug price?

*Dr. Ippolito. Yes, if I am completely honest, if you were going to do this, if you really wanted to just set the price of a drug, I do not know why you would ask another

country to do it. The U.S. should just do it themselves if that is what you want to do.

But, yes, the issue is look. All these other countries exist in a world where the United States exists. I am not applauding the fact that we spend so much money on drugs necessarily. We have a huge market. All right?

And what that means is we have an outsized influence on the markets. So these other countries can basically assume whatever we do, it is okay. The U.S. is going to subsidize the drug no matter what.

We, unfortunately, have a harder challenge to solve here, and so when we make these kinds of decisions, I would prefer that we make them a little bit more domestically, but that is just my view.

*Mr. Ferguson. Thank you.

Dr. Miller, a quick question for you. You mentioned a study that talked about spending more on advertising than R&D. Where did that information come from?

*Dr. Miller. I cannot remember who did the study. It was published a couple of times. A couple of different studies were talked about in the Washington Post. I can get you --

*Mr. Ferguson. Well, since you have brought it up here, can you find that and submit it to the committee for record?

*Dr. Miller. Absolutely.

*Mr. Ferguson. Thank you.

*Dr. Miller. Absolutely.

*Mr. Ferguson. Thank you for that.

*Dr. Miller. And I am pretty sure it is documented. The --

*Mr. Ferguson. Okay. I appreciate you submitting that back to us.

And with that, Mr. Chairman, I yield back.

*Chairman Neal. I thank the gentleman.

With that let me recognize the gentlelady from Florida.

*Dr. Miller. Can I say one thing about the access point?

I am sorry. I think one thing just to not blow past and for rural beneficiaries, if you lower their out-of-pocket, their access will be increased immediately for drugs that are available now, and that is the only point that I thought got missed in there, and I wanted to address that.

*Chairman Neal. Thank you.

*Mr. Ferguson. That is the short term. I am concerned about the long term.

*Chairman Neal. The gentleman's time has expired.

Let me recognize the gentlelady from Florida, Ms. Murphy, to inquire.

*Ms. Murphy. Thank you, Mr. Chairman.

And thanks to the witnesses for your testimony today and for your incredible endurance.

As some of my colleagues have done, I want to put a human face on the issue of prescription drugs. I think it is important to keep reminding ourselves that this issue may involve complex policy and complex politics, but at its core, it is about people.

And people like Ms. Reid, thank you for sharing your story, but also people like Sandra from my district. And I told her story here at this hearing back in February. She is a 66-year-old retiree in Orlando who worked her whole life. She is on Medicare, and her only income is from Social Security, about \$1,200 or so a month.

And these are not handouts. You know, she paid into these programs for years, and Sandra has diabetes. Her medications used to cost \$100 at the pharmacy counter, and not long ago for reasons that she certainly cannot explain and that nobody can explain to her, the cost tripled to \$300 a month, and as a result, Sandra can no longer afford to pay for

both her medicines and her food and her housing expenses. So she stopped taking her medicine.

And despite her age, Sandra tried to go back to work to earn more money so that she could afford the medicine again. However, she is not taking the medicine that she needs, and she is too sick to work.

And she had recently been hospitalized multiple times, and that is terrible for Sandra. There is a human cost to that, but it is also expensive for Federal taxpayers.

We live in the greatest country on earth, which is why it is so upsetting for me to hear stories like Sandra's, all the time. Every time I go out in my community somebody comes up to me with tears in their eyes sharing a story about struggling to afford their medicines.

And I hear these stories from old people, from young people. I hear them from folks on Medicare, from folks with private insurance. I hear them from constituents with cancer, heart disease, mental health struggles, and countless other health conditions.

And when these men and women come up to me, some of them are angry and frustrated and deeply discouraged by a drug pricing system that they do not really understand and that seems to defy rational explanation.

But most of them are just really sad and worried about their future, as Ms. Reid has shared with us today. And for me it is not enough for me to offer them sympathetic words. That does not really help them. What would help them is action here in Congress.

And that is why I am so glad that we are taking action on H.R. 3 with this hearing today and with the markup in the coming days.

And while I do not think the bill is perfect, I think it is making a serious effort to tackle a very serious problem. But I have to note that this bill is really aimed at only one player in this whole drug pricing supply chain, and let me make two points clear about that.

First, as I have said before, and I want to reiterate, Congress needs to require every player in the supply chain to make improvements with their own spheres, from drug makers to insurance companies, to PBMs. Everyone needs to be part of the solution for it to be effective and enduring.

So this bill should just be one element of a larger legislative effort, a first step so to speak.

And second, I really do not have a whole lot of patients for people who vilify their biopharmaceutical sector. There are some bad actors. No doubt about that, but there are in every line of business, and we should be addressing those issues.

But there are a lot of good actors, too, and companies whose workers devote their days to making medicines that improve lives, extend lives and save lives, and I think we should pass strong legislation to ensure patients can afford the amazing drugs these companies make, but we should never take these companies' contributions to health care for granted. If we do, I think we do so at our own peril.

Dr. Miller, I am probably asking you to repeat yourself, but I do want to tackle head on the main argument that has been made against this bill, which is that it could stifle innovation.

In plain terms, can you tell me why you think that this bill can lower drug costs, as it clearly will do, without compromising the ability or will of companies to keep making the drugs and creating innovations for the market?

