

**THE PATIENT PERSPECTIVE:  
THE DEVASTATING IMPACTS OF  
SKYROCKETING DRUG PRICES  
ON AMERICAN FAMILIES**

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**HEARING**  
BEFORE THE  
**COMMITTEE ON  
OVERSIGHT AND REFORM**  
**HOUSE OF REPRESENTATIVES**  
ONE HUNDRED SIXTEENTH CONGRESS  
FIRST SESSION

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JULY 26, 2019  
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*The documents listed below are available at: <https://docs.house.gov>.*

- \* Rep. Connolly’s Statement for the Record.
- \* Unanimous Consent: National Hispanic Medical Association Letter, and Initiative for Medicines Access and Knowledge Letter; submitted by Chairman Cummings.



**THE PATIENT PERSPECTIVE:  
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**Friday, July 26, 2019**

HOUSE OF REPRESENTATIVES  
COMMITTEE ON OVERSIGHT AND REFORM  
WASHINGTON, D.C.

The committee met, pursuant to notice, at 9:29 a.m., in room 2154, Rayburn House Office Building, Hon. Elijah Cummings (chairman of the committee) presiding.

Present: Representatives Cummings, Maloney, Norton, Raskin, Rouda, Welch, Speier, Kelly, DeSaulnier, Khanna, Gomez, Ocasio-Cortez, Pressley, Tlaib, Jordan, Meadows, Hice, Grothman, Cloud, Roy, Miller, and Keller.

Chairman CUMMINGS. The committee will come to order. Without objection, the chair is authorized to declare a recess of the committee at any time. This full committee hearing is convening regarding the patient's perspective and the devastating impacts of skyrocketing drug prices on American families. I recognize myself for five minutes to give an opening statement.

Today, we are closing this work period the way we started our work this Congress, with a hearing on prescription drug prices. This is a bipartisan issue that I have focused on for many years. The first witness in our hearing this Congress was a woman named Antoinette Worsham, a mother whose daughter died at 22 years of age after rationing insulin because she could not afford it. And it was the subject of our hearing on the HIV prevention drug in May.

Today, five patients and their family members are here to share their stories. I urge all members to go back to your districts and to talk to your constituents about their experiences struggling to pay for life-saving drugs. I fear you will discover that we are facing a drug-pricing crisis in America. We've seen time and time again drug companies skyrocketing prices are forcing families to make gut-wrenching choices every day. Many families have to choose between caring for themselves and their loved ones or paying for basic necessities. These skyrocketing prices are forcing families to take on debt, sacrifice their homes, or sacrifice their healthcare altogether. Imagine having to pick between having a roof over your head or protecting your child's life, between eating that day or taking a pill that you need to simply stay alive. For Americans around the country, these situations are an everyday reality.

Think about it. Americans are dying every year while pharmaceutical companies enjoy more and more profits. Our witnesses today represent the one in four Americans who struggle to afford

the drugs that keep them healthy and, in many cases, keep them alive. Unfortunately, drug companies continue to raise prices, rake in record profits, and lavishly reward their executives and shareholders, all while stifling competition and preventing access to life-saving drugs. Drug companies make up only a quarter of the healthcare industry, but they collect more than half of its profits. Some drugs are developed with Federal funding, yet the industry ignores its responsibilities to the American taxpayer and reaps massive profits from our investments.

Drug companies use a variety of tactics to increase their profitability. They use loopholes in the patent system and the pay-for-delay agreements with competitors to extend monopolies so they can keep increasing their prices. Even when there is supposed to be competition, so-called competitors increase their prices in lock-step, stuffing their pockets while the American families are left paying the bill. To be sure, we all want drug companies to be successful. We want them to innovate. All of us depend on the pharmaceutical industry to develop cutting-edge therapies and breakthrough drugs, but what we cannot abide is profiteering at the expense of patients and the American taxpayers. That is why the committee has been investigating the pharmaceutical industry's price increases.

This investigation, which began in January, focused on the 17 highest costing drugs for the Medicare part D program. Our investigation has made significant progress, but we plan to do more. Let me be very clear, the committee will take all the steps necessary to ensure full compliance with our investigation, including with our requests to drug companies for documents showing why they're increasing their prices dramatically, and how they're using the proceeds, and what steps can be taken to reduce the prices.

Our investigation will allow the American public to lift the veil on the industry's pricing practices, and we will help inform the policy solutions to bring drug prices down. This is a problem that everyone, even in this polarized time, can come together to address. And I am hopeful this hearing will be another step in that direction.

Now I yield to the distinguished ranking member of our committee, Mr. Jordan.

Mr. JORDAN. Thank you, Mr. Chairman. The cost of prescription drugs is way too high. The chairman knows it, I know it, our constituents know it, and certainly—certainly—our panelists know it. I want to thank you all for being here today. Some on the other side of the aisle, though, feel that that these high drug prices represent a failure of markets, a failure of capitalism. They feel that markets don't work, and the result is companies exploiting patients to line their pockets. They have gone so far as to embrace socialism as the answer to this problem.

The reality is they have the situation completely backward. It's not a failure of the free market that has resulted in drug prices being too high. The failure stems from government's intervention in the pharmaceutical and healthcare markets. How did we get here? Laws and regulations that the government has put in place have led to the abuse of the patent system and the lengthy ap-

proval process at the FDA. These and other loopholes delay needed generic competition.

These challenges are tough. They require us to roll up our sleeves and do the tough work together—together—to figure out how to make the system work better. We made some progress, both administratively and legislatively. Under the Trump administration, the FDA has been approving generics at a record rate. In October 2018, the FDA approved 110 generic drugs and tentatively approved 18 more, including 23 first generics for brands that lacked competition and 17 complex generics, resulting in \$26 billion in savings for the consumer.

From May 2017 through September 2017, there was an average of almost 73 generic applications approved per month, up from about 57 approvals per month from January through April.

And in May of last year, President Trump signed into law the right-to-try bill, which allows terminally ill patients access to experimental treatments as soon as they are deemed safe by the FDA, rather than having to wait the years it takes for the drug to go through the entire bureaucratic process. The right-to-try law provides new treatment opportunities for patients who exhausted all other existing options.

We also are working on a number of bills, including a few that have already passed the Judiciary Committee unanimously. One of those bills is the CREATES Act, a bill that I cosponsor. The CREATES Act would ensure that generics get timely access to life-saving drugs so that they can be available to more people more quickly. I'm hopeful that the bill will be put on the House floor in short order. There is speculation that Speaker Pelosi and the House Democrats will be putting forward a drug-pricing bill when we return from the August recess. I hope that the approach the Democrats take is different than what we saw in the past and seek to deliver real solutions to our real concerns.

Democrats set back the American healthcare system drastically the last time they were in charge, when they rushed a partisan bill through Congress, with no Republican collaboration. It would be wrong to salvage the Obama Administration's disastrous healthcare legacy by putting controversial partisan bills in the drug-pricing package.

The United States is light years ahead of the rest of the world when it comes to ground-breaking medicine, and it's no wonder. Our pharmaceutical companies spend over \$169 billion annually on research and development. Certainly companies are entitled to make money on the drugs they invest in and develop. I hope we can all agree on that. But that process cannot be distorted by government interventions that result in inflated prices.

We must work to find ways to preserve America's cutting-edge innovation but ensure that the system works so that these innovations make it to as many patients as possible. I want to thank David Mitchell for joining the panel. It's good to see you again. His commitment to this issue is inspiring. Thank you for returning. I know you testified in front of the subcommittee I had the privilege of chairing last Congress. And I'm especially grateful for Laura McLinn joining the panel as well. Her son Jordan has Duchenne muscular dystrophy. Thanks to innovation by companies here in

the United States, Jordan is not just walking but running and living a complete life. He would be here himself today, I understand, but he's at summer camp, which is probably where kids need to be in the summertime. I also want to thank the other witnesses for being with us today. I look forward to a productive discussion this morning.

Mr. Chairman, I thank you for holding this hearing, and I yield back.

Chairman CUMMINGS. Thank you very much. Now we will turn to our witnesses who are here to share their stories. First, we have Mr. David Mitchell. He is a patient and the founder of Patients for Affordable Drugs, from my state, Bethesda, Maryland. Welcome.

Ms. Ashley Krege, a patient from Houston, Texas.

Ms. Laura McLinn, the mother of a patient from Indianapolis, Indiana.

Ms. Sa'Ra Skipper, a patient from Indianapolis, Indiana.

And Pam Holt, a patient from Granger, Indiana.

Before I swear you in, let me just explain to you that we don't have as many members here today because we were expecting to be in session today, and we're not, which means that a lot of Members had to leave to go home. But understand, we appreciate you being here, and I wanted to make sure—some people asked me whether I should postpone this hearing, and I said, out of respect to you all, I wanted to make sure that we held this hearing, and so I hope that you understand that.

If you would all please rise and raise your right hand, I will begin swearing you in. Raise your right hand, please. Do you swear or affirm that the testimony you are about to give is the truth, the whole truth, and nothing but the truth so help you God?

Let the record show that the witnesses answered in the affirmative. Thank you. You may be seated.

The microphones are extremely sensitive, so please speak directly into them. And, without objection, your written statement will be made a part of the record.

With that, Mr. Mitchell, you are now recognized for five minutes.

**STATEMENT OF DAVID MITCHELL, PATIENT, FOUNDER,  
PATIENTS FOR AFFORDABLE DRUGS, BETHESDA, MARYLAND**

Mr. MITCHELL. Thank you, Chairman Cummings, Ranking Member Jordan, thank you, and to my Congressman, Mr. Raskin, thank you for being here. I'm honored to be here. I'm David Mitchell, founder of Patients for Affordable Drugs. More importantly, I have an incurable blood cancer, and prescription drugs are keeping me alive. Every two weeks, I spend a half a day at a clinic getting an infusion of drugs that are currently priced annually at \$650,000. I've relapsed twice, and, unfortunately, I'm failing on this current drug regime. Eventually, I'm going to run out of options. So the importance of innovation is not theoretical for me, it's literally life and death.

But my experience as a patient taught me one irrefutable fact, and that is, drugs don't work if people don't afford them. When I learned I was sick, my doctors put me on a drug called Revlimid. Pam Holt will talk about her experience with Revlimid, but for Medicare patients in general, out-of-pocket costs for Revlimid can



run to \$15,000 a year. The principal reason it's so expensive is because its maker, Celgene, has gamed the system and refused to sell samples to generic companies who want to bring a competitor to market.

But Celgene isn't alone in making high prices for drugging. Take Johnson & Johnson, I take one of its drugs called Darzalex. The monthly price is \$36,000. It has increased almost 20 percent in just a little over three years. Or Pfizer: Meg Jackson Drache (ph) from Magna, Utah, has fibromyalgia and neuropathic pain. Meg was prescribed Lyrica, but when she found out it would cost her \$550 out-of-pocket each month, even with a discount card, she decided to take only a third of the dose her doctor recommends for her.

But to address the problem of out-of-control prices, we really have to come to grips with some larger facts. Despite what drug companies tell us, sky-high prices are not about innovation. Multiple studies show that there is no correlation between the cost of R&D and the price of the drug. And taxpayers foot a huge portion of bill for the basic science that leads to new drugs. Every single drug approved by the FDA from 2010 to 2016 was based on science funded by taxpayers through the NIH. In fact, the NIH is the single largest funder of biomedical research in the world.

Meanwhile, independent analyses show that nine out of 10 drug companies spend more on advertising and marketing than they do on R&D. Why do drug companies charge so much? Because they can. Yes, drug companies should profit when they develop innovative drugs, but we are way out of balance right now, and it's costing us all in our family finances, our health outcomes, and our lives. So I want to suggest three things that we could do today to rebalance the actual risk of innovation with a fair price for patients: one, reform patent law; two, end the days of monopoly pricing power without taxpayer negotiations and force transparency from drug middlemen.

Let's start with patent law. Brand drug companies are abusing our system to extend their government-granted monopolies and block competition. They use a whole array of tactics. Mr. Jordan mentioned REMS abuses, anticompetitive pay-for-delay deals, patent thickets, evergreening, sham citizen petitions. We need to correct those, and there are bills moving through Congress to do that.

Next, we need direct Medicare price negotiations, and we need to restructure Medicare part D. Our current system isn't working. We pay two to three times what other countries pay for the exact same drugs. One big reason is that other countries negotiate. We should, too. International reference pricing, as proposed by the administration, or inflation caps that were just passed out of the Senate Finance Committee on a bipartisan vote are other ways to approach this to restrain list prices.

We also need to restructure Part D along the lines of the legislation that cleared Senate Finance yesterday.

And, finally, we need more transparency around PBMs. These huge companies cut deals that determine how much patients pay, but it's all secret. Competition, free markets, can't work without transparency.

Right now, there's a fundamental question drug companies want us to ask about drug prices. What are we willing to pay to save a

life? And while that's easy when it's your child's ability to live, to breathe, when it's your wife's diabetes, when it's your own cancer, the answer is anything. But that's the wrong question. The question we should be asking is, what is the right amount of money that drug companies should make on these drugs? With literally hundreds of clinical trials under way for new gene therapies that are currently priced at a half a million dollars or more, we can't pay just any price the drug companies demand. Neither American families nor our healthcare system can afford that.

I feel incredibly grateful to be here today representing patients all across the country. I believe the moment is at hand, and we can address this problem, and with bipartisan support, we will. Thank you again for having me.

Chairman CUMMINGS. Thank you very much.

Ms. Krege?

**STATEMENT OF ASHLEY KREGE, PATIENT, HOUSTON, TEXAS**

Ms. KREGE. Chair Cummings, Ranking Member Jordan, members of the committee, thank you for having me here today to share my story. My name is Ashley Krege. I'm 35 years old, and I live in Houston, Texas. I'm one of the thousands of Americans who took the world's top selling drug known as Humira. I took Humira to treat a chronic autoimmune condition called psoriasis, which causes pain and inflammation. After finally getting approved for the drug, I had to pay \$753 a month. To say this was a financial hardship would be an understatement. The drug cost more than my car payment, more than my business insurance, more than my food bill each month, but I made the decision to suck it up and pay because the drug worked. After months of successful pain and symptom management on Humira, I was informed the drugmaker AbbVie had raised the price, and my new monthly payment was going to be almost \$1,100 a month. I simply could not afford it any longer. I had to make the difficult decision to wean myself off of the drug that had provided me months of relief. It was already expensive for me at \$750 a month, and I couldn't afford the 40 percent price increase.

Let me tell you a little bit about Humira. The drug is far from new. It's been on the market since 2002, and the price has gone up nearly 400 percent, at \$5,174 a month. AbbVie is making billions on the backs of patients, \$20 billion alone in global sales last year. That is more revenue than every NFL team combined.

And AbbVie has done everything in its power to block competition and keep cheaper generics off the U.S. market. They have struck deals with more than a dozen companies that try to develop biosimilars. They filed 247 patent applications in order to delay competition in the U.S. But while AbbVie was hiking prices and blocking competition in the U.S., a biosimilar came to the market in Europe. As a result, AbbVie began selling Humira for 80 percent less—overseas.

Unfortunately, that's not the end of my story. I had a similar experience on Enbrel, which is another drug examined by your investigation. Price hikes again led to unaffordability, and I stopped taking that drug. As a result, my symptoms came back. To give you an idea of what a full-body psoriatic flare-up feels like, I'd like to

imagine getting a terrible sunburn, the kind that makes your entire body feverish, then add falling into a bed of fire ants. That is what it feels like during a flare without medication, and that is why I'm here today. Because there are two bills in the House of Representatives that would help patients like myself. H.R. 1499 and H.R. 2296 have both passed the Energy and Commerce Committee. The first bill would stop branding companies like AbbVie from paying off generic companies that plan to bring a competitor to market. In exchange for this payment, the generic manufacturer often delays its product's entry into the market, and patients like me are stuck facing bills of \$1,100 per month for Humira.

The second bill called the Fair Drug Pricing Act would increase transparency and require justification for price hikes like the one AbbVie enjoys taking on the backs of patients like me. These bills are just a start. They would not solve all of the problems in our drug-pricing system or end all of the ways that drug companies abuse their monopolies. Americans like me are desperate for relief for high-cost prescription drugs, and you have the opportunity to advance legislation that curbs two of Pharma's most egregious practices. I hope today's hearing isn't the last stop, and thank you for your time.

Chairman CUMMINGS. Thank you very much.

Ms. McLinn?

**STATEMENT OF LAURA MCLINN, MOTHER OF PATIENT,  
INDIANAPOLIS, INDIANA**

Ms. MCLINN. Chairman Cummings, Ranking Member Jordan, members of the committee, it's an honor to be here today. Thank you very much. My name is Laura McLinn, but most people just know me as Jordan McLinn's mom. I come here today simply as that—Jordan's mom. The words I speak are my own, and they come straight from my heart. Jordan is my amazing, funny, kind, compassionate, faith-filled little boy, but he's also in a race with the clock for his life. Because just before his 4th birthday, a doctor told us he has a rare and fatal muscle-wasting disease called Duchenne muscular dystrophy.

According to the natural history of this disease, Jordan has already lived about half of his life, at just 10 years old. DMD affects about one in every 5,000 boys, and over a short time, it robs them of their ability to do the things that most boys love to do—walk, run, play, climb, participate in sports, ride bikes, use the bathroom independently, feed themselves, dress themselves. Eventually, even the strength to hug their moms is ripped away. Jordan gives the best hugs ever. So for him not to be able to do that to me is not okay. The heart and lungs are eventually affected which leads to a very young and devastating life expectancy.

Because of innovation and laws that Congress has passed over the years, I'm here today to tell you that my Jordan now has hope. He is the epitome of hope. He's defying the natural history of this disease, and he is a direct participant in helping to create hope for others.

About two and a half years ago, Jordan became one of 16 lucky boys in North America to be accepted into a clinical trial for a therapy designed to slow the progression of his Duchenne. He's made

weekly trips out of state during this time to receive infusions without a single complaint, ever. During this time, we've noticed that Jordan is doing things that we were told a 10-year-old child with Duchenne wouldn't typically be able to do. He's still walking, quite well. He's playing outside for hours. He's climbing stairs in a normal way, while most kids at this age can't climb the stairs at all or can't do it very easily. He's dancing, running, jumping into pools, catching balls. Keep in mind, Duchenne progressively robs boys of these very things.

Just last week, a research team showed me MRI images of some of Jordan's muscles, and they told me that they did not look like the images of a person with Duchenne muscular dystrophy.

When Jordan was first diagnosed, there was no clinical trial that he could participate in. Now there are multiple treatments in the pipeline. It is absolutely incredible how fast the science is moving. But Jordan and other patients like him cannot afford to see this innovation slow or stop. I desperately need these scientists, doctors, and drug companies to continue to develop drugs for my son and the millions of others with devastating diseases. And for that reason, I'm here today to remind you that we must continue to encourage and reward innovation.

Because of bipartisan work that many of you have been a part of over the years, fast-track designation, accelerated approval pathway, innovative trial designs, I expect that Jordan's drug is going to be approved soon. When that happens, it's probably going to be expensive, as are most drugs for rare diseases. These aren't old drugs that have been around for years, though. Let's please be careful in these conversations about drug pricing, not to mesh those two. Innovation is expensive, and it's also the only thing that's going to help ensure that boys like my Jordan can be a part of the first generation to change the natural history of this devastating disease.

If we lose innovation, we lose the most valuable thing that we can't put a price tag on—human lives. We cannot afford to let that happen. So, as we work to tackle these issues of access and affordability of existing treatments, treatments currently in clinical trials, and treatments and cures yet to be discovered for boys like my friend Maurice's son Joseph, who is 16 and waiting because he doesn't have anything yet. I implore you to do so carefully and remember that one size does not fit all. We can't afford to discourage those discoveries and the development of new therapies. If we had done that 10 or 20 years ago, Jordan wouldn't be doing what he's doing today; he wouldn't be benefiting from these treatments.

Back home in Indiana today, parents are gathering to pick up their kids from MDA camp, and they're hearing all about their kids' adventures. I won't be there for Jordan. Instead, with his blessing, I came here to share this with you—the critical importance of driving forward the promise of new and better treatments for all of those who wait. I can't wait to get home to hug him tonight, and hopefully I'll never have to stop receiving those hugs.

Because Jordan can't be here today, to speak for himself, I did want to leave you with a favorite quote of his. It's his life verse. It's from Jeremiah 29:11, from his favorite book. It says: For I

know the plans I have for you, declares the Lord. Plans to prosper you and not to harm you. Plans to give you hope and a future.

Thank you today, all of you, from the bottom of my heart, for wanting to make hope tangible, for caring about the future of millions of patients depending on you to keep innovation alive, and for also caring about helping patients access these treatments, which is very important. Keeping in mind, though, please, that one size does not fit all. I hope you ask questions, and I also welcome each of you to reach out to me personally after the hearing to just continue this important dialog. Let's work together and just keep doing the next right thing. Thank you very much.

Chairman CUMMINGS. Thank you very much.

Ms. Skipper?

**STATEMENT OF SA'RA SKIPPER, PATIENT, INDIANAPOLIS,  
INDIANA**

Ms. SKIPPER. Good morning, Chairman Cummings, Ranking Member Jordan, and members of the House Committee on Oversight and Government Reform. My name is Sa'Ra Skipper, a member of Affordable Insulin NOW and T1International. Thank you so much for inviting me to come speak with you today and for taking the time to listen to just some of the ways pharmaceutical companies are putting corporate profits above the lives of people like me.

As a resident of Indianapolis, Indiana, I live in the shadow of Eli Lilly's national headquarters, and my life has been at the whim of the company since I was diagnosed with Type 1 diabetes when I was five years old. Since then, Eli Lilly's refusal to control the cost of the drug I depend on has wreaked heartbreak and havoc on my life, my sister's, and those who care about us. I don't remember my life without this burdensome disease. Being diagnosed at such a young age, I had to grow up fast. I had to appreciate life very early on because if my dose was miscalculated by one unit, it will cost me my life.

I can remember being in the hospital multiple times a week, nurses secretly spying on my mom to make sure she wasn't eating my food because my blood sugar would drop so fast. But, in actuality, my body was rejecting the insulin. I can remember showing teachers scars on my fingertips from checking my blood sugar levels because they didn't believe I was diabetic when I complained about not feeling well. Having such a huge responsibility at such a tender age makes me feel robbed of my childhood.

Being the middle child, I tried to stay in my lane as a little sister, even though my brother may not think so, and I take my duty as a big sister very seriously. When my baby sister Shelby was diagnosed with Type 1 diabetes at the age of seven, the bar of setting a good example was set a thousand times higher. I remember seeing my sister and mother weeping. I recall taking Shelby in the bathroom of the doctor's office and trying to comfort her and tell her it would be okay. Shelby and I have a fear of going through the same challenges as our Aunt Joy, our mother's sister that passed away at 47 due to complications of Type 1 diabetes.

My sister and I have been fighting for our lives since we were children, and it has not been easy. It hurts to know that some Type 1 diabetics travel to Mexico or Canada for insulin or even buy insu-

lin off of the black market. The fact that four people under the age of 30 died last month due to rationing and not being able to afford their insulin is gut-wrenching. According to a survey done by T1International, one in four people ration their insulin. This is unacceptable. This is why the movement to make insulin affordable for all is so important.

During my freshman and sophomore year of college, I had to ration my insulin. For reasons to this day I still don't understand why I was denied Medicaid, and I aged out of my pediatric endocrinologist. The last prescription I received from my doctor came with a note saying: I'm sorry, but this is the last prescription I can fill for you.

My professors knew my predicament and yet some could care less and didn't care to help me in class, since I spent the majority of it in the bathroom or asleep. I survived by eating less food so that I could take less insulin to make my vials stretch. This is the fear that I had to live throughout my education. This is the reality that so many people with diabetes face every single day.

Let's shift gears. It's May 2018. I'm working full time for a big corporation with benefits, but even with insurance, my insulin supply, my 30-day insulin supply was a thousand dollars. That's just insulin. That price does not include test strips, needles, and other vital supplies.

I couldn't afford to purchase my full supply of insulin, so my sister risked her life by sharing hers. One night I took my nighttime dose of insulin, and I left the vial on the dresser for my sister to see. I assumed that she would think that I had already taken my dose, since I left the vial on the dresser, but she didn't. She thought that I still needed to take my insulin for the evening, so she took less of her normal dose to ensure that there was enough left for me to take. She put herself at risk. The next day she went into diabetic ketoacidosis, had to be hospitalized for four days, the veins in her body blew, and she had to have a PIC line in her neck and almost went into a diabetic coma.

I couldn't afford my insulin because Eli Lilly, and others, refused to control the cost of insulin. It almost cost my sister her life. Price-gouging is killing people. These pharmaceutical companies are committing murder and getting away with it. You all as leaders have some say so in making a change, and while young people continue to die from rationing, you are just as responsible as the people profiting off of their lives.

Change for this issue will not be a sprint. The marathon continues. And while young—and as a patient advocate like me, I will not stop speaking out until you find a way to put an end to the insulin price crisis in America. No matter how long it takes, we will be building our numbers and demanding change, because our lives depend on it. Thank you.

Chairman CUMMINGS. Thank you very much.

Ms. Holt?

**STATEMENT OF PAM HOLT, PATIENT, SOUTH BEND, INDIANA**

Ms. HOLT. Chair Cummings, Ranking Member Jordan, members of the committee, thank you for inviting me to share my story. My name is Pamela Holt. I'm from Granger, Indiana, just outside of

South Bend. At the age of 40, I was suddenly widowed when my husband died from a sudden heart attack. I raised three children on my own. I was fortunate at that time to be a teacher and then an administrator, with what I felt were good benefits that set me up for a good retirement.

That all changed, however, when I was diagnosed with multiple myeloma three years ago—the same illness as David. Multiple myeloma is an incurable but treatable blood cancer. Upon my diagnosis, I underwent a bone marrow transplant and chemotherapy. I'm literally blessed to be in remission today. I'm living on borrowed time, but I'm thankful for every day.

However, to keep my cancer at bay, I must take the drug Revlimid. Initially, this plan felt really good. I would get to live longer, help to raise my grandchildren, spend summers at our favorite lake in Wisconsin, and for that, I'm really grateful. But when I learned the cost of Revlimid, I was horrified. The price of Revlimid is over \$250,000 per year. Last January, on Medicare part D, because I am 70, I went in and out of the doughnut hole, paying \$4,950 that first month, and then more than \$8,000 out-of-pocket over the rest of the year. This is on Medicare with a good supplement.

That cost was totally unaffordable for me. After just one year, it sent me into serious debt. I was entirely under water, and I had to make the heartbreaking decision to refinance my house. It was three years from being paid off, and now I'm starting completely over. In the last year, I've been fortunate to receive a grant for the cost of my Revlimid out-of-pocket, but this assistance is year to year, and it can always fall through. It's income-dependent. I don't feel I should have to depend on these yearly grants to be able to live and afford a medication that I need to survive. There are years that I do qualify and years that I don't qualify.

I feel I've spent my life doing some of the right things—contributing to my community, teaching public school, raising my children. I don't feel it's right that despite all this hard work and careful planning, I find I face financial challenges because of cancer I have no control over. I'm really thrilled and grateful for the additional time Revlimid has given me. But having cancer is really hard. I shouldn't have to lose my savings and stress over finances just to stay alive.

I'm encouraged by the action Congress is starting to take in the hearings of the last couple months, and I'm particularly grateful for this committee for listening. What patients need most is a real change to the system and congressional action that will bring down drug prices.

For me, one solution would be the CREATES Act, which Mr. Jordan talked about. CREATES addresses a tactic the company that makes Revlimid, Celgene, uses to deny generic companies access to samples of Revlimid. This prevents generic competitors from coming to market and allows Celgene to set the price of Revlimid high. I came to D.C. last year to encourage Congress to pass this important piece of legislation. I'm grateful that the bill has passed the House Energy and Commerce and Judiciary Committees, and I really hope it gets over the finish line as soon as possible. Thank you.

Chairman CUMMINGS. Thank you very much.

I now yield myself a few minutes to ask a few questions. First of all, I want to thank our witnesses for being here. Clearly, you have shared very, very, very personal stories of pain. I often say that so often out of our pain comes our passion to do our purpose. Pain, passion, purpose. So we thank you.

You are here to remind us that the actions of drug companies in raising prices have real consequences for real people. Ms. Skipper, let me start with you. What is the most difficult choice you or your family members have had to make because of the price of a prescription drug? And then just so you'll be prepared, Ms. Holt and Ms. Krege, I'm going to ask you the same question. Go ahead.

Ms. SKIPPER. Thank you. I feel that the most difficult thing was just keeping up with rent. We had to move around a lot, and my parents—it was either we paid the rent, or we—or me and my sister lived. As an adult now, I feel that I've made the sacrifice of really just enjoying my life. I'm 23 years old, and I'm tired. I don't want to be tired anymore. And I don't want anybody else to feel like how I feel. And I feel like it's unfair that not just only the four people under the age of 30 who died last month, but any and everyone who has been affected by rationing, that they didn't get to have that decent quality of life.

Chairman CUMMINGS. Ms. McLinn, I want to go to you, that same question. Ms. McLinn, what has been the most difficult decision you had to make? Ms. McLinn, you also said something that was so powerful when you talked about your son, like, a race against time. And one of the things that I've noticed is that NIH is a phenomenal place and coming up with things that used to be fatal; they're coming up with solutions to make them chronic. Hopefully the things that are going on that you talked about will be helpful to your son. But go ahead. What's the most difficult decision that you had to make with regard to your situation, ma'am?

Ms. McLINN. Well, one difficult situation that I've had to face, a decision with Jordan, is actually a decision that was difficult but also a decision that when he was diagnosed, I didn't even think I would be able to be in the position to have to make a decision. Jordan actually qualified for two clinical trials for similar drugs that are designed to do the same thing. And I actually had to make a decision at the last minute to choose one drug company over another because of the clinical trial design.

In one of the clinical trial designs, our boys were asked, a third of them, to be on a placebo, for 96 weeks. That's really hard when you know what happens so quickly and at this age, because like I said, at Jordan's age, we never thought he'd be doing the things he's doing. So, if he were in a clinical trial right now, receiving a placebo for 96 weeks, we know what happens. So we know what happens when these kids don't get treatment. So, for me, that was—I mean, it's kind of a bittersweet thing to say. I mean, I never thought I'd be able to actually have clinical trials to choose for my son. So I'm extremely grateful for the innovation, but I also think—I know this isn't the purpose of this committee, but I do think that it's worth saying, since you asked me the question, that we also need to continue to rethink the clinical trial design for rare and fatal diseases as well.



Chairman CUMMINGS. Ms. Kregge?

Ms. KREGGE. For me, probably one of the most difficult decisions is having to make the choice to go on affordable but pretty hard immunosuppressants. The current one I'm on that is affordable—I just got married. My husband and I have had to make the decision to—I can't have kids if I'm on it. It's absolutely not allowed because it's a hard—it's an old chemo drug. That sucks, to be quite frank. I wish there were generic options for me. I don't mind paying for a drug, but it needs to be accessible and affordable.

I'm self-employed. I do well. There's no way anyone can afford \$1,100 a month. And they just keep introducing new biologics, which are even more expensive than the current ones on the market because there are no generics available. That's huge for somebody like me.

Chairman CUMMINGS. Thank you.

And Ms. Holt?

Ms. HOLT. I think the most difficult, or one of the most difficult things was the induction therapy I needed, the chemotherapy I needed, I went to the drug counter, and my bill was over \$4,000. I couldn't pay it. I was just shocked. So that was delayed three months until I came up with the cash in order to pay that to start my treatment. That was difficult.

It was also really difficult to refinance my home. I'm thankful I had a home to refinance. Other people aren't that lucky. But to be that close to being debt-free, and having to start over, was very, very difficult for me.

Chairman CUMMINGS. Again, I have many, many more questions to ask, but I'm going to—my minutes are up. So we'll now yield to Mrs. Miller. Mrs. Miller?

Mr. JORDAN. Mr. Hice.

Chairman CUMMINGS. Oh, I'm sorry. Mr. Hice.

Mr. HICE. Thank you, Mr. Chairman, and I want to thank each of you for being here, sharing your stories. They're heart-wrenching and they're very real and very personal for you and for your loved ones. I'm grateful for you coming and sharing with us today. There's a difficult balance that somehow we have to strike in all of this, and you're bringing some suggestions to the table that I think need to be looked at.

So all of this needs to be looked upon from a big perspective. You all are in a situation where the cost of medication for you and your loved ones is just astronomical. Others—and there's about five percent—fewer than five percent of Americans actually are having to pay the list price on drugs. And I don't know if any of you are having to pay the list price or you're getting help on that or not, but fewer than five percent actually pay the list price. I know a couple of you, Ms. Holt and Mr. Mitchell, you all spoke specifically of Revlimid, and, you know, I went back and looked at Celgene. I mean, that took over 14 years for them to develop that drug, \$800 million to produce that drug, and from what I've been able to see, there's about 140,000 patients taking Celgene's hematology and oncology medicines, and they have been assisted through Celgene's patient support programs which has contributed over \$1.4 billion back to patients who are involved in taking similar drugs. And

they reinvest some 37 percent of the revenues back into research and development.

So I think there's—somehow we've got to strike a balance here. There's no question as to the enormous cost to people like you, who are here today, and all of us in this room are grateful for the tremendous job that drug companies are doing to come up with drugs that help, where you're able to be with your grandchildren. But being able to get those drugs back to us in an affordable way is another issue that has to be addressed. Again, I'm grateful for you coming here, but pharmaceutical companies spend over \$169 billion annually on research and development, and we are blessed to be in this country where those companies are putting that kind of money into research and development to help with situations like this.

One thing, Ms. McLinn, that I was intrigued about with your situation, in reading about your story, is the right-to-try interest that you have worked with then Governor Pence. Can you tell us a little bit about your experience with that, fighting for the right to try?

Ms. McLINN. Sure. When Jordan was five, we actually didn't have a clinical trial available to us. So I heard about a drug that was coming up through the pipeline, but based on the inclusion criteria, I didn't believe at that time that Jordan would be able to make it into the clinical trial. So I'm passionate about patients receiving access to treatments. I don't care what the pathway is. I'm just passionate about patients being able to access those treatments. So at the time Jordan didn't—we didn't think he would qualify for a trial.

We started fighting for the right-to-try law, which says if a drug has made it through phase one and a patient wants to try it and you have a drug company and a doctor willing to make that happen, you should have a right to do that. So we did start in our home state of Indiana, when Mike Pence was our Governor at the time, it passed with unanimous bipartisan support across the Nation, really. Then we did start to work on Federal legislation, which was passed into law last May. The law does bear Jordan's name. Jordan's not receiving a treatment through the right-to-try pathway, though. He's receiving a treatment through a clinical trial, which is what we wanted to start with. But I am happy to tell you today about our friend Matt Bellina, who is a former Navy pilot, battling ALS, and he didn't make it into a clinical trial.

But a few months ago, Jordan got to be there with Matt when Matt received his first treatment of an experimental treatment for ALS through the right-to-try pathway. So it's been really awesome to be on that journey and for Jordan to be a part of kind of seeing that come full circle and seeing someone that has been able to benefit. And, last week, Matt became the first person ever to receive a fourth treatment, and he's doing very well. So that's a little about our journey.

Mr. HICE. Thank you. Thank you, Mr. Chairman.

Chairman CUMMINGS. Before we go to Ms. Norton, Mr. Mitchell, would you comment on—I want to hear, I want this hearing to be effective and efficient. Would you comment on this—what Mr. Hice just said? Because he makes a very good point, when he talks

about research and development and the fact that there are programs to discount drugs.

Mr. MITCHELL. Well, a couple of things, Mr. Chairman. Thank you. First of all, approximately two-thirds of Americans pay some or all of the cost of their drugs based on list price. People in high deductible plans pay list price for their deductible period. People on Medicare pay their out-of-pockets and part D based on list price. People who don't have healthcare coverage pay based on list price. And Secretary Azar points out that's roughly two-thirds of all Americans paying in whole or in part based on list price. So that's the first thing I want to straighten out. That's a lot of money for a lot of people when prices are high.

Second, I know that with respect, sir, that you just quoted Celgene lore about the development of Revlimid, but Revlimid is a drug that was invented—actually, thalidomide—Revlimid is a derivative of it—was invented in the 1950's and Celgene stumbled into it accidentally, based on clinical trials that were done in academia. That drug came to market in 2005, Revlimid did. There's still no generic for Revlimid, and the reason is that the company has been able to extend its monopoly by abusing the laws that are put in place.

You know, I fully agree that when a drug company brings an innovative new drug to market, we want them to profit. Our whole system is based on that. Five years for small molecule, seven for orphan, 12 for a biologic, and make a lot of money. But at the end of that period, Congress has said we're supposed to let markets drive down price through competition, and Celgene has prevented that from happening. The result is, it was introduced in 2005 at \$6,000. It costs \$18,000 today. One capsule of Revlimid cost \$720. This is an old drug. There is no excuse for this. And Celgene is not plowing all the money that they claim to plow back into R&D. They're milking an old drug, which is how they're keeping their stock price up. If we didn't let them do that, they would be forced to innovate to make money, which is what we want them to do.

Chairman CUMMINGS. Thank you very much. I just wanted you to clarify that. Thank you very much.

Ms. Norton?

Ms. NORTON. Thank you very much, first, for this hearing, Mr. Chairman, but very much for the testimony we've heard today, and I appreciate Mr. Mitchell's elaboration. No one on this side wants anything less than a fair return for the extraordinary work that the drug companies do. We've had abundant evidence here of a great deal more than what anybody would regard as fair return. Of course, people go to Canada, and that's the most—there's every reason to believe that drug companies there want a fair return, too.

I think you have made the best case—better case than we could have made—by describing your own experience. I'd like to ask Ms. Skipper a question because I was intrigued by the fact that both she and her sister had had diabetes. Is this Type 1 diabetes?

Ms. SKIPPER. Yes.

Ms. NORTON. This is very serious diabetes. You have this diabetes manifest itself when you were children?

Ms. SKIPPER. Yes.

Ms. NORTON. Now, insulin is one of those drugs we'd want to look at to see whether there has been an increase over time. I don't know of improvements that have been made in insulin. Do you know of improvements that have been made in insulin? When you get insulin, are you told you're getting better insulin than, let's say, you would have gotten 10 years ago?

Ms. SKIPPER. No, ma'am. It's been the same insulin.

Ms. NORTON. So the drug itself has not changed?

Ms. SKIPPER. No.

Ms. NORTON. What about the prices?

Ms. SKIPPER. The prices have gone up, I believe, like, over 300 percent in the last 10 years.

Ms. NORTON. How has that affected, this increase in prices—you indicated you had been in college during part of this time. I believe I remember you said that if the drug was miscalculated by one unit—

Ms. SKIPPER. Yes.

Ms. NORTON [continuing]. you could risk your life?

Ms. SKIPPER. Yes.

Ms. NORTON. Did you ever ration the drug?

Ms. SKIPPER. Yes. Yes. When I said that I had to eat less food, that—okay, so with insulin, there's like a little calculation, how many carbs you're going to eat. Then you have to figure, like, with your blood sugar and a correction factor, what's correct for your blood sugar. So I didn't have enough insulin, so I ate less food so that I could—I mean, I didn't have a choice but to take less insulin, because I wasn't getting a consistent supply. So I had to eat less food because I didn't have enough insulin to really, you know, take care of myself.

Ms. NORTON. So you were trying to make your insulin, what insulin you had, last longer?

Ms. SKIPPER. Yes, ma'am. Yes. Now, how could you calculate? Did you have some scientific way, some measurement to calculate whether or not you were at risk when you decided to take less insulin or how much insulin to take less than was the calculated dose?

Ms. SKIPPER. Well, so I don't have any pancreatic function, so if I do the math, like—do you mind if I give you an example?

Ms. NORTON. Yes.

Ms. SKIPPER. So, if my sugar is 250, and my target is 150, I would have to subtract the 250 and the 150 and divide that by what is called a correction factor. So, for every I say, like, 35 points over my target, I would have to take one unit, and then I would add that to—I'm on a scale of, for every seven grams of carbohydrates, I would take one unit. So that is how you calculate it. But if I don't have an actual monthly supply of that, I have to figure out how to make that stretch. So, by eating less food, I mean, I wasn't able to really affect—correct for my blood sugar.

Ms. NORTON. Leaving this calculation to you sounds itself very risky, and I understand that your sister was hospitalized—

Ms. SKIPPER. Yes.

Ms. NORTON [continuing]. and nearly died last year as a result of rationing insulin. How did that happen? Did she incorrectly calculate?

Ms. SKIPPER. She took less. We were literally sharing the same vial of insulin. So we were both using the same vial of insulin. So she took less than what she was supposed to take to ensure that there was enough insulin left in the vial so that I could take my dose. But it was like a—she didn't realize that I had already taken my dose. So she took less so that I could be able to take my dose.

Ms. NORTON. All I can say, Mr. Chairman, is case made.

Chairman CUMMINGS. Thank you very much.

Mrs. Miller?

Mrs. MILLER. Thank you, Chairman Cummings, and Ranking Member Jordan, and thank all of you all for being here today.

Ms. McLinn, thank you for sharing your family's story and your experience. As a mother and a grandmother, it's really heart-wrenching to hear. I'm so glad that the innovation and research is helping Jordan and giving him and so many other people hope. In your testimony, you discussed the importance of not finding a one-size-fits-all solution when it comes to treating patients. Can you talk about what this means for your family?

Ms. MCLINN. Well, just for an example, Jordan has a rare disease that affects 1 in 5,000 boys. The drug that Jordan is trying right now is really only designed to help eight percent of patients. So Jordan has a rare disease, and then he's a rare subset of that. So we have lots of drugs right now coming up in the Duchenne pipeline, and not just for Duchenne, but for lots of rare diseases. So, even though Jordan's doing well and he has a treatment now, it's not a cure and—it's designed to slow the progression of his disease. I mean, he's 10. He's still young, but he's doing well, but we need more treatments to continue to be developed. We need treatments for Maurice's son Joseph, who I told you was 16 years old. We need treatments for all of our boys, and we need treatments that have yet to be discovered. So innovation is so important to us, and it's not a one-size-fits-all.

Like I said in my testimony, these are heart-wrenching stories that these other witnesses are sharing. I want to be careful that we're not meshing the two together, because something has to be done about this, right? But we also have to protect innovation and make sure that companies are—that they're still going to work in this space. I need them in this space and so do so many other people.

Mrs. MILLER. I think you hit the nail on the head with your comments there, and we all do want to do something and I—it seems to me that you're buying time, and by the time your son is 16, you're hoping that it's been, you know, changed even more. Again, it's so heart wrenching.

What suggestions would you have for Congress on how we can better encourage the innovation and reward it?

Ms. MCLINN. I honestly don't have a big, like, a-ha answer to that. I really just came here today to remind you as you're having these discussions, just remember to not make decisions, if you're changing policies, please do not make decisions that will impact the innovation and squelch that, because I think it is okay that companies are making a profit. How much? I don't know.

I look at how much money—just in Jordan alone, we travel out of state. He's two and a half years in, and for first two years, we

went out of state every single week, and we're just one, and he's one of 16 in this trial. This is a small trial. Some clinical trials are much bigger than this. I just look at how much money—and I can't—I mean, I don't know how much, but I know traveling's not expensive.

I think of the doctors, the nurses, the surgeries. He's had two muscle biopsies where they've had to take a sample of his muscle before he started the trial and another up with 24 weeks later to see if he was producing more dystrophin, and I'm happy to tell you that all 16 boys are producing more dystrophin, which is incredible. When you think about the surgeon who did that, the nurses in the room, the scientists, the storage of those muscle biopsies, there's so much that goes in. There's a lot of expense that goes into clinical trials, and I just want to make sure we're not forgetting about this as we have these conversations.

Mrs. MILLER. I think your grasp is great, and we can all learn from this.

One of the hardest parts of my job is trying to see the unintended consequences of whatever we legislate or whatever we make as a law or a rule because, five years down, one year down, we may be dealing with something we didn't intend to happen. So we're always trying to be so careful with what we do. Thank you very much for all of you for being here today.

I yield back my time.

Chairman CUMMINGS. Thank you.

Mr. Welch.

Mr. WELCH. Thank you.

I want to thank you. You know, every once in a while, we get an opportunity do something useful in Congress, not often, but today's one of those days. I just want to give you my reaction because it's not for you to tell us what we should do to bring these prices down. You're the face of the harm caused by our failure not to bring the prices down, and each one of you has a separate story.

I know you lost your husband at 40, raised those kids alone.

You know, you and your sister are sharing your insulin.

And what I love about listening to you is you're living your life. You know, you've got a real challenge. This is outrageous. You shouldn't have to be contending with unaffordable medications. That could happen to anybody who's sitting up here. It's just the luck of the draw. And when one is faced with that, there's not a fairness thing. You don't know why it happened. There's nothing you did to make it happen, but then you own it, and you have to make a decision and each one of you made the decision. You're going to live your life. You're going to fall in love and get married and live with the—yes, I mean, that's really life affirming.

And what I find so inspiring about it is you're not angry. I mean, you're frustrated. You're worried, but I didn't hear anger. You're entitled to some anger at us because it's our job to make certain that these companies don't rip off the patent system, don't rip off the taxpayer, don't game the system. It's for us to figure out how they're doing that.

And, you know, you've testified, Mr. Mitchell, many times. You're really, I think, as knowledgeable as anybody about all the ways in which the companies put the profits ahead of people.

I think it's really, really helpful for you to be here, for us to hear you because we're starting to come together. We passed some—you know, Mr. Cummings, of course, has been a leader on trying to get the prices down for years, and it's starting to make a difference. You know, the Senate finally passed legislation yesterday that's going to put a significant dent in the rip-off. It could bring down the cost by about a hundred billion dollars.

And, you know, what I get so frustrated about is the self-righteous justification from a lot of the companies that are making a lot of money that, if we do anything to make the prices affordable, anything close to what is paid for all these medications in all the other countries except ours that it will end, quote, innovation. It may end hundred-million-dollar paydays, which I hope it does.

But, you know, the bottom line is, we are all in this together, and we have to have—politics is about trying to find ways where the things that are common problems, we can come up with solutions that work for all of us. That's the job, and there's got to be a commitment that I know the chairman has and many of us, if you get medication, you've got to be able to afford it.

And I just want to say on my behalf—and I bet I speak for everybody—thank you so much for deciding to just keep living your life each day, despite the challenge you face. My hope is that we will do our job to deserve your respect that you have earned yourselves. So I just want to say thank you.

Mr. Mitchell, I got a little time left.

Mr. MITCHELL. I'm going to use your time if you'll allow me, Mr. Welch.

Mr. WELCH. I will, yes.

Mr. MITCHELL. I want to quote Secretary Azar, who said, you know, I have been a pharmaceutical CEO, and I'm aware of the old, tired talking points that, if we take \$1 out of the profit, that the engine of innovation will grind to a halt in this country.

I'm tired of those talking points and so is President Trump, and I just want to say, "Amen."

Mr. WELCH. Thank you.

But thank you all very much.

Mr. Chairman, thank you.

Chairman CUMMINGS. Mr. Jordan.

Mr. JORDAN. Thank you, Mr. Chairman.

First of all, Ms. McLinn, you are living proof of something that I have long believed. We have all these lobbyists running around this town but no high-priced lobbyist will ever be the mom on a mission. We appreciate your passion and obviously your love for your son Jordan.

You talked about your situation, and if you don't mind, how are you—do you have private insurance? How are you covering these tests and trials that Jordan's a part of?

Ms. MCLINN. The drug company pays for it.

Mr. JORDAN. Oh, really? Interesting.

Ms. MCLINN. And I think that's really important to know, that these clinical trials are expensive and the money doesn't always come from taxpayer money, and I know some does, and I know that NIH, you know, I know that there's funding for rare disease, but Jordan's trial is being paid for by his drug company. So all of those

trips we make, all of the doctors, the nurses, the drug, I mean, all of it, they're paying for that.

So that is why, believe me, none of us want high drug prices, and no one in this room, no one in this country, you know, thinks we want that, but I just don't want us to miss the point that sometimes there are reasons that drug prices are high, and I think in Jordan's case it's reasonable to expect that his drug is going to be expensive for that reason.

Mr. JORDAN. Yes.

Dr. Mitchell or—excuse me—Mr. Mitchell, you mentioned in your opening statement three things you think need to happen. Can you walk us through those again? 'Cause I guess—and you, Mr. Hice mentioned earlier, you're—I think both you, Ms. McLinn, all of them talk about this balance we need. You want the innovation to happen because, I think as you said in your opening statement, without innovation, they're not gone to find what needs to be found for you to continue to live. So, innovation's critical. But price matters, too. And I think—I mean, that's where we're at. So let's figure out how we can keep both, and I think you had three points you made in your opening statement.

Mr. MITCHELL. I really appreciate you offering me the chance to repeat them, sir.

We need to reform patent law. You know, the CREATES Act that you helped sponsor and helped advance in Congress is important. Pay-for-delay deals that don't allow generics and biosimilars to come to market timely. Citizen petitions, 90 percent of which are filed with the FDA with drug companies and 92 percent are kicked by the FDA that former Commissioner Gottlieb flagged as a problem. Patent picking that Senator Cornyn has tried to take on.

This is to make the system that you all built work so that we can reward the innovation with the period of exclusivity and patent time and let them make a lot of money because you did innovation. You took a risk.

Mr. JORDAN. Exactly right. I mean, there's a reason patent protection's in the institution.

Mr. MITCHELL. That is correct.

Mr. JORDAN. We want that innovation. We want people to take risk, come up with great idea, innovative things and do it.

Mr. MITCHELL. Exactly. So we get to make the balanced, so that that time when you intend is over, competition and free markets can drive down the price.

Mr. JORDAN. Exactly right.

Mr. MITCHELL. That's our system the way it is today. So it's not working. That's one.

Two, we fundamentally believe that the United States should do what every other country in the world does. It should bargain directly with the drug companies. We should strike the noninterference clause, and Medicare should negotiate drug prices. We think that negotiation is the essence of a capitalist system. You know, when you're in a situation where someone can come in and dictate a price to you, that's not free market. That's giving a monopoly and allowing the monopoly to be enforced at taxpayer expense.



And then, third, we do think we have a problem down the supply chain. One of the problems with our system is that when list prices go up, everybody down the supply chain makes more money. So they all have an incentive to have list prices continue to go up. PBM is chief among them.

We think that secret rebates are bad policy. We don't think they work for patients. As a patient, I can't know if the preferred drug on a formulary is there because it's the best drug or it's the least expensive among equally effective drugs or if it's there because the PBM got a big kickback from the drug company. This is happening, and so we would like to you address also transparency with PBMs.

Those are our three big things. There are others.

Mr. JORDAN. I understand.

Mr. MITCHELL. Thank you.

Mr. JORDAN. Yes, and I appreciate that.

The key to me is we have this amazing system where we do get innovation. We do get the greatest drugs developed, brought to market, researched, developed, brought to market right here in the United States. We can't stop. We have got to make sure that continues but happens in a ways that people can actually afford medicine that they need, treatment that they need, which is—so, thank you all for being here today.

With that, Mr. Chairman, I yield back.

Chairman CUMMINGS. I thank you very much.

Mr. RASKIN.

Mr. RASKIN. Mr. Chairman, I thank you very much and I want to praise you for joining this extraordinary important hearing at the beginning of our recess, and I wish all the media which swarm over this Congress when we conduct oversight into governmental corruption and criminality were here today because this is a crime, too. This is corruption. This is a nationwide scandal.

And I must say that this is the finest and most inspiring panel of witnesses that I've seen since I got to Congress, and I hope that every American takes the time to watch your testimony today or tonight or over the weekend and I wish I had an hour to question all of you.

Mr. Mitchell, I have a special attachment to your testimony because it is so lucid and brilliant and clear and also because you're my constituent in Bethesda, Maryland, and you make the eighth district of Maryland proud. I wish I knew someone who had millions of Twitter and Snapchat followers all over America who would could retweet your testimony. Maybe I could prevail upon one of our distinguished freshman members of the committee to make you famous today, Mr. Mitchell.

My friend from Ohio launched his remarks today with the now-obligatory attacks on socialists, but it's not socialists who are jacking up the prices to make prescription drugs unaffordable for millions of Americans, and it's not socialists who are stifling competition. It's the large pharmaceutical companies themselves. And this would be no surprise to my beloved Adam Smith who understood that the companies are in the business of profit not out of altruism, but out of self-interest. That's what makes the market work, but if you allow those companies to get so big and so powerful that they take over the system, they will destroy competition and every sig-

nificant free market economist has understood that. I think that's the burden of your testimony, Mr. Mitchell, that that's what's going on.

If they can make profit by paying off generic competitors to stay out of the market, and thereby keep prices inflated, they'll do it. If they can make extra profit by obtaining new drug patents for old drugs that have long been on the market, they'll do that. If they can inflate their profits by lobbying Congress to keep us from engaging in the cardinal market activity of negotiating for lower prices, they will do that, too. And our job as Representatives in Congress is not to bow down to large corporations but to stand up to them for the public interest and for the people.

Mr. Mitchell, in just two years, as a person dealing with an illness, a serious illness, you have built a community of more than 150,000 patients and families to fight for lower prescription drug prices, to fight for real competition, and to fight against monopoly pricing in medical services. Now you say that these high drug prices are not about innovation. That may have been the single most important thing you said.

Explain why high drug prices are not about innovation.

Mr. MITCHELL. There is no correlation—and multiple academics have studied this—between the cost to develop a drug and the price at which it is set. It is set as high as the company can set it because of what you said: they're profit maximizers. As long as we let them do that, they will continue to do that. Why would they stop? It's their job to take care of their shareholders. And that's my concern - that that wrecks the balance between ensuring that we give a really good, rich return for excellent innovative new drugs and ensure that a price is set that is affordable.

May I give you one example?

Mr. RASKIN. Yes, and then I have a followup with another question.

Mr. MITCHELL. I'm very concerned because NIH reports, Francis Collins, Director of NIH, reports there is an impending cure for sickle-cell coming out of NIH, and it turns out that NIH has invested \$300 million in something called LentiGlobin BB305, and NIH reports it's spending a \$100 million a year right now on sickle-cell cure.

These gene therapies are coming to market between \$500,000 and \$2,000,000. If we have a cure for sickle cell that comes out of NIH that will be for a 100,000 people in this country who have sickle-cell, it will cost us a hundred billion dollars; and there are 400 gene therapies in development. How are we going to pay for this?

Mr. RASKIN. Let me followup on that. I'm the proud Representative not only of you, Mr. Mitchell, but of the NIH which invests billions of dollars in scientific and medical research to fight the killer diseases that our population is struggling with.

When they come up with breakthroughs, those scientific inventions and discoveries are used by these companies. So should the public investment in the research be also considered when we're deciding about the regulation of prescription drug prices?

Chairman CUMMINGS. The gentleman's time has expired.

But you may briefly answer the question.

Mr. MITCHELL. Thank you, Mr. Chairman.

Yes, we believe it should. We also think we should pay attention, when we talk about the drug companies financing clinical trials, that we have given them tax breaks for that. The Orphan Drug Act gives them for the trials that are done for Ms. McLinn's son a tax break under the Orphan Drug Act. So taxpayers are not only financing research through NIH but through various tax advantages that accrue to the companies for doing that research. And by the way, don't stop that. Keep it going. I need new drugs, or I'm going to die, and that's straight up a fact. So we want it, but we want the drugs to come forward at prices we can afford.

Chairman CUMMINGS. Thank you.

Mr. Keller—Roy? Mr. Roy.

Mr. ROY. I thank the chairman, and specifically I want to thank the chairman for continuing to have hearings on this topic and shining the spotlight on this issue. I concur with my colleagues who are saying that this is an inspiring hearing of sorts, listening to this great panel, and that this is something where hopefully we've got a bunch of bipartisan interests in trying to solve.

Mr. Mitchell, I'm been particularly interested in what you had to say. I would agree with my colleague from Maryland that you've presented this in a particularly lucid way, a way that I think shares what I believe. I would also add the quote from Ms. McLinn: It's okay companies are making a profit. How much, I don't know.

That pretty much sums up my general philosophy on this, right? I want innovation to continue. I want companies to make the maximum dollar they can make to encourage innovation within some sort of boundaries, recognizing that our patent system that's constitutionally prescribed is critical to the formation of these drugs.

I was, as I was listening to your testimony, Ms. Holt, I spent a lot of time with people dealing with myeloma when I was at MD Anderson seven years ago with Hodgkin's lymphoma. In fact, I was trying to remember when it was, and I was sitting here, looking through my old email files and Gmail; I was looking through it and found July 28, 2011, which I guess would be, this coming Sunday, would be eight years. This is the email back and forth with my wife when I was at the doctor's office, thinking I had walking pneumonia, and I was starting to figure out I didn't, and so I now know that that was - July 28 was the date.

Then found out a few days later, got the results it was non—or Hodgkin's lymphoma, and I said: Is that the good kind or the bad kind, like Hodgkin's or Non-Hodgkin's?

The doctor said: Well, I guess it's the good kind.

But going through that obviously sort of changes your perspective. I was on a trial, brentuximab, down at MD Anderson. I spent every two weeks from August through January 2012, going down to MD Anderson in the trial clinic section there at MD Anderson and getting treated with this, and it was not FDA-approved at that point. It was FDA-approved for relapse patients. I was a, you know, new patient.

And I'm very grateful that that drug was being brought to market, that a pharmaceutical company was making money doing it. Some of the research that went into developing that, of course, as Mr. Mitchell, you've said, came through NIH and other avenues of

publicly funded research, including, I think, through the University of Texas and other avenues.

So, for me, the questions that I'm trying to wrestle with and, you know, often, in Congress, we don't acknowledge what we don't know, when, in fact, we generally, there's a lot more that we don't know than that we know, but, you know, I don't know the answers to how much money that is coming through NIH and publicly funded research that then goes to a privately held corporation and what agreements then exist, then how much profit should be allowed. Right? Because I cringe when I think about, well, the government setting what profit is allowed, right? I believe the markets, and I want the markets to work. But as my colleague from Maryland was talking about, we don't always have a full market going on here in terms of competition because we've got all these issues.

I don't mean to filibuster here because, like my colleague said, I'd like to sit here for an hour and have a give and take because I've been intrigued by what you all have had to say. I'm interested in a number of different pieces of legislation, including some of the ones that have been mentioned. I think, Ms. Kregel, my fellow Texan, I think you mentioned some legislation, each of you have. And I'm looking at all of that.

I'm cosponsoring Legislation 3199, the TERM Act, the Patients for Affordable Drugs Now, which I think, Mr. Mitchell, you are part of founding, is supportive of and trying to stop some of the games that patent companies play by dragging these things out and tweaking the formula and then moving it down the line.

These are all things that I think we need to look at, you know, again, provided that, as, Ms. McLinn, I think you have rightly pointed out, and you, too Mr. Mitchell, I think all the panelists, that we preserve innovation, make sure that there are an abundant supply of drugs that are continuing to be developed so that we have these lifesaving cures and that we're able to then distribute that around the world, which these companies are structured to do for profit.

But we've got a lot of work to do to try to make sure the patent system is not gamed, PBMs and middlemen aren't driving up prices unnecessarily, getting more transparency in the process, and I think the three points you outlined, Mr. Mitchell.

So I just did what I hate to do, which is I think I used my five minutes without asking a question. I apologize for that. I looked down. I realize I've used the five minutes. I appreciate the questions you guys have answered and that you've spent the time here, taking the time out of your busy schedules to be here.

And I thank the chair for having this hearing.

Chairman CUMMINGS. Thank you very much.

Ms. Ocasio-Cortez.

Ms. OCASIO-CORTEZ. Thank you, Mr. Chair. I appreciate you holding this hearing.

I think just first and foremost to each and every one of you I just want to say first that I'm sorry. I'm sorry that you all are going through the things that you're going through. I know that—I understand and have experienced not all of what you all are experiencing but some of it.

When I was 16 years old, my father was diagnosed with a rare form of lung cancer. He was in experimental trials in order to save his life. My family almost lost our home in order to try to keep him alive and just try to keep our family together. A lot of folks, you know, many people know that I was working in a restaurant when I got elected, but they don't know why and the reason why was because we lost my father to a rare form of lung cancer. We couldn't find treatment for him.

And so the other thing that I want to say, too, is that none of this is your fault. So often we are made to feel guilty for the things that we cannot afford when there is no reason that our treatments should be this expensive in the first place. One of the things that I wanted to kind of get at is this idea that all these drugs should be as expensive as they are right now because I don't think that that is true.

Ms. Skipper, you said that with your insurance, your insulin is a thousand dollars a month. Is that correct?

Ms. SKIPPER. Yes.

Ms. OCASIO-CORTEZ. When insulin was first developed, the patent was sold, do you understand—do you know the story?

Ms. SKIPPER. Yes, for a dollar.

Ms. OCASIO-CORTEZ. For a dollar, right?

Ms. SKIPPER. Yes.

Ms. OCASIO-CORTEZ. That's how much the patent for all insulin was sold for.

Do you know the reason why it's a thousand dollars with insurance for you?

Ms. SKIPPER. No.

Ms. OCASIO-CORTEZ. Neither do I.

Ms. SKIPPER. Yes, I have no idea.

Ms. OCASIO-CORTEZ. And, frankly, I don't think corporations—well, I don't think corporations will give us a reason why.

A lot has been made about how much money has been spent on research and development. Between 2006 and 2015, about \$465 billion was invested in research and development. And I think every dollar put into research and development of pharmaceuticals is a good dollar spent.

But let me see. Mr. Mitchell, are you familiar with stock buybacks?

Mr. MITCHELL. I know what they are.

Ms. OCASIO-CORTEZ. And what is a stock buyback?

Mr. MITCHELL. It's when a company decides to purchase shares of its stock in order to drive up its stock price.

Ms. OCASIO-CORTEZ. So, between those roughly 10 years, \$465 billion was spent on research and development. The amount that pharmaceuticals spent on that same time to buy their own stock for the sole purpose of driving up the price was \$516 billion. So they spent more than their entire budget on research and development on a tactic to drive up their own stock price. Stock buybacks used to be illegal in this country, and once they were made legal, they were made—they were allowed. And one of the things is that when a company buys their own stock, it drives up the price of their stock.

And something that's not talked about is that CEO pay is tied to stock price. So CEOs right now are not incentivized to invest in research and development. They're incentivized to raise their stock price. So, you know, there's a lot of debate as to what can be structured, whether we can go single-payer, whether we maintain our insurance system the way that it is, how you make it more competitive, whether you don't, et cetera.

But I think one very clear thing that we can see, Mr. Chair, is that if we eliminated stock buybacks, we could reduce the cost outlays of insurance company—of pharmaceutical companies by at least half when you compare just research and development and the stock buybacks alone.

Again, I just want to thank each and every single one of you for sharing your stories today because there's no reason for a drug as simple as insulin, which costs \$21 in Canada for a 10-millimeter bottle, to cost the equivalent of a mortgage payment or sometimes two mortgage payments.

With that, I yield. Thank you.

Chairman CUMMINGS. Thank you very much.

Mr. Meadows.

Mr. MEADOWS. I thank you, Mr. Chairman.

I thank each of you for your testimony today. My apologies for being a little bit late. Actually, I was at the White House, working on prescription drug prices. So I want to let you know that this is bringing a number of us together from opposite sides of the aisle. I've had a number of conversations with the chairman. We both have a passion to not just make this political but to make it real.

And, Ms. Skipper, you should never have to ration yourself with insulin. You should also be able to have that affordable drug, as Ms. Ocasio-Cortez just mentioned, because that's a drug that's been around for a long time, and I can tell you that there was one regulation that was changed actually just a week ago that will start to help with that. There are more that are being proposed, but we need to work in a bipartisan way.

I think have you a commitment, and I'm here to tell all five of you. You have a commitment for a bipartisan effort to really make sure that we do this. My good friend from Vermont, Mr. Welch, mentioned that they passed something out of Senator Grassley's committee yesterday. Now is that the perfect answer? I can tell you it's not. We have—but I can tell that you that Democrats, Republicans are looking at this very, very closely and help is on the way in the near future. I can tell that you I believe that we must the announce an initiative that hopefully will gain traction legislatively in the House and in the Senate and act on that I believe in September when we come back from recess.

Mr. Mitchell, I want to hit on one area. You mentioned PBMs, the middleman that continues to in ways drive up prices. It has become part of our delivery system, and so, as we look at that, we created PBMs, and I don't know if you know that, but when HMOs around, we actually created PBMs, and yet we are seeing this artificial increase in retail prices that makes it very, very difficult.

Would you agree with that?

Mr. MITCHELL. Yes, the headwaters of the problem is the list price is set by the drug companies, but we have a system down-

stream that supports diverse incentives, and as patients, we have a real problem with secret rebates because we don't think they are designed to serve us. We think they're designed to serve the people who make money on the system.

Mr. MEADOWS. Right. All right.

Ms. McLinn, thank you for sharing the fact that you're benefiting from a clinical trial aspect. One of the things that I believe would be helpful—and perhaps you can be a great advocate for this—is, as we look at clinical trials, the expense of getting groundbreaking drugs to market, there's a clinical 1, clinical 2, clinical 3 trial.

And what I believe, just like we've done on a few drugs, HIV and a few other cancer drugs, is, once we do that clinical 2 trial and we've shown that there is some safety, allow those to go ahead and come to market. Allow those so that, while we're doing that clinical 3 trial, and we know that the harms are limited, that we go ahead and allow those to come to market. It allows a whole lot of smaller companies who are innovative to bring them to market.

Do you think that that would be helpful?

Ms. MCLINN. Yes.

Mr. MEADOWS. All right. I was hopeful that was going to be your answer.

The other aspect that we have to get to is, because of the way that we've structured prescription drug prices, not just for Medicare part D, but because of the PBMs—and it is a very integrated system in terms of delivery. So you've got retail price. You've got net price. You've got rebates. You've got—but when we start to try to hit on one lever or the other, it has an opposite. It can have an opposite effect.

For example, Ms. Skipper, if we were to actually work on one area and say that we're going to eliminate the PBMs, some companies actually take the rebates that they get from PBMs to lower insurance prices and so you—it is a very, very complex thing.

So here is my commitment to you. I believe it's one that the chairman supports. I can tell you it's one that the administration supports because I just left. We're going to lower prescription drug prices, and we are going to do that without increasing insurance premiums to pay for. It is time that we act, and the time is now.

I thank you all for being here, and I yield back.

Chairman CUMMINGS. I want to thank the gentleman, Mr. Meadows. Just to assure you, he's absolutely right. There's not a week that goes by that we are not trying to figure this out and trying to work with the White House to get it done from other angles.

And I want to thank you for working with us.

Now, Ms. Pressley.

Ms. PRESSLEY. Thank you, Mr. Chairman.

And I'd like to say how much I appreciate your leadership, and it is a source of pride for all of us on the committee that the very first hearing that we had in this committee in this session was on reducing prescription drugs.

I want to thank all of you for being here today.

Ms. Skipper, let me say that you're 23 years old, and you're tired. We're tired, like you, that millions of families are suffering. It's not only those of you individually battling this but all the people who love you and support you in this journey and the fact that you have

to weaponize your lived experience in order to be seen and heard. You think that's for listening, but I think that's too low a bar. It's high time we act and you are rationing life-saving medication, and it seems that for far too long we've been rationing our response and our compassion and our due diligence, and so it is critical that we act, and we act in a bipartisan fashion.

You know, although insulin has not changed since the mid 90's, its price has skyrocketed. And communities of color have been disproportionately impacted. According to the American Diabetic Association, Black and Latino Americans are more than 70 percent more likely to be diagnosed with diabetes than White Americans, and one in three adults in this country will have diabetes by 2050. The price of insulin has nearly tripled from \$3,200 to \$6,000 over the last decade, an impossible price tag, especially for our young people and young adults.

Ms. Skipper, could you just speak to how have you been obtaining insulin in the recent months and years?

Ms. SKIPPER. Through donations, donations from people from my community, my church, and sharing with my sister. That's burdensome also because I feel like I'm taking away from people who could also be using this life-sustaining medicine, but it also makes me appreciate that there is some good in the world in the selflessness of some people. I can't tell you the last time that I filled a prescription for my insulin. So, it's just—it's been really hard to just kind of guesstimate how long my supply is going to last.

Ms. PRESSLEY. And you talked about, you know, getting a new job and one that includes employer-based healthcare coverage. Could you speak a little bit about that and what that coverage has meant and what the difference has been?

Ms. SKIPPER. I mean, it's meant good if I want to go to the doctor for, like, a checkup, go get my teeth cleaned, get some new glasses, you know, go to the gynecologist, or anything like that. But for what I actually need to live, it's just - it is hard. It's just really hard, and I just don't understand. I just don't understand.

Ms. PRESSLEY. So just, I want to dig into that a little bit more because there are other associated costs which people often overlook in this. So if you could just expound to upon that a little bit.

Ms. SKIPPER. Yes. So it's not just insulin. I need needles. I need test strips. I need, like, alcohol swabs, glucose tablets, extra food just in general. Then I also have celiac disease. So it's not like I can just eat anything, or, you know, so it's just very—it's been very costly to live, and I do feel sometimes like this is not—I didn't put this on myself. So why do I have to suffer? Why do we have to suffer?

Ms. PRESSLEY. And so there was actually a recent *BuzzFeed* article that was just speaking about the fact that many 20-somethings who are no longer, if you're not carried on your parents' insurance, you know, the precarious position that that is putting so many young adults in, and it's particularly acute with regard to someone like you living with Type 1 diabetes.

So I understand you and your sister haven't been able to use a parent's insurance in recent years but have faced similar struggles to those who have lost their parents' employer coverage at that age.



Can you tell me what happened when your mother lost her job when you were children?

Oh, yes, I'm sorry.

Ms. SKIPPER. I'm sorry. Just things started to spiral out of control. I was really scared. A few months after she lost her job, I was suicidal because I just—I didn't want to continue to struggle. I didn't know how me and my sister were going to make it. I didn't know how my mom was even going to be able to provide for herself. So losing her coverage, it just put us in a really bad spot.

Ms. PRESSLEY. Well, thank you, Ms. Skipper.

Thank all of you.

And, you know, the fact that from hospitalizations to stock piling or buying insulin on the black market, too many Americans are cutting corners in their medical care simply to stay alive, and that is just unacceptable. Thank you.

Chairman CUMMINGS. Ms. Kelly.

Ms. KELLY. That was hard to hear.

Chairman CUMMINGS. Ms. Tlaib.

Ms. TLAIB. Seriously, Chairman?

I'm the eldest of 14. I've been taking care of people all my life. So, when I have emotions, it's because I've seen challenges. This committee hits home so, so much. I just want to thank all of you so much for speaking up because I mean, I know I can speak to some of us here. There's a lack of urgency, right? There's lack of urgency. When the mother was talking about missing, you know, coming here because she had to be a voice for so many people that can't be in this room, I want to thank you for that because I know how hard it is. It's funny. Our kids are going to be fine sometimes. We're the ones actually feeling more guilt than they are. They're like: Mom, I'm doing great. I'm with my friends.

But one of the things that I—this broken system and the frustration I have—and I had all these questions. I wanted to pull out these human stories. But I think you all have put a human face to something that for years I feel like hasn't truly been translated into the human impact until it got so broken down, so to the point where you have people rationing, that you have people actually dying right before your eyes because we've allowed corporate greed. We've allowed corporate greed to come before the people.

We, the government in this Chamber, we're responsible to protect you from it. And I want to apologize. I want to apologize. I've only been here seven months, but not on my watch will I not be able to humanize the impact and push back against corporate greed, and I want you to know it's not just us. It's Congresswoman Kelly and all of us in this room, many of us now not in this room. But I want you to know, like, we really, truly, sincerely care about your life.

A woman came up to me at a coffee hour and said: Rashida, I don't understand. They're saying that insulin is not preventive care.

Of course, I dug deep. She goes: You don't understand. Insulin prevents death.

I said: Absolutely.

And she said her company, this is a big company, said that they decided to change the system so now that she had to literally, like,

sit for a whole month before she can go pick up her son's insulin, \$2,800 that she had to put together, \$2,800.

And I said: No, I can't wait for a bill to pass. I can't wait for people to wake up here. I'm going to put it on my letterhead.

So, on my letterhead I said, "What are you doing? You are a corporation," I took the mission statement of the corporation, put it in there, and said, "But you're supposed to be about people, right? What about the," and without telling them who it was, I said, "What are you doing? You're allowing people to die on your health insurance."

And she told me she went in last week to go pick up her son's insulin. She got together \$2,800. I know where she lives. It was hard for her to raise that money. She went in and she said: I don't know what you did, but it's \$244 now, right?

That's still too much, my—but that means there's a will. They're waiting for us to tell them to stop, right? Moms know this. When there's bad behavior, we've subsidized. We've done the research and development. We've done everything we're supposed to do to say to them that you're supposed to be able to provide to the American people access to drugs that help them live. And I just want you to know, continue to be bold. Continue to ask for more. Even when folks say, "We all agree," that's great, but actions speaks louder.

So I only have—I want each of you to tell me in your own personal opinion, why do you think we haven't acted in Congress?

We'll start with you.

Mr. MITCHELL. Drug companies are a monopoly, have monopoly pricing powers, and monopolies by definition have unlimited resources to defend their monopolies with political campaign contributions and lobbyists. There is 1.5 lobbyist for every one of you in the U.S. Congress, 1.5. That's like daunting odds, as my dad would have said. So I think it's both the fact that they use their monopoly pricing power to maintain their monopoly pricing power and to stop reform from happening.

Ms. KREGG. You know, I don't know the answer. But I think this hearing is, like you said, putting a human face to the issue. I think there's a lot of donations that happen. So maybe it gets pushed back to back of the shelf, but I can definitely tell sitting here today that you guys are going to do something about it. My disease is really treatable. It's not so treatable for these people. That's not okay.

Ms. MCLINN. The question "why haven't you acted," I think it's an interesting question because I'm going to say I think Congress has acted. I think, because of Congress, my son is participating in a clinical trial that I believe is helping him. I believe that patients are accessing treatments sooner and I think that everyone in this room and everyone listening is acting right now, and I think that's what we need to focus on. I think let's not dwell on why we haven't solved this yet. Let's keep doing the next right thing and let's just figure it out and let's just do that.

Thank you very much.

Ms. SKIPPER. I would say, from a patient perspective, not really knowing the—you know, I don't know how, you know, how all of this works, but it seems like the people up top benefit from this

and not acting. I don't know if it's in a financial way or whatever way, but it just seems like you get a piece of the pie some way, somehow.

Thank you.

Ms. HOLT. And I'm just a retired teacher from Indiana. But, to me, it's money. I think it's money. It's the lobbyists. It's the pressure put on people to do things according to the money rather than the good. I also see a lot of bipartisan fighting that I think is inconsequential when it comes down to people's lives, that there needs to be more cooperation. I do think—I'm 70 years old. I'm hopeful things will change before I die. I'm hopeful in meetings like this that things are finally happening.

I started coming to Washington, DC, two years ago to help promote the CREATES bill. I'm frustrated that it's still not passed entirely, but I'm excited that it's making progress. So I'm learning how the government works and how slow it is. For me, that's frustrating, but I'm excited to see progress being made. Thanks.

Chairman CUMMINGS. Thank you very much.

Ms. KELLY.

Ms. KELLY. I'm ready. Thank you for having my back.

I, too, want to thank all of you for being here. It's not easy to tell your story in front of Congress, cameras, and people in the audience. So I truly, truly appreciate all of you being here.

Mr. Chairman, I appreciate you for having this, and I'm proud to serve on this committee, but I'm also proud to be a member of Energy and Commerce. So it makes me feel good to hear that you say, you know, we're moving along, and what we're doing is meaningful, and we are really working in a bipartisan way, which is good to hear, you know, because there's so many other ways that we're not but we definitely are in energy and commerce.

When I came to Congress, which I've been here, I'm in my 17th year, my district had the highest rate of foreclosures in the state of Illinois. Some of it, people lost their jobs. Some of it they went for a hokey-doke mortgage. But also some of it was because of medical reasons, and they couldn't afford to keep their homes. So I think we're on the rebound. Things are getting a little better in the other—for the other reasons but not for the medical reasons.

I also am the chair of the Congressional Black Caucus Health Braintrust. And of the top 10 diseases that people die from, African Americans are No. 1 in 8 of them. So, Ms. Skipper, we work a lot with your issue.

The other thing, in that capacity, I am responsible for two conferences a year. And one conference, someone shared that they have asthma and their asthma, the inhaler, is \$325 in the United States, and she left her inhaler at home, and she was in South Africa, same exact inhaler, same exact company, everything, exactly the same and the inhaler was \$25.

So, in coming to Congress, I've gotten more aware of the issues that, you know, everyday people, my next-door neighbor, whoever, have to go through in this fight with lowering prescription drugs or having to choose, you know, between paying bills and buying your drugs or eating, you know. So I promise you I will continue to work really, really hard in this area on both of these committees.

One question—and I don't know if you know the answer. My colleague, Ocasio-Cortez, always has a lot of stats. So you may have some of the answer, but the money that companies spend in advertising, you can't open a magazine without seeing pages and pages and pages. I didn't know if you would know.

Mr. MITCHELL. Six billion dollars a year, and we subsidize it. That's the unfortunate thing. We're the only other—there's only two countries in the world that allow direct-to-consumer advertising of pharmaceuticals, us and New Zealand. And we give a tax break to these companies to send those advertisements our way, and the only reason they do it is to make more money on encouraging people, perhaps, in some cases, to use drugs they don't necessarily need even.

Ms. KELLY. Okay. And if there's—I mean, I'm one of the last people to ask you a question. Is there anything more you want to us know that you didn't already say? Anything?

Mr. MITCHELL. I do want to say, Ms. Kelly, I would love to come visit with you and talk about the sickle cell cure that NIH is bringing forward soon and how we're going to make sure that that drug, developed inside the walls of NIH, they're running clinical trials right now at NIH—they've spent at least a half a billion dollars—how we make sure that that drug comes to the market at a price that is affordable and accessible.

Ms. KELLY. I have been meeting with people, and I'm in this building, 2416. So come and visit anytime.

Mr. MITCHELL. Thank you.

Mr. RASKIN. Would the gentlemen yield?

Ms. KELLY. The gentlelady?

Mr. RASKIN. Yes, I meant you.

I just wanted to followup on this question about advertising. I never thought of that before.

Thank you, Mr. Mitchell, for telling us that it's only the U.S. and New Zealand which permit television advertising for prescription drugs.

Are you suggesting that you think that should be banned or that the cost of those ads should not be tax deductible for the businesses as ordinary business expenses? Have you done work on this problem?

Mr. MITCHELL. The courts have ruled that the drug companies have a First Amendment right to advertise, but the National Academy of Sciences, Engineering, and Medicine came forward with a report 18 months ago and recommended that you eliminate the tax deduction for that advertising, and that will reduce it by a large amount, and that would be good. I don't know why we're subsidizing their advertising.

Chairman CUMMINGS. Thank you.

Ms. KELLY. Thank you.

Chairman CUMMINGS. Thank you very much.

Mr. DeSaulnier.

Mr. DESAULNIER. Thank you, Mr. Chairman. Thank you for having this hearing.

And to the ranking member, thank you for making it non-partisan.

I just want to followup a little bit on that earlier discussion. Having spent a good deal of time on this—and I would recommend to anybody—I like to recommend books—“Our Daily Meds.” It’s a book by a former New York Times reporter. I don’t know if, Mr. Mitchell, you’ve read it, and it’s called “How the Pharmaceutical Companies Transformed Themselves Into Slick Marketing Companies and Hooked the American Public.”

So this is not some new phenomenon. If you read that book and do the research, we took pharmaceutical companies from being driven by research. The CEOs were usually researchers. They became the CEOs. And they got a reasonable rate of return on their investments. And then, for a variety of reasons, not just directly the pharmaceutical industry but more toward the finance industry, this book will tell you they did extensive focusing groups, 15, 20 years ago. They looked at professions and industries that Americans trusted, and it turned out that we trust people with white smocks. We trust doctors and pharmacists and researchers. So they went in and bought out controlling shares, and they turned them into marketing companies.

So, to act like this is something that just happened, it’s just become so bad that we’ve finally gotten attention. And it needs to be stopped. I know my colleagues have heard this before, but sometimes you repeat things lots of times in this building. I know this because I have a pill in my pocket that’s sold by Johnson & Johnson, and it keeps me alive. I have a form of leukemia, and I’m thankful for this pill. It’s five hundred bucks. I’ll put it up here. It’s the most expensive thing on me until 3 o’clock in the afternoon, and most of the research for that pill came from DARPA in the Department of Defense. If you learn the study of blood cancers, it started because of sailors and soldiers getting mustard gas during World War I. And we spent a lot of research trying to help sold years to be inoculated, and we found out about how our blood systems were covered.

So this pill that costs \$500 here in the United States of America—and I’m lucky enough that I signed onto a public option that was in the county that I was a county supervisor for years ago, and everybody told me: Don’t do it. You’ll have to get your medical service at the county hospital.

And my kids and I went to the clinic, and we got great service. It’s a classic option. The public option would work in this country and does work in some instances. They help so that I don’t have the kind of costs that you have because that’s my supplemental.

That pill cost \$400 a year ago, and then they changed the formula, and now it’s \$500. This pill in Australia costs \$6.37 with subsidies. Fully loaded, it costs \$37. Where does the rest of that money go to? It doesn’t go to research.

So, Mr. Mitchell, a study published in the Oxford Journal of Law and the Biosciences found that just 22 percent of drugs receiving new patents between 2005 and 2015 were actually new drugs. The study concluded, quote, rather than creating new medicines, pharmaceutical companies are largely recycling and repurposing old ones. According to a GAO study, innovative products accounted for only 13 percent of FDA approvals each year from 2005 to 2016.

So therein lies the problem. At another hearing, we had a pharmaceutical executive here, and I said: We want investment, but we want you to get a reasonable rate of return. It was supposed to be high risk, high return. You have now gamed the system so it's very low risk and high return. And in the meantime, people are going bankrupt. People are losing their lives.

Ms. McLinn, I have a son. One of my two son's name is Jordan. So your story relates to me on multiple levels.

This is outrageous. It's just outrageous. It's a crime. These people shouldn't be executives. They should be in prison, in my view.

Mr. Mitchell, do have you any comments?

Mr. MITCHELL. When drug companies do what you just described, file old—or new patents on old drugs—78 percent—I'll do it the other way—of all the patents filed on drugs are filed on existing drugs. If they are filing patents on existing drugs to extend their monopoly on those old drugs, they're not doing what they all say we want up here which is investing in innovation, investing in research and development, which will bring the cure for Ms. McLinn's boy, that may cure my cancer before I die.

And so you guys really have got to stop this abuse that allows them to milk old drugs by gaming the system instead of doing what we need them to do, which is invest in innovation and new drug development. And we have to keep in mind that a lot of that is also subsidized by the American public, but you have to get them back, focused on developing new drugs instead of just milking profits from—developing new drugs instead of milking profits from old drugs.

Mr. DESAULNIER. Thank you, Mr. Mitchell.

I want to thank you all once again. Your testimony is really important. People need to hear our stories.

Thank you, Mr. Chairman. I yield back.

Chairman CUMMINGS. Mr. Khanna.

Mr. KHANNA. Thank you, Mr. Chairman. Thank you for your leadership.

Thank you to all of you for sharing your stories, for being so vulnerable, for sharing something that is so personal, and for your courage in doing that to help our country move forward. I appreciated Representative Tlaib's comments that you're here not just as an academic exercise, you want to see some action.

One of the things that we've been talking about as a country for the longest time, but don't do anything, is Medicare for All. Medicare for All will finally give the government the ability to negotiate and lower these drug prices. And Lyndon Johnson, when he first passed Medicare, anticipated eventually we would have Medicare for All. And then 25 years ago, Senator Moynihan had 25 hearings in the Senate Finance Committee on healthcare reform, all of these experts, and at the end of it, he says: Well, there's one solution. Let's extend Medicare.

President Trump in 2000, in his book, said: Why don't we have a single-payer healthcare system? It's better than anything we have.

Yes, we keep talking about this. We keep having folks like you come testify, and nothing gets done. So I want to ask each of you,

starting with Mr. Mitchell, do you think Medicare for All would help?

Mr. MITCHELL. Mr. Khanna, Patients For Affordable Drugs only focuses on drug prices, and we want very much for people to have access to affordable, accessible care, but we don't have a position on Medicare for All, or any of the steps that you could take to ensure that people get access to comprehensive coverage. I apologize.

Mr. KHANNA. What's your personal opinion?

Mr. MITCHELL. I am not going to express one because I'm here on behalf of the organization. I stay in my lane and do drug prices.

Mr. KHANNA. I respect that.

Ms. Krege?

Ms. KREGE. Sorry, but I think you asked a question a little bit over my head. I don't really have an opinion on that. I'm only telling my experience with my issue about a drug that costs \$1,100 a month with insurance.

Mr. KHANNA. I respect that.

Does anyone have any opinion on it? Ms. Skipper?

Ms. SKIPPER. As I previously stated, like, I don't know, like, all the ins and out of everything, but I can say this. Being the face of Affordable Insulin NOW campaign, I go down by Instagram news feed, and I see people from other countries who are just completely outraged that I have to pay for insulin at all. So, if that is what Medicare for All leads to, then that is something that I definitely support. For someone with fibromyalgia or anything like that, doesn't have to pay hundreds and thousands for something that they need to live, then, yes, I would support that.

Mr. KHANNA. Ms. Holt?

Ms. HOLT. I may be the only one on this panel that is on Medicare right now. And Medicare for me involves Medicare plus a supplement, and even with that, my drug prices are sky high. So, if that does not change, then no, I'm not in favor of Medicare for All.

Mr. KHANNA. That's a very fair point, and part of that is because the Medicare hasn't been able to negotiate for drug prices, which some of us have wanted to do. Part of that is because we don't have generic competition. Let me ask a second question. The President came on the State of the Union, and he said: Americans should not be paying more for our drugs than people in Britain, in France, in Germany.

Would folks here—and we can start with Mr. Mitchell and anyone else who wants to are answer—support the idea that if an American drug is priced higher than the drugs in these five leading countries—Germany, France, Britain, Japan—then Americans should pay the same price as people in other countries, or we should open it up to generic competition?

Mr. MITCHELL. Mr. Khanna, we strongly support direct Medicare price negotiations. Strike the noninterference clause, direct the Secretary to negotiate drug prices. There's absolutely no reason that we should be paying two to three times what other countries pay for the exact same drugs, in the exact same boxes. You can fix it, if we can pass direct Medicare price negotiation.

Mr. KHANNA. Anyone else want to weigh in?

Ms. SKIPPER. I would agree with Mr. Mitchell, the founder of T1International actually moved from her home, from the United

States to London, to be able to afford her insulin. And I know there are probably more like her who have had to leave the country in order to live, to afford to live. Thank you.

Chairman CUMMINGS. Thank you very much.

Mrs. Maloney?

Mrs. MALONEY. Thank you, Mr. Chairman, for this really incredibly important hearing, and all of our panelists, for helping to build a case and putting really the misery that Americans are facing with these unaffordable drugs. I believe it's a national scandal that they are able to charge these prices without any accountability for how they're raising it, why they're raising it, and I want to mention four ways that Congress could act tomorrow to combat this, based on your testimony today.

First of all, competition, the pay-to-delay, that competitors are literally paid not to come forward with a generic or other ways that they delay the process moving forward. I've heard from your testimony also the gaming of the system, where they say that they delay and delay when you should have a generic. They file patents for old drugs so that the time is longer. That's also hurting people. And what Mr. Ro Khanna just pointed out, the fact that they can be so much cheaper overseas is an absolute outrage, that we pay for the production, the research, and yet when it goes overseas, it's affordable, but not here in America.

And I think your story really on insulin is so moving. This was discovered well over a hundred years ago. The scientist gave it to the American people. He didn't want people to make money off of his invention, and yet now it's unaffordable—or not even affordable in many places in America, to the point that Americans are dying. We need to change this and work to make it happen.

And I want to followup with Ms. Krege on your story, where you talked about your inflammatory condition. Can you describe what it's like, what this condition is like, and what your drug that you received, that is now unaffordable, Humira, tell us what Humira does for you and what it's like if you don't have this drug that you cannot afford now?

Ms. KREGE. Oh, man, that's opening up a can of worms. Well, your epidermis is your largest organ. So, when I'm in a full psoriatic flare-up, I mean, the last one was two years ago, and it lasted 10 months. I was literally covered from head to toe in what some would call lesions. On top of that, all of my joints ache. I'm self-employed. I'm a hairstylist, and it affected my business. I had to wait six months to go through three appeal-ment processes, knowing that I would not be able to afford the drug once I got approved, and there's no generics available. This drug has been out since 2002. That's crazy. It's 80 percent cheaper overseas. The science is there.

Mrs. MALONEY. It's a scandal.

Ms. KREGE. Yes. A generic—the science is there.

Mrs. MALONEY. And in your testimony, you said—your written testimony, you're a successful hairdresser. You make a very good salary, better than most Americans. Yet the cost of your drug was more than your car payment, more than your business insurance, and more than what you spend for food in a month.

Ms. KREGE. Yes. The first few months, it went up 40 percent.



Mrs. MALONEY. And not having it has totally impacted your health. Can you still work without the drug or do you—

Ms. KREGE. I can, because I've been in basically remission the last two years. I've had to wean off of Humira. I've had to go back on it. I've had to wean off of it. I'm currently on an old drug.

Mrs. MALONEY. And you also wrote that AbbVie has filed over 250 patents, additional patents, on Humira, effectively delaying the generic drug and any competition for decades. Is that correct?

Ms. KREGE. Yes.

Mrs. MALONEY. See, that is manipulating the system to not allow Americans to afford it. We should stop that and ban that immediately.

Ms. KREGE. I'd like to say that those 247 patents, that was only last year.

Mrs. MALONEY. What's the total, do you know?

Ms. KREGE. Do you know?

Mr. MITCHELL. I believe they filed 247 patents, three short of what you estimated. So you're close enough.

Mrs. MALONEY. And now I understand that you also take Enbrel now, manufactured—

Ms. KREGE. No, I do not take Enbrel. I've been on Enbrel before, but the cost of that was just under \$1,200 a month.

Mrs. MALONEY. Well, I just want to say that I am distressed beyond belief that they have manipulated the system to run the price up so that you can't afford the drugs that you need, and I am sorry that you've had to face this challenge for your health. And it is something that we as a Congress need to act on as soon as possible, and all of you have helped make the case, and I want to thank you.

Chairman CUMMINGS. Mr. Gomez?

Mr. GOMEZ. Thank you, Mr. Chairman.

This is an issue that unfortunately has been going on for decades, right? I was curious about price gouging when it came to insulin. I did a quick Google search one day, and I found a lawsuit from 1940, I believe, 1941, basically accusing the companies of price gouging. So this is not anything new. It's been going on for decades. The question is, what are we going to do about it? A lot of times it's difficult, but we got to keep pushing and coming up with some new ideas, and I think that there is more of a commitment than ever, but that doesn't mean it always translates to legislative victories.

I was in the California legislature, and we did push through some reforms there. It was still difficult, but we got it done. But I always say that we need to continuously highlight people's stories to make a powerful impact. And that's why I'm glad all of you are here. I want people to really hear your stories and empathize.

One of the things I always realize is that, you know, the impacts vary from person to person, but it's definitely something that people should be able to feel, even if they're not directly impacted.

Ms. Skipper, you mentioned in your testimony that you and your sister shared insulin in order to manage your Type 1 diabetes. How long did you and your sister share insulin?

Ms. SKIPPER. We're still sharing.

Mr. GOMEZ. Still sharing? Wow. When did you and your sister first decide to share insulin?

Ms. SKIPPER. I don't—well, I don't think it was more or less a decision to do it. I think it was something that—

Mr. GOMEZ. You were forced to do?

Ms. SKIPPER [continuing]. we were forced to do. I don't—how long would you say? Yes, about seven years.

Mr. GOMEZ. What kind of impact does it have on your health to share insulin? I mean—

Ms. SKIPPER. To sum it up, I don't know what a good day is. Like, I don't know what a day to feel okay, like, I don't know what that feels like. There hasn't been a day where I don't have—like, I don't have a high blood sugar reading. There hasn't been a day where I don't have, like, aches and pains. There hasn't been a day where I've been completely exhausted. So, yes, to explain it—

Mr. GOMEZ. Yes.

Ms. SKIPPER [continuing]. the best way I can, I don't know what a good day feels like.

Mr. GOMEZ. Yes. So we do know that because you don't know what a good day feels like, because of your symptoms, that there is probably an underlying and chronic impact on your health?

Ms. SKIPPER. Yes.

Mr. GOMEZ. That will probably—you know, I'm not a doctor, but I'm assuming that it's not good in the long-term. We need to make sure you and your sister get the support and the insulin that you need.

What were you feeling while your sister was in the hospital?

Ms. SKIPPER. Angry. I was very angry. I was angry, and for some reason I had—I felt guilty. But I don't know why I felt guilty because I know that I don't control the price of this drug. I just didn't understand why I'm giving this corporation 40 hours a week, and I can't afford to have what I need, and my sister has basically put her life on the line to ensure that I'm alive. So I was very angry. And, also, like I said, like guilt, and very shameful, because I just—very shameful, because we—it just was hard to see my sister fighting for her life. And it was just—I was ashamed that I couldn't get what I needed so that she did not have to be in that position.

Mr. GOMEZ. I feel your anger. I think the American people should also feel your anger. You know, I grew up without health insurance. I've seen it. I know what it's like to see your parents worry about you, like, if you get sick, what does that mean, right? Are you going to get better? Can you get the access you need? We have positives in our healthcare system, but we have a lot of negatives that we got to work together. But I think sharing your story and making sure people know about it, especially with the T1International organization, to make sure that we share those stories. There's some folks here that have 4-or 5 million Twitter followers that can help amplify it, but I think—I don't have that many—but I think that at least adding our voice over and over could help make a difference. So I thank you all of you for being here and sharing your stories. It's important.

Thank you so much, and I yield back, Mr. Chairman.

Chairman CUMMINGS. Thank you very much.

Just one thing, Mr. Mitchell, Celgene has nearly tripled the price of Revlimid, the cancer drug that our witnesses—you and Ms. Holt are taking? Is that right?

Mr. MITCHELL. More than tripled.

Chairman CUMMINGS. Yes, okay. And that's since it was launched in 2005. A yearly supply of this drug can cost almost \$250,000 per year. And Celgene sold about \$10 billion worth of the drug in 2018 alone. What did Celgene do with all of the money? Well, first, it gave its CEO a pay raise. His compensation was worth \$16.2 million in 2018. And \$3 million more was added to that—and \$3 million more than the previous year. Salaries, tell me about that, of these drug manufacturing CEOs, and do you think that plays a role in these price hikes?

Mr. MITCHELL. Yes. And I think that the issue that was raised about stock buybacks and a short-term focus of the drug companies, is one of the things not getting us what we want because they're running up prices in order to drive up their stock price in order to get higher bonuses, do more stock buybacks, and not enough focus is being paid on the innovation that we all—every one of us at this table wants. So you take an old drug like Revlimid, in one year, I think it was 2018, they ran up the price 19.8 percent, in one 12-month period. And one of the reasons they did it is because they have a failed Crohn's disease drug trial. They had to take a \$700 million charge, so they increased the price of Revlimid to plug their hole, in order to prop up their stock price. These are the games these companies play.

Chairman CUMMINGS. Thank you very much.

Mr. Jordan, do you have anything, because I'm getting ready to close out? I want to thank all of you for being here today. Before I conclude today's hearing, I would like to enter into the record two letters the committee has received in recent days—one from the Initiative For Medicines Access and Knowledge and one from the National Hispanic Medical Association. These letters discuss the acute impact the drug companies' actions and high prescription drug prices are having on patients and communities all across the country. I ask unanimous consent that these letters be entered into the record. So ordered.

Let me, again, thank all of you for being here. It is not easy to, on national TV, by the way, to talk about your pain. And you're talking about some of the things that are so very, very personal. And a lot of times, you know, when people are suffering, it's almost like they're suffering alone. They feel like society, nobody knows what they're going through. I can tell you that there are a lot of people who feel the same way that you feel. They may not be going through what you're going through exactly, and that's why we in the Congress, we have to move. We don't have any choice.

I saw something here today, and I'm so proud to be the chairman of this committee. I watched our members cry. I watched you all cry. And it's because there is a tremendous pain that comes with hearing your stories. And I think, for most of us, your pain is our pain. Your dreams are our dreams. Your hopes are our hopes. And I just wanted to encourage you to keep forging on, Ms. McLinn, Ms. Skipper, Ms. Holt, Ms. Krege, and Mr. Mitchell.

You know, I heard you talk about, Mr. Mitchell, how there will come a day when your options run out—when your options run out. And I'm sure that you worry about going in to the doctor, and the doctor telling you, "Sorry, your options have run out," but when

there are options, when they are at our fingertips, but because of costs and greed, it's almost like you're reaching for the option and you just can't get there. And it would be one thing if it was just going to debilitate you for a minute, but when your life is going to end—as I often say, when you're dead, you're dead.

And so it reminds me of when—in my district, Johns Hopkins, one of the greatest hospitals in the world, doing a lot of great things—as a matter of fact, the hospital that saved my life—but I know that there are a lot of people outside of that hospital who just want to get in the door. They know the cure and the treatment is there. They just can't get in the door.

And so, to all of you, I want you to keep forging ahead. Keep in mind the words that I said and I want you to put them on the DNA of every cell of your brain: pain, passion, purpose.

Ms. McLinn, let me tell you something, you being here today, all of you, you're giving other people hope. You really are.

But we have a responsibility, too. We, up here, have a responsibility to make sure we give life to your hope—give life to your hope. And that little boy who's racing and I know—I just watch you as you talk about that hug and how precious that hug is, and what it means to you, and I assure you can hardly wait to get back to him, but when you come in here, Ms. McLinn and Ms. Skipper and all of you, and talk about what you are going through, but you're still forging on and that you're trying to help somebody else—by the way, keep in mind, it's not just you that you are seeking help for. And that's the thing I love about all of you. You said: You know, no matter what, I'm going to make life better for somebody else, too.

And so we're going to do everything in our power to help you get to where you got to go because life is precious. It really is precious.

And, Ms. Holt, as I listen to you, and you talked about sometimes feeling—or you gave the impression that at times you felt that your life was spiraling downward. That is not a good feeling. Not a good feeling when you've given so much in life over and over again. Taking care of—you're, what, a schoolteacher—and doing everything you were supposed to do. Everything you were supposed to do. And all you wanted to do was be able to hug your grandchildren, be able to go to the park sometimes, be able to—do you do texting? To be able to text them. You see, I'm a little—you and I are about the same age, so—I am challenged and don't mind admitting it. But the fact is those are basic things, just basic things. And so you want to be able to go down the aisle maybe with a daughter when she's getting married. You want to tell her how to wear her dress and what kind of shoes to wear. All that goes to the quality of life. And by the way, it's not just living; it's about living a quality life. A life of quality. And so, again, I thank all of you for being here.

I want to tell you—and this may make you feel some hope—we're going to have the drug company folks sitting in them same seats as soon as we come back. And we're going to try to understand some of why they're doing what they're doing. And I do believe that—by the way, as I close, the first conversation that I had with President Trump was something that he said, and I will never forget it. He said: The drug companies are getting away with murder.

That's what he said: getting away with murder.

And he's right. Because every time somebody cannot afford that medication, every time they have to share insulin and people have to share insulin and all the things that you've talked about, they are. And I'm not putting it all on the drug companies, but this is the United States of America. This is the greatest country out here, and we ought to be able to resolve these issues.

I want to thank the members for being here, and I cannot end this hearing without saying this, because it's been really bothering me: You know, we get a lot of complaints. We get a lot of dialog about our freshmen Members. And I got to tell you, the freshmen Members on our committee—Ms. Ocasio-Cortez, Ms. Tlaib, Ms. Pressley, Mr. Rouda, Ms. Hill—are some of the hardest working Members of the Congress, and I told somebody the other day that, as I listen to them, I am inspired because I realize that I'm marching toward the twilight of my life, but to know that they are there, that they will take up this mantle, and they will carry this ball down the field and get over that line—excuse me, for a football metaphor; I am a football fan—that means something to me. It is important to me. And so thank you very much.

And, with that, without objection, all members—did you want to say something else?

Without objection, all members will have five legislative days within which to submit additional written questions for the witnesses to the chair, which will be forwarded to the witnesses for their response. I ask our witnesses to please respond as promptly as you are able to. This hearing is adjourned.

[Whereupon, at 11:56 a.m., the committee was adjourned.]

