Oversight and Investigations Subcommittee

Priced Out of a Lifesaving Drug: Getting Answers on the Rising Cost of Insulin

April 10, 2019

10:30 am, 2322 Rayburn

Purpose

This is the second in a series of hearings exploring the rising cost of insulin.

Members Present

Chairman DeGette, Ranking Member Guthrie, Chairman Pallone, Ranking Member Walden, Representatives Kennedy, Ruiz, Griffith, Brooks, Kuster, McKinley, Castor, Mullin, Tonko, Clarke, Sarbanes, Schakowsky, Peters, Bucshon, Barragan, Carter

Witnesses

Mr. Mason, Senior Vice President, Lilly Connected Care and Insulins Global Business Unit, Eli Lilly and Company
Mr. Langa, Executive Vice President, North America Operations, and President of Novo Nordisk, Inc., Novo Nordisk
Ms. Tregoning, Executive Vice President for External Affairs, Sanofi
Mr. Moriarty, Executive Vice President, Chief Policy and External Affairs Officer, and General Counsel, CVS Health
Ms. Bricker, Senior Vice President, Supply Chain, Express Scripts
Mr. Dutta, MD, Senior Vice President and Chief Medical Officer, OptumRx

Opening Statements

Chairman DeGette said that insulin has become outrageously expensive. The price has doubled since 2012, after nearly tripling in the past 10 years. When patients can't afford their insulin, they have to skip or ration doses or forgo their bills. It is unacceptable that anyone in this country cannot access the drug their lives depend on. Last year, the Diabetes Caucus issued a report exposing some of the underlying problems in the insulin market: perverse payment incentives and a lack of pricing transparency. At the previous hearing, the American Diabetes Association testified on the effects of skyrocketing insulin prices. However, the other witnesses could not point to why insulin prices are so high in this opaque, convoluted market. The witnesses at the hearing today have a direct effect on the prices of insulin today for consumers. They play a large role in the supply chain for drugs and have received a lot of criticism, but there cannot be any finger pointing or passing the buck. Many entities share the blame.

Ranking Member Guthrie said that 9.4 percent of the population have diabetes. The insulin prescribed today is different from the insulin discovered 100 years ago; there is a lot of exciting research on the horizon. However, net prices have stayed the same or gone down, while list prices have been tripling. If patients are uninsured or underinsured, they may pay the list price. High-deductible health plan enrollment has also increased, leading to more patients paying list price. The drug supply chain lacks transparency. Both the manufacturers and PBMs have been blamed, as well as other entities like health insurance companies. There are incentives to increase prices throughout the supply chain. The health

insurance companies decide whether to keep the rebate or pass the rebate at the point of sale. While there are reassurances that the net price is being kept the same, patients are still paying exorbitant prices at the counter. It is important to collectively find a permanent solution to guarantee affordable medicines.

Ranking Member Walden said that at last week's hearing, all of the witnesses agreed that the current pricing system for insulin is harming many patients, leading to short- and long-term problems. The committee must identify and break down barriers. A letter was sent to the witnesses earlier in the year about the cost of insulin in the market. The discussion today is centered on reducing costs, but it must be remembered that the drug manufacturers and PBMs have an important role in ensuring patients having access to insulin. Insulin manufacturers have created patient assistance programs and created lifesaving drugs through innovations. Manufacturers rarely receive the list price for their medicines. PBMs use different tools to control cost while promoting healthcare. For example, CVS created a diabetes cost program and OptumRX created a program to lower cost. Express Scripts announced a new patients assurance program for insulin. These programs are only a band aid and long-term solutions must be created. Distributors, pharmacists and health insurance plans should also be included in future hearings, as they are part of the supply chain as well.