*Dr. Miller. Okay. I think we are very clear on where the reductions come from, from the Part D restructuring, the inflation rebate, and the negotiation provision, the targeted negotiation provision.

The reason that I do not think that it undercuts R&D, you will still have a north of \$6 trillion market out there. These firms are profit seeking. R&D drives product; product

drives profit. They are not going to walk away from their profit.

This is a huge market. The United States will continue to be a huge market. These prices will still be higher than anywhere else in the United States.

And to those jobs, those R&D jobs that you are speaking to, you can redeploy resources even in the industry that could go into those R&D jobs, and I will stop there.

*Ms. Murphy. Thank you.

And I yield back.

*Chairman Neal. I thank the gentlelady.

With that we will recognize the gentleman from California, Mr. Gomez, to conclude inquiry.

*Mr. Gomez. Thank you, Mr. Chairman.

And thank all of you for being here.

I often go last, but it gives me an opportunity to ask the questions that nobody else got to ask. Sometimes that is good; sometimes that is bad.

But let me just start off by just stating that I do appreciate the leadership of the chairman of this committee on trying to bring down cost of prescription drugs. And we know for far too long working families have struggled to pay for the medication they need and at the same time pay for the basic necessities of life, everything from food to shelter. It is something that they struggle with day in and day out.

And I believe that some people will argue that this bill, H.R. 3, the "Lower Drug Costs Now Act," goes too far, and others will argue it does not go far enough, but I think what we all need to acknowledge is that it is still an important step to take.

And I hope President Trump will support it if he wants to live up the promise to allow Medicare to negotiate with pharmaceutical companies to lower drug prices for all Americans.

In addition to high drug prices, we are also focusing today on ways to improve the Medicare program for those who need it most. Language access is central to the delivery of equitable, high quality care for individuals with limited English proficiency. Any trip to my district, to any part, Chinatown, Filipino Town, Creole Town, or City Terrace, you will be reminded that Los Angeles is one of the most ethically and linguistically diverse cities in the entire country.

And that is why earlier this year I wrote a letter to the Administrator of the Centers for Medicare and Medicaid Services urging CMS to increase the number of languages used in Medicare's educational enrollment materials.

Mr. Chairman, I ask for unanimous consent to submit that letter for the record.

*Chairman Neal. So ordered.

[The information follows:]

*****COMMITTEE INSERT*****

*Mr. Gomez. Thank you so much.

CMS already translates most outreach material into Spanish, but Medicare should go further so that all beneficiaries who speak Chinese, Korean, or any other language have meaningful access to understand these important materials.

When I got elected, one of the first things I did is promise to promote the services of my office and the languages of the communities that I represent. I was the first one to ever do mailers in Korean, mailers in Spanish, very specific to these communities because that is the only way they can access it.

The "Language Access for Medicare Beneficiaries Act," H.R. 4675, legislation I introduced to ensure that Medicare's educational and enrollment materials, especially the "Medicare & You" and your handbook, are available in additional languages.

This is an important issue to make sure that everyone can access our health care.

With that I also wanted to go into some questions. Dr. Miller, this is for you.

Dr. Miller, with your deep familiarity with the Medicare program, I would like to ask a series of yes/no questions to get a sense of how Medicare interacts with providers of care.

First question: in the Medicare Part A program, do we allow hospitals to charge whatever price they want to Medicare and beneficiaries? Yes or no?

*Dr. Miller. No.

*Mr. Gomez. Moving on to the Part B program, do we allow physicians to set whatever prices they choose for Medicare and its beneficiaries? Yes or no?

*Dr. Miller. No, we do not.

*Mr. Gomez. No. What about the home health services? Are those providers able to charge Medicare any prices they please?

*Dr. Miller. No.

*Mr. Gomez. And what about nursing homes? Can they charge any price they desire?

*Dr. Miller. No, they also cannot.

*Mr. Gomez. Now, is it not true that we allow drug manufacturers to charge Medicare whatever price they want with no opportunity to negotiate lower prices?

*Dr. Miller. Just a little nuance there. The PBMs can negotiate with them if there is a competitive drug. If the drug does not have competition, then you are open to being charged any price.

*Mr. Gomez. And that kind of goes to Ms. Murphy's point as well.

So what is the policy justification then for allowing the Medicare program to limit prices from physicians and hospitals, but explicitly prohibit even the negotiation process for drugs facing no competition to secure lower prices for our seniors under the Medicare out-patient drug benefit?

*Dr. Miller. And the thing I would say is that where you have competition, Part D is competing with the PBMs. Where you do not have competition, I think that is what H.R. 3 is going after, is to see if there is a price that could be agreed to, and then the inflation index also puts a limit on price.

So I think this legislation is intended to try and get the drug sector to operate like other parts of Medicare.

*Mr. Gomez. Thank you.

We definitely believe that, you know, there is something amiss when it comes to who gets to negotiate and who does not. So thank you for your response.

With that I yield back.

*Chairman Neal. I thank the gentleman.

I want to thank our witnesses for their testimony today.

Please be advised that members have two weeks to submit written questions to be answered later in writing. Those questions and your answers will be made part of the formal hearing record.

With that the Ways and Means Committee stands adjourned.

[Whereupon, at 2:08 p.m., the committee was adjourned.]

Submissions for the Record follow:

[American Federation of State, County and Municipal Employees](#)

[American Society of Health-System Pharmacists](#)

[National Community Pharmacists](#)

[American Federation of Teachers](#)

[Gabriel Levitt](#)