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THE NEED TO MAKE INSULIN AFFORDABLE FOR ALL AMERICANS

HEARING

OF THE

COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS

UNITED STATES SENATE

ONE HUNDRED EIGHTEENTH CONGRESS

FIRST SESSION

ON

EXAMINING THE NEED TO MAKE INSULIN AFFORDABLE FOR ALL AMERICANS

MAY 10, 2023

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C O N T E N T S

STATEMENTS

WEDNESDAY, MAY 10, 2023

THE NEED TO MAKE INSULIN AFFORDABLE FOR ALL AMERICANS

Wednesday, May 10, 2023

U.S. SENATE,
COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS,
Washington, DC.

The Committee met, pursuant to notice, at 1:02 p.m., in room 216, Hart Senate Office Building, Hon. Bernard Sanders, Chairman of the Committee, presiding.

Present: Senators Sanders [presiding], Casey, Baldwin, Murphy, Kaine, Hassan, Smith, Luján, Hickenlooper, Markey, Cassidy, Paul, Collins, Murkowski, Braun, Marshall, Romney, Mullin, and Budd.

OPENING STATEMENT OF SENATOR SANDERS

The CHAIR. The Senate Committee on Health, Education, Labor, and Pensions will come to order. And let me begin by thanking the CEOs of Eli Lilly, Sanofi, and Novo Nordisk, the three major manufacturers of insulin, for being with us today, as well as the heads of CVS Caremark, Express Scripts, and OptumRx, the three major pharmacy benefit managers.

They had to juggle their schedules, and we very much appreciate all of them for being here. I also want to take this opportunity to thank Eli Lilly, Sanofi, and Novo Nordisk for in recent months, as I think you all know, announcing a substantial reduction in their list prices for some of their insulin products.

This is an important step forward. For me, the bottom line of this hearing is not complicated. I don't care whether you are a Democrat, Republican, Independent, whatever you are, all over this country, people are saying enough is enough. They are sick and tired of paying outrageously high prices, not only for insulin, but for other products as well.

They want action, and this Committee is going to do what we can to respond to their needs, and we need the help of the people on the panel to do that. And as we gather today—and I know we have some advocates in the audience who have spent a great deal of time fighting to lower insulin costs.

We thank them for what they do. I think it is important that we acknowledge too many Americans who died because they rationed their insulin, 1.3 million Americans do that, and some of them died. Alec Smith was 24 years old, and he dreamed of opening a sports bar. He is dead because he could not afford insulin.

Antavia Lee Worsham was 22 years old and worked two jobs to support herself. She is dead because she couldn't support—she couldn't afford insulin. Allen Rivas was 20 years old and already lost his home because of insulin cost.

This young man is also dead. And these are just a few of many Americans who have needlessly lost their lives because of the outrageously high cost of insulin. Further, we must acknowledge the thousands of Americans who ended up in emergency rooms or hospital beds suffering from diabetic ketoacidosis, a very serious medical condition as a result of rationing their insulin. 1.3 million Americans in the richest country on Earth cannot afford insulin.

The Committee today is convening for two major reasons, in my view. One of them is a little bit personal. A couple of years ago, I took a trip from Detroit, Michigan, to Windsor, Ontario, with a busload of people. You know why I went? Windsor is a beautiful town. That is not why I went.

I went with those people in order to purchase insulin in Canada, which they were able to do for one-tenth of the price that they were paying in the United States of America—one-tenth of the price for the exact same product. And I will never forget as long as I live the tears coming out of a mother's eyes because she could suddenly afford insulin.

What I promised them is that they are not going to have to go to Canada or other countries to buy a lifesaving product, that in America we can make sure they get it here as well. And second, this Committee is not only going to be dealing with the crisis in insulin, we are going to do everything we can to end the outrage in which Americans, our people pay by far the highest prices in the world for virtually every brand name prescription drug on the market.

Whether it is a drug for cancer, for heart disease, for asthma, or whatever the illness, we end up paying the highest prices in the world. And we want to know why there are Americans who are dying or becoming much sicker than they should because they can't afford the medicine they need. Those are the questions that the members of our panel are going to have to answer today and in the future.

Today, one out of four Americans cannot afford the medicine that their doctors prescribe. That is beyond comprehension. And let's be clear, the high cost of prescription drugs not only impacts the health of individual Americans, but the budget of the United States of America.

If we paid the same prices for prescription drugs as major countries around the world were paying, we could save over $1 trillion in 10 years. I know many of my Republican friends are concerned about the deficit. I share that concern. Pay the same price as people around the world, you save $1 trillion over 10 years. That is real money.