Chairman Pallone said people are having to make sacrifices to pay for their insulin. The witnesses at last week's hearing described a broken system. Today the companies who make the drugs and negotiate their prices are responding to the criticism heard last week. The companies need to make money to succeed, and in a normal market the price will be appropriate, but the market is broken down since there is limited competition and limited incentive to maintain affordable prices. While most people do not pay the list price, uninsured patients do, and even insured patients can be affected when the list price rises. PBMs are also here, whose role it is to negotiate lower drug prices on the behalf of the insurance plans, and there is the question of whether the discount is being passed on to the patients. PBMs and manufacturers point their fingers at each other, leaving no accountability. The back and forth arguments are frustrating and unacceptable.

<u>Testimony</u>
Mr. Mason said that Lilly introduced the first commercially available insulin in 1973. In 2018, Lilly announced its commitment to a research development partnership to potentially eliminate the need for insulin. He said that he has personal experience with his diabetic family members worrying about the cost of insulin. Lilly has not increased insulin list prices since 2017, but it is important to focus on out-of-pocket costs. Most people who need insulin have private or government insurance, but their out-of-pocket costs are based on list prices. Those most exposed are the uninsured, those with Part D, and those in the deductible phase of a high deductible insurance. Lilly is providing automatic discounts at the pharmacy counter to cap the payment at $95 for those in the deductible phase, and the launch of a half-priced version of Humalog. With fees and meaningful solutions, Lilly tried to build a safety net. The solutions are working to reduce out-of-pocket costs, with 95% of Humalog prescripions less than $95 at the pharmacy, and 43% of them zero. They are still

stopgap measures. Longterm systematic solutions are needed. The policy ideas suggested by CVS in the written testimony would save lives and money while cutting straight to affordability. The CREATES Act and the pay-for-delay bill are also commendable.

Mr. Langa said that there is a lot of discussion about list price. In the current system, lowering list price won't bring meaningful release to all patients and may jeopardize patients with insurance. List price is only part of the story. Once list prices are set, the system demands that the manufacturers negotiate with PBMs and insurance plans to set the formularies, which is critical. Rebates and discounts accounted for $0.68 of every dollar of Novo Nordisk gross sales in the US. Net prices of insulin products have declined year over year since 2015. Despite the investment in rebates, some patients end up paying list price at the counter. Novo Nordisk has no control over what insured patients pay at the counter, which is dictated by benefit design. More patients have benefit designs requiring higher out-of-pocket costs, so they don't get the full benefit of rebates. This needs to change. Patients need to benefit directly from the rebates paid by manufacturers. When the health care market shifted towards high deductible plans, Novo Nordisk pledged in 2016 to limit list price increases to single digits annually. The pricing pledge complemented other programs with the goal of reducing out-of-pocket costs, such as the partnership with Walmart. In 2017, Novo Nordisk partnered with CVs and ExpressScripts to offer human insulin for less than $25 a dose. Since 2003, free insulin has been provided to those eligible under the patient assistance plan. The current system is broken. All stakeholders must cooperate to find meaningful solutions.

Ms. Tregoning said that patients are rightfully angry at the broken system. Over the last 20 years, Sanofi has been a leader in the advancement of new diabetes treatments. Two years ago, Sanofi made a pledge to keep list price increases at or below the US health expenditure projected growth rate. In 2018, the average aggregate net price declined by eight percent while the average aggregate list price increased by four percent. Insulin is a clear example of the growing gap between list and net prices. For Lantus, the net price has fallen by over 30 percent since 2012 and today it is lower than what it was in 2006, yet since 2012, average out-of-pocket costs have risen approximately 60 percent for those with Medicare and commercial plans. Sanofi also developed assistance programs including copay assistance and free insulin for low-income and uninsured patients. Approximately 75 percent of those taken Sanofi pay less than $50 a month. Last year, Sanofi launched a program allowing patients to access insulin for $99 per vial, the lowest cash price in the US. Sanofi will expand this program: patients will be able to access the Sanofi insulins they need for $99 a month at the pharmacy counter starting in July. However, broader system reform is needed. Sanofi supports recommendations outlined in the written testimony.

Mr. Moriarty said that list prices have increased nearly 50 percent over the past five years. The primary challenge is that there have been no generic alternatives despite insulin being on the market for 100 years. CVS has taken a number of steps: negotiating the best possible discounts on behalf of the beneficiaries served, reducing the cost of diabetes drugs by 1.7 percent; replacing high cost insulins like Lantus with lower cost insulin Basalgar, decreasing member out-of-pocket costs. Among patients who switched to Basalgar, their

A1C levels increased, leading to increased medical cost savings. CVS also offers a number of tools for patients to decrease their out-of-pocket costs: Caremark members are provided real-time information on the lowest cost alternative; CVS Pharmacy customers have the Savings Finder Tool. Beyond this, CVS partnered with Transform Diabetes Care to ease the complexity of self-management. More effective lower-cost alternatives need to be brought to market by ending pay-for-delay schemes and zero cost copays must be introduced for preventative medicines like insulin.

Ms. Bricker said that Express Scripts negotiates lower drug prices with drug companies, generating savings returned to patients in the form of lower premiums and lower out of pocket costs. Clinical support services let individuals lead healthier lives. Innovative programs include the Diabetes Care Value Program, offering remote monitoring of blood sugar levels, Inside Rx, a cash discount program for those with high coinsurance or the uninsured. The national preferred flex formulary provides health plans the flexibility to immediately add plans to their formulary. Recently, Lilly announced it is reducing the list price of Humalog by 50 percent, and Express Scripts encourages others to do the same. Express Scripts announced the patience insurance program, capping the out of pocket cost at $25 for 30 day supplies of insulin, in collaboration with the manufacturers represented here. List prices are exclusively controlled by manufacturers. In the absence of lower list prices, the role of negotiated rebates has become increasingly important in reducing healthcare costs for consumers. In total, 95 of rebates and discounts received by Express Scripts are returned to companies, plan sponsors and consumers. For insulin, the plans saw a 1.4 percent decline in unit cost, which was achieved by leveraging pharmacy discounts and driving competition among manufacturers. Market-based solutions must put downward pressure on drug pricing.

Mr. Dutta said that OptumRx's negotiated network discounts and clinical tools are reducing annual drug costs on average by $1600 per person. The process starts with a clinical assessment of the formulary by independent committee, which is based on evidence, not cost. About 90 percent of the OptumRx prescription claims are for generics. But for insulin, there are no true generic alternatives. Many branded insulin products are therapeutically equivalent, OptumRx negotiates with manufacturers on behalf of the customer. There is commonly a fixed copay of $35 for those insured. OptumRx has taken action to help those with high deductible insurance, saving $130 on average per eligible prescription. Last month, the point-of-sale discount solution was expanded to all new employer-offered healthcare plans beginning January 2020. Nevertheless, insulin prices remain too high due to lack of competition, which is odd for a nearly 100-year-old drug that has not seen significant innovation in decades. The most impactful way is to open the market to true generics and biosimilars. OptumRx supports reforming the patent system and closing loopholes that allow the stifling of competition. Congress can increase competition and lower prices by passing the CREATES Act, prohibiting pay-for-delay and evergreening, accelerating biosimilar options, and decreasing the exclusivity period for drugs.

<u>Questions and Answers</u>

Chairman DeGette said that there are all these workarounds to get a lower insulin price from the really high list price. Lilly increased the price of Humalog from $35 in 2001 to $275 today. Novo Nordisk increased the price of NovoLog by 350 percent from 2001 and on January 8, 2019, the insulin prices went up by five percent. Sanofi increased the price of Apidra from $86 in 2009 to $270 last year, and since January 1, the three main brands saw 4.4 to 5.2 percent increases. Everyone is saying that there are these workarounds, but not everyone gets them. The question is why the list price is so high. She asked Mr. Mason how Lilly justifies the huge increases in list price. **Mr. Mason** said that 75 percent of the list price is paid by rebates or discounts. $210 of Humalog pays for discounts and rebates. **Mr. Langa** said that there are misaligned incentives due to rebates. **Mr. Tregoning** said rebates. **Mr. Moriarty** said that this is the pharmaceutical manufacturer's purview. **Ms. Bricker** said it is not a result of rebates. **Mr. Dutta** said that list prices have skyrocketed even in non-rebated drugs; there is no correlation between rebates and list prices. **Chairman DeGette** said that every component of the drug system is contributing to an upward pressure on the list price.

Ranking Member Guthrie said that list prices have gone up while net prices have gone down. He asked the drug manufacturers what would happen if they set the net price equal to list price. **Mr. Mason** said that Humalog's list price is dropping by 50 percent. Access through health plans is not tied to list price, and list price cannot be disrupted so access is not harmed. **Mr. Langa** said that it would be a dramatic impact to lose a position on the formulary after lowering list price. The perverse incentives are spending $18 billion a year in discounts, rebates and fees with none of that going to the patients. **Ms. Tregoning** said that rebates are not going through to patients, they're going to other parts of the system. There is no visibility with how they are getting used. **Ms. Bricker** said that formulary decisions are made on net prices. If manufacturers wanted to lower the list prices, there would be no formulary decisions as long as net price stayed the same.

Rep. Kennedy submitted to the record a Boston Globe piece about mothers who brought the ashes of their children to Sanofi in Boston to protest insulin prices. There is a bipartisan frustration. Data indicates that from 2002 to 2013, the average price went from $231 to $762. 50 percent of the baseline price is not PBMs. **Mr. Mason** said that net prices have gone down since 2009. **Rep. Kennedy** asked if a price has ever been lowered from the formulary. **Mr. Mason** said that Lilly is launching a lower price Humalog. Net prices have been lowered from the past 10 years. **Rep. Kennedy** asked what evaluation is taken to lower prices. **Mr. Mason** said that Lily has to provide rebates. **Rep. Kennedy** asked if Novo Nordisk has ever lowered list prices. Mr**. Langa** said no. The biggest vehicle today is formulary positions. Anything that risks that is something that must be strongly considered. **Rep. Kennedy** asked what Congress can do to improve patient access. **Mr. Langa** said that everyone must come together to stop insulin rationing. **Ms. Tregoning** said that patients must be aware of the assistance programs. It takes a matter of moments to access those via phone or the Internet.

Ranking Member Walden said that Sanofi launched Admelog at a list price about 15 price less than the list price for Humalog. Admelog is not on the formulary for any commercial

plans. So given Admelog was launched at a lower list price than Humalog, are there issues for gaining formulary access with Admelog. **Ms. Tregoning** said that Sanofi has brought a number of products at lower prices to patients and faced similar challenges with securing formulary access. **Ranking Member Walden** asked if more follow on biologics and biosimilars of insulin will reduce the list price of insulin or if the biologic market functions differently than the introduction of a generic of a small molecule drug. **Ms. Tregoning** said that there is already competition in the insulin market, such as Lilly's follow on biologic versin of Lantus. CVS spoke to the fact that they could leverage greater rebates to negotiate. **Ranking Member Walden** asked if Lilly has told any PBMs or health insurance plans that it will no longer provide rebates for Humalog if PBMs or plans put Admelog on the formulary. **Mr. Mason** said no. **Ranking Member Walden** asked if Sanofi has told any PBMs or health insurance plans that it will no longer provide rebates for Lantus if PBMs or plans put Basalgar on the formulary. **Ms. Tregoning** said no. **Ranking Member Walden** asked the same to Mr. Moriarty. **Mr. Moriarty** said no. **Ranking Member Walden** asked why Admelog why it isn't included in the formulary. **Ms. Bricker** said that the net price for Admelog made it more expensive than competing products. **Mr. Dutta** said that the lowest cost product gets preferential position on the formulary. **Mr. Moriarty** said that for Basalgar, the follow-on biologic was moved to preferred status. **Ranking Member Walden** asked if list price is taken into consideration for formulary decision. **Mr. Dutta, Mr. Moriarty and Ms. Bricker** said no, it is only net price.

Chairman DeGette asked why PBMs aren't putting Admelog on the plans**. Mr. Moriarty** said that Basalgar is the follow-on biologic with preferred status. **Mr. Dutta** said it would cost the payor more because the list price isn't what the payor is paying.

Rep. Ruiz said that there has been little regard for what works for patients in today's discussion. Out-of-pocket costs must be reduced for patients. One out of four adults diagnosed with diabetes in the Coachella Valley are living below the federal poverty line. Reducing the list price of drugs or increasing the number of generics does not solve the problem if out-of-pocket costs are not reduced. **Rep. Ruiz** asked who is earning the profit from increasing list prices that patients pay for. **Mr. Mason** said that net prices have gone down since 2009. **Rep. Ruiz** asked Mr. Langa which entity in the supply chain is prioritizing affordability and access for insulin. **Mr. Langa** said Novo Nordisk is. There is a small profit despite nets going down. The profit has been relatively stable. **Rep. Ruiz** asked if the CEO's pay has increased. **Mr. Langa** said yes. **Rep. Ruiz** asked if Express Scripts passes any savings on to beneficiaries. **Ms. Bricker** said that Express Scripts has supported point of sale rebates for 20 years. **Rep. Ruiz** asked how the public can know this if there is no transparency. **Ms. Bricker** said that plan sponsors can view all negotiated retail contracts. **Rep. Ruiz** asked if barriers to passing discounts onto patients are at the point of sale. **Mr. Moriarty** said that CVS Health advocates for zero copay. **Rep. Ruiz** asked what each of the witnesses is willing to give up to make insulin accessible and affordable. **Mr. Mason** said $108 million last year. **Mr. Langa** said $18 billion invested in discounts and fees. **Ms. Tregoning** said Sanofi is working on its patient assistance programs.

Rep. Griffith said that there are numerous fees and discounts in the prescription drug supply chain calculated on insulin prices. Fees are based on a percentage of the list price of insulin. He asked the witnesses why that is the case. **Mr. Mason** said that there is demand for rebates. **Ms. Tregoning** said it is the system. **Rep. Griffith** asked why it isn't based on a flat fee. **Mr. Mason** said it is the current system. **Rep. Griffith** asked Mr. Moriarty about the February 6 letter sent to CVS Health asking to list all the contracts impacted by the list price of medicine. CVS did not directly answer, but the default template revealed that CVS may receive administrative fees based on a percentage of the list price of the medicine. **Mr. Moriarty** said that over 98 percent of the fees received from the services go back to the plan sponsors. **Rep. Griffith** said that the one percent fee can be charged based on the price of the medicine. **Mr. Moriarty** said it represents the cost associated with the process. **Rep. Griffith** asked if a flat fee would be better. For Part D, CVS charges one percent, but across the board, two percent is charged as a part of the rebate on top of the administrative fee. **Mr. Moriarty** said CVS can do it if the flat fee represents the net price in the market. However, it would result in higher costs because CVS implements measures that lower prices. **Rep. Griffith** said that the administrative fee should be the same for a $4 drug or a $40,000 drug. **Mr. Moriarty** said that the total number across is $300 million for the administrative fees.

Chairman Pallone said that his constituents are totally disgusted and want a set price. He asked why the competitive marketplace model doesn't work. He asked Mr. Mason why Lilly hasn't brought down the list price if it is within his power. **Mr. Mason** said that Lilly has brought down everyone in a high deductible plan to $95. **Chairman Pallone** asked if Lilly is willing to reduce it more. **Mr. Mason** said that it is already reduced despite the quantity purchased. **Chairman Pallone** asked what would happen if the government reduced the price. **Mr. Mason** said competition is working. **Chairman Pallone** asked why Novo Nordisk isn't reducing list prices. **Mr. Langa** said that Novo Nordisk would put all the formulary positions in jeopardy. **Chairman Pallone** said that Novo Nordisk is blaming the PBMs again, and maybe the government should set the price and get rid of the PBMs. **Mr. Langa** said that Novo Nordisk believes in a market-based approach. The average rebate in 2018 was 68 percent, a 48 percent increase in rebates from years past. **Chairman Pallone** asked Ms. Tregoning why Sanofi can't lower the list prices. **Ms. Tregoning** said lowering list price might not help patients and could actually cause patients on the formularies to lose access. A market-based system is important for continued innovation. The results of the negotiations are not finding their way to patients. Sanofi is covering through copay assistance or value saving programs, but cannot control the out-of-pocket costs. **Chairman Pallone** reiterated that the system is not working and his constituents are frustrated.

Rep. Brooks said that it is increasingly common for insurers and PBMs to offer one manufacturer's line on their formularies. She asked why formularies don't have all insulin products, and what would happen if a child has to switch insulin products if their parent's insurance is forced to switch formularies. **Mr. Dutta** said the first assessment is purely clinical and based on whether a product is unique. If it is unique, it is put on the formulary; when therapeutically equivalent products are created, then there is an opportunity to negotiate. A process is offered for a patient and their doctor to request their product, and if

there is sufficient rationale, they are allowed to have that product. **Rep. Brooks** asked what would happen if PBMs stopped excluding certain insulins from the formularies. **Ms. Bricker** said there are many formularies. The formulary that provides the greatest savings for the clients limits insulin options because the deepest discount was secured from the manufacturer once the placement is awarded. Patients can absolutely select formularies. If exclusivity were removed, prices would go up. **Mr. Moriarty** said that prices would go up because drug companies would not offer the discounts that currently exist. **Mr. Mason** agreed. **Mr. Langa** said that physicians should be able to make the decision, not the formulary. **Ms. Tregoning** said that Express Scripts would support a fixed fee system for PBMs as long as patient access and affordability could be guaranteed. **Mr. Langa** said that the rebate rule is supported. **Mr. Mason** agreed.

Rep. Kuster said that 10 percent of New Hampshire residents have diabetes. Insulin manufacturers and PBMs may have lost focus on who they are meant to work for: the patient. Insulin has been around for a long time without a change in the chemistry. There has been a change in delivery mechanism, but that can't explain the price increase. **Rep. Kuster** asked what can be done to increase transparency for patients. **Mr. Mason** said that the biggest issue is for patients in high deductible plans, which is a gap in the system. There is a stopgap measure to buy those people down to $95, but that is a short-term fix. **Rep. Kuster** said that there is a discount for volume purchasing. She asked how patient transparency can be increased. **Ms. Bricker** said that Express Scripts strongly believes in real time benefit checks. It is critical to ensure that there isn't friction at the counter. Plan sponsors should also understand the value given to them through the discounts negotiated for them. Express Scripts absolutely supports modernizing Part D.

Rep. McKinley said that NovoLog has a list price of $237, not $17 if it were adjusted based on CPI from its 1967 price. He asked what kind of innovation has been implemented that would cause such a drastic increase in insulin prices. **Mr. Langa** said that the patient is kept in mind. Even small incremental changes in quality of care mean a lot for the patient. **Rep. McKinley** said he believes in research, but innovation is supposed to drive the price down, not up. **Mr. Langa** said that Novo Nordisk is innovating for the future. **Rep. McKinley** said that there aren't rising list prices for construction material, so he doesn't understand why it is unique to the pharmaceuticals. **Mr. Langa** responded that it is due to misaligned incentives. The higher the list price, the higher the rebate, and those rebates don't get passed through to the patients. **Rep. McKinley** asked if rebates should be discouraged. **Mr. Langa** said Novo Nordisk supports the rebate rule.