Let's be clear, while Americans pay outrageously high prices for prescription drugs, the pharmaceutical industry and the PBMs make enormous profits every year. In 2021, ten major pharma-

ceutical companies in America made over $100 billion in profits, and their CEOs get very high compensation packages.

Last year, the three major PBMs in America made over $27 billion in profits. In other words, people in this country get sick. They can't afford the medicine. And yet the drug companies, the PBMs, make huge profits. In terms of insulin, let us not forget that a vial of insulin, and this is a vial of Humalog right here, costs less than $10 to manufacture, as I understand it.

Somebody will correct me if I am wrong. I think it is less than $10 bucks. Meanwhile, Eli Lilly increased the price of Humalog 34 times since 1996, from $21 to $275. The same exact product. No changes at all. Why did they do it? Because they could. Because nobody here has stopped them.

They can charge any price they want, and they did. But it is not just Eli Lilly. Novo Nordisk increased the price of Novolog 28 times from $40 in 2001, to $289. And Sanofi, a company that increased the price of Lantus 28 times from $35 in 2001, to $292. In every instance, it is the exact same product that rose—costs rose astronomically.

Let's be clear, this is a problem that is unique to the United States. In France, 20 years ago, the cost of Lantus was $40. Today it is $24, went down. This country, those prices soared. Meanwhile, as insulin manufacturers continue to increase prices, PBMs sign secret deals to increase their profits by putting insulin products on their formularies, not with the lowest list price, but the ones that gave PBMs the most generous rebates.

The good news is that was a result of a lot of public pressure, we have recently seen the major drug companies substantially reduce their prices, and that is good news. Eli Lilly announced it will reduce the price of Humalog by 70 percent.

Novo Nordisk announced that it reduced the price of Novolog by 75 percent. Sanofi announced that it will reduce the price of Lantus by 78 percent. It seems to me our job on this Committee is twofold.

First, we must make sure that these price reductions announced by the drug companies go into effect in a way that every American with diabetes gets the insulin that you need at an affordable price. And this Committee intends to hold a hearing next year to make sure that is, in fact, happening.

In other words, we just don't want words, we want actions. But lowering the cost of insulin is only part of what we must accomplish. This Committee must do everything possible to make sure that the American people no longer get ripped off by drug companies and PBMs. And we have got to ask some hard questions.

If Eli Lilly can lower the price of Humalog by 70 percent, why is it still charging the American people about $200,000 for Cyramza, a drug that treats stomach cancer? $200,000, but that same drug is sold in Germany for just $54,000. Why is that?

If Novo Nordisk can lower the price of Novolog by 75 percent, why is it still charging Americans with diabetes $12,000 for Ozempic when the exact same drug can be purchased for just $2,000 in Canada? If Sanofi can reduce the price of Lantus by 78 percent, why is it still charging cancer patients in America over

$200,000 for Caprelsa, a drug that can be purchased in Japan for just $37,000?

These are the questions that the American people are asking. They want to know why nearly half of all new drugs in America now cost over $150,000. Who can afford $150,000? What world are you living in?

How does it happen that cancer drugs, which in some cases cost just a few dollars to manufacture, a few bucks to manufacture, you guys are selling for $100,000? Really? Really? Do we not have any consciences, any moral values?

We got a lot of work to do in this Committee. And the bottom line is we want to—we appreciate the work being done on insulin. We thank all of the advocates out there for fighting. But we got to make sure that Americans can afford the price of prescription drugs.

With that, let me introduce, Senator Cassidy.

OPENING STATEMENT OF SENATOR CASSIDY

Senator CASSIDY. Thank you, Chair Sanders. In a sense, this is the culmination of a portion of my life. I went to medical school in New Orleans, did my residency in Los Angeles, and then treated patients in Baton Rouge, each time in a hospital for the poorly insured or for the uninsured.

Diabetes was a constant, but also the ability to afford the drug was a constant as well. And it has been interesting for me because I have seen the work that you have done, the technology that you, the drug companies, have put together that have made these medicines more convenient to take and have made it easier for the diabetic to manage their diabetes.

One—tip of a hat to you. But on the other hand, the ability, as we all know, the ability to afford the insulin is equally important as to the innovation that may have occurred because of obviously, if you cannot afford the innovation, it is as if the innovation has never occurred.

Now, 100 years ago, diabetes was a death sentence. In 1983, when I graduated from the medical school, a lot more difficult to control than now. So not only have we had the medical breakthrough, but we have had you come up with products that have made it easier for the diabetic to manage. I thank you for that. It goes without saying, in that time period, we have had a remarkable increase in the quality of life.

That the teenager going to high school is much better and much more managed, and therefore, she is more likely to take her drug, and we all thank you for that. But one more time, you have got to be able to afford the innovation.

Now we have to look at these, as Senator Sanders framed it, the issue is, is it the pharmaceutical manufacturers? Is it the pharmacy benefit manufacturers? That is the kind of discussion here. And that is why I am glad you are here.

When I go to church and people are pulling on my jacket, they want to know about drug prices. And if they are diabetic, they want to know about, what about the price of prescription drugs?

And if it is the parent of a diabetic, they are really pulling on my jacket. So, the PBMs, vertically integrated with the largest insurance companies in the world, managing about 80 percent of the prescription drug claims.

I have learned to say what I have been told, not what I know. But what I am told is that in recent years, the net price of insulin has actually decreased, even as the list price has increased. The money is going someplace. But the patient, particularly the patient who is in her deductible, is paying list price, and somehow the money is going from her pocket to folks who are far richer than she.

Now, I appreciate the roles that pharmacy benefit managers play. We had some Zoom hearings with academics come in and the academics all will state that, at their best, PBMs drive down net price for patients. So, I will stipulate that. But it is clear that the savings are not always reaching the patient, and that at times, particularly when she is in her deductible, she is really paying a lot. And that is when we hear the horror stories of folks that cannot afford.

To have the manufacturers, to have the PBMs here is just really wonderful. The goal of today's hearing is to find answers and to find solutions, not to point fingers, although there will be some finger pointing, it is Washington, DC, but on the other hand, to figure out what is going on and to address why are prescription drug costs so high, particularly for the issue of insulin, and what is the respective role of each of the players.

I suspect that if we realign incentives, we can actually find a way to benefit patients. I have learned in my—since graduating from med school way back in 1983 that oftentimes bad behavior is driven more by bad incentives than by bad actors. So, what can we do about those incentives?

Tomorrow, we will continue our markup on bills addressing PBMs and generic drugs. The goal is making sure—to try and make sure that everybody has access to these drugs and that they can afford it. But today is our opportunity to inform our legislation.

I am committed to working with my colleagues to find common ground on solutions that fulfill our objectives, and by the way, the President will sign into law and that the House of Representatives will pass.

This should be our goal. Once more, thank you for being here. I look forward to your testimony as to how you propose we can lower costs for American families. With that, I yield.

The CHAIR. Senator Cassidy, thank you very much. Our first witness is Mr. David Ricks. He is the Chair and Chief Executive Officer of Eli Lilly. Senator Braun, as I understand it, wanted to introduce Mr. Ricks, because he is from Indiana, where Eli Lilly is located. Senator Braun.

Senator BRAUN. Thank you, Mr. Chairman, Ranking Member Cassidy. Yes, I would like to introduce Mr. David Ricks, fellow Hoosier, CEO of Eli Lilly and Company. Indiana is a place of a lot of companies that have loomed large, not only in pharmaceuticals. We are the biggest manufacturing state per capita in the nation.

With experience ranging from sales to drug development, Mr. Ricks has served in a variety of domestic and global leadership roles with Lilly, most recently becoming its CEO in 2017. Eli Lilly was the first pharmaceutical manufacturer to commercially produce insulin and currently markets several forms of insulin.

Thank you so much for agreeing to be here in person to not only discuss your products, but you and I have had many discussions on what ails the industry in general, from hospitals to insurance companies, to pharmacies, PBMs within it, even practitioners.

A big lack of transparency, inherent competition that drives most other industries. So, thank you for being willing here today and to answer some of those questions.

The CHAIR. Mr. Ricks, you are recognized.

STATEMENT OF DAVID RICKS, CHAIR AND CHIEF EXECUTIVE OFFICER, ELI LILLY AND COMPANY, INDIANAPOLIS, IN

Mr. RICKS. Thank you, Chairman Sanders. Thank you, Senator Braun, for that introduction, Ranking Member Cassidy and distinguished Members of today's Committee. I am pleased to be here to participate in this hearing. My name is Dave Ricks. I am the Chairman and CEO——

The CHAIR. Mr. Ricks, can you hold that mic a little bit closer to your mouth, please.

Mr. RICKS. I am the Chairman and CEO of Eli Lilly and Company. I joined Lilly, an American company headquartered in Indiana, 26 years ago because I believed in our mission. Innovation is at the heart of what we do, particularly for people with diabetes. As has been said in 1920, type I diabetes was essentially a death sentence.

The first animal derived insulins, which Lilly introduced, extended life expectancy to a person's 30's. Today, after a century of innovation, life expectancy is now well into a person's 60's, but we are not done. Diabetes still significantly reduces people's life expectancies. And even with modern insulins and devices, two-thirds of people struggle to keep their disease under control.

There is more work to do, not only on diabetes, but on cancer, and on Alzheimer's, and other serious conditions. That is why Lilly invests 25 percent of our total revenue, this year $8.5 billion, into R&D that enables us to introduce new medicines. 19 In the last decade alone, including the world's first monoclonal antibody for COVID, and many more medicines coming in the pipeline.

In fact, just last week, we shared exciting results from a new study, studying out one of our medicines in Alzheimer's disease, which followed billions of dollars in investment, literally decades of work, and several failures that preceded it. Of course, medicines do no good if people can't afford them and access them.

That is why I am proud that we have led the industry in making insulin more affordable. Our efforts have driven what people pay for a month's supply of Lilly's insulin down to $20.48 per month, about $0.75 a day. And that was before our recent announcements, which will drive those averages even lower. We began these efforts years ago.

Lilly hasn't raised the list price of any Lilly insulin since 2017, the year I became CEO. We have only cut them. In 2016, we launched Basaglar, the first follow on biologic insulin in the United States at a discount to the original brand. In 2019, we launched Lispro, brought a box of it here with me today, a non-branded copy of our leading selling Humalog at a 50 percent discount.

We cut that price to 70 percent and then May 1st, it is now $25 a vial. And when the insurance system was not working for some people who need insulin, we were the first company to cap their out-of-pocket costs at $35 per month, now automatic where we are technologically possible. And I believe we are still the only company that will cap all of our insulins at $35 per month.

These efforts have saved people with diabetes last year $185 million, and year to date about 100,000 people per month, saving about $20 million for those 100,000 people. We have led the way on affordability against the headwinds of a health care system that unfortunately can incentivize others to prefer higher list price medicines.

Higher list prices, allow for higher fees and rebates, which can increase patients' out-of-pocket costs while benefiting employers, insurance companies, and people who don't use medicines. Lilly's Lispro is just one of many examples.

Even though it is identical to Humalog and costs 70 percent less, I have brought boxes of both here, only one in three people today in the United States have access to the lower priced Lispro, and a preference for higher prices over a lower priced product that is identical should never happen.

The list prices for insulin over time gets a lot of attention. But even before a recently announced price decreases, our net price of Humalog, what we take home after rebates and discounts was about the same as when we launched in 1996, accounting for inflation. Last year, about 80 percent of our list prices went to pay ever increasing fees and rebates to companies who don't invent, didn't develop, nor manufacture the medicine.

With the remaining 20 percent, we cover the cost of making and distributing the product, which also supports about 4,000 high paying manufacturing jobs here in America with full benefits and pensions. We finance our patient affordability commitments and also contribute 25 percent of that net revenue back into R&D for newer and better medicines, including insulin.

Reforms are needed. We need a system that supports both world leading innovation and lower out-of-pocket costs for Americans. Those reforms must help patients at the pharmacy counter, while also incentivizing U.S. companies to continue investing in world leading amounts of R&D, which results in Americans having access to more and newer medications than any other country in the world.

We are ready to continue to do our part at Lilly, and we are confident policy solutions are both simple and achievable. Thanks for having me today.

[The prepared statement of Mr. Ricks follows.]

PREPARED STATEMENT OF DAVID RICKS

Chairman Sanders, Ranking Member Cassidy, and distinguished Members of the Committee, thank you for the opportunity to participate in today's hearing. My name is David Ricks. I'm the Chair and CEO of Eli Lilly and Company.

I joined Lilly—an American company headquartered in Indiana—26 years ago because I believed in Lilly's life-saving and life-sustaining mission. Innovation is at the heart of what we do, particularly for people with diabetes. In the early 1920's, people with type 1 diabetes had a life expectancy of only a handful of years after diagnosis. With the first animal-derived insulin, Lilly extended life expectancy into a person's thirties. Now, following a century of innovation, life expectancy for people with type 1 diabetes is in their sixties.

But we're not done. Diabetes still significantly reduces a person's life expectancy. Even with modern insulin and devices, two thirds of people struggle to keep their disease under