Rep. Castor asked the manufacturers if rebates or fees tied to list price were eliminated, then list prices would definitely go down. **Mr. Mason**, **Ms. Tregoning** and **Mr. Langa** said yes. **Rep. Castro** said some manufacturers use the patient assistance programs to increase their tax deductions. She cited the Lilly Cares Foundation. She asked if manufacturers should benefit financially from the patient assistance programs. **Mr. Mason** said that Lilly spent $108 million on savings offers that are not a tax write-up. **Rep. Castor** asked if fees paid to PBMs and wholesalers are standardized and delinked from list prices would affect what the patient pays. **Ms. Bricker** said that 95 percent of all fees and rebates are passed

on to the plan sponsors. Delinking does nothing to prevent manufacturers from increasing the price. **Rep. Castor** asked how Congress can change the system to better help patients. **Mr. Dutta** said that OptumRx advocates for point-of-sale rebates and preventative drug lists such that insulins would not apply to the deductible for those with high deductible and coinsurance plans.

Rep. Mullin asked if there is a tax advantage for the rebates. **All the witnesses** said no. **Rep. Mullin** asked if the charitable contributions are a tax advantage. **Mr. Mason** said no. **Rep. Mullin** asked if insulin is being used to offset the cost of research for future drugs. **Ms. Tregoning** said revenue from all drugs help fund research. The revenues from diabetes are going down for Sanofi in the US since net prices have gone down so dramatically. **Rep. Mullin** asked how long patients stay on patient assistance programs. **Mr. Langa** said it varies by program. **Ms. Tregoning** and **Mr. Mason** said they do not have that information.

Rep. Tonko asked if the witnesses were aware of patients rationing insulin. **All the witnesses** said yes. **Rep. Tonko** asked if the witnesses ever had to personally ration insulin. **All the witnesses** said no. **Rep. Tonko** asked if the witnesses had to choose between feeding their family and buying lifesaving medication. **All the witnesses** said no. **Rep. Tonko** asked if the witnesses struggled to afford medication. **Mr. Langa** said yes, the other witnesses said no. **Rep. Tonko** said that system is horrendously broken and the companies represented at the witness table are benefitting from this. He asked where all the profits are going. **Mr. Mason** said that net prices are going down. **Rep. Tonko** asked if net prices should go down further. **Mr. Mason** said the heart of the issue is whether the rebates are passed on to the consumer.

Rep. Clarke asked if net prices are subject to ebbs and flows. **Mr. Mason** said no. **Rep. Clarke** asked why it is still unaffordable if net prices are going down. **Ms. Tregoning** said that the insulins of today are different from the initial ones. Net prices have been going down steadily and that is expected to continue. The lower net prices are not finding their way to patients. The system became more complex and rebates are being used to finance other parts of the healthcare system. **Rep. Clarke** asked what would happen with the rebates removed. **Ms. Bricker** said then no one would be advocating for the patient. Rebates are just a volume discount. PBMs serve a critical function for ensuring affordability. **Rep. Clarke** said that profit and greed are keeping prices high.

Rep. Sarbanes asked if the rebate system is transparent. **Ms. Bricker** said 100 percent for the consumers and plan sponsors, but it is not transparent to the public because the confidentiality allows for price negotiation. **Ms. Tregoning** said that Sanofi would support transparency across the entire chain. **Rep. Sarbanes** said that the system has been built to allow gaming and that the witnesses have their repetitive talking points. He does not buy the argument that the consumer will be worse off with absolute transparency. The government may have to get involved.

Rep. Schakowsky said that there is a commitment to fighting price gouging on both sides of the aisles. She mentioned her transparency bill. She said that the manufacturers and lobbyists are in trouble. The charity care is a tax deductible and she resents that.

Rep. Peters said that he does not want to blame the witnesses for a system that is set up with perverse incentives. This is a market failure at best and it is now appropriate for government to take action by taking out the incentives to charge higher prices. There is a risk of anticompetitive behavior between the PBMs and plans.

Rep. Bucshon said that the system needs change. He asked if manufacturers have ever demanded advance notice of list price decrease. **Mr. Dutta** said yes. **Ms. Bricker** said no. **Mr. Moriarty** said no. **Rep. Bucshon** asked if manufacturers pay a higher fee or rebate if they don't increase their list percentage above a certain percentage in that contract year. **Mr. Dutta** said he is not aware of that. **Ms. Bricker** said no. **Mr. Moriarty** said no. **Rep. Bucshon** asked if the manufacturer pays a certain rebate even if they decrease the list price. **Mr. Dutta** said he is not aware of that. **Ms. Bricker** said no. **Mr. Moriarty** said no. **Rep. Bucshon** said that he is an advocate of reforming the 340B program. Novo Nordisk has provided information that insulin products are at penny pricing in the 340B program. Moreover, they showed that for one of the insulin products at this price, the number of packages sold under the 340B program has increased from just over 270,000 in 2014 to over 735,000 in in 2018. Other insulin products have also seen large increases in the number of packages sold to 340B entities. He asked what impact the 340B program has had on Novo Nordisk pricing in the commercial and private markets. **Mr. Langa** said that the products are 99.9 percent discounted. The challenge with the 340B program is what entities receive the designation, rather than the program's effect on commercial pricing. **Mr. Mason** said that the 340B program does reduce net sales, but those discounts help those that legitimately need the help. **Ms. Tregoning** said that 340B products are heavily discounted, but she's not sure those discounts are making their way to patients. **Rep. Bucshon** said that he firmly believes that the 340B program needs to be reformed so that it continues to exist for the hospitals and patients that need it, but with added transparency.

Rep. Barragan asked what Eli Lilly's revenue for this coming year is. **Mr. Mason** said $25.3 billion. **Rep. Barragan** said that the Lilly CEO in 2018 earned $27.2 million in a pay package. The American people see that. She asked the witnesses if they recognize that the pricing system is causing people to die every day. **All the witnesses** said yes. **Rep. Barragan** said that Congress has to step in and do something. The government is currently prohibited from negotiating with drug manufacturers for Part D enrollees. If this were lifted, the government could bring down drug pricing. She asked the witnesses if they support the government being able to negotiate prices under Part D. **Mr. Mason** said it's not needed. **Mr. Langa** said yes. **Ms. Tregoning** said no. **Mr. Moriarty** said no. **Ms. Bricker** said no. **Mr. Dutta** said no.

Rep. Carter said that Eli Lilly said that list prices increased more rapidly during greater consolidation of the drug supply chain. **Mr. Langa** said yes. **Mr. Mason** said yes. **Rep. Carter** said that Mr. Moriarty represents CVS drug stores, Aetna and Caremark. He said

Cigna acquired Express Scripts, which also contains a mail order pharmacy. He then said OptumRx is the PBM and United Healthcare is the insurance company, as well as a mail order pharmacy. **Rep. Carter** asked whether the money saved by PBMs gets sent back to the insurance company that they own in some cases. **Mr. Dutta** and **Ms. Bricker** said yes.

Chairman DeGette said that in 2001, Humalog cost $35 a vial. Today, it costs $275 per vial for the same product with the same formulary. The generic Humalog is only $137 a vial, which is way beyond where it was in 2001. Now Sanofi has a new generic Admelog, which still costs over $200 a vial. The generic equivalent is not any cheaper. There are people paying list price, and they are the ones with high deductible plans, the ones in the donut hole of Part D, and the uninsured. The pharmaceutical companies are not doing this for a public interest reason—they had $320 billion in profits last year, with PBMs having $23 billion in profits. Everyone is making a profit except for the people buying insulin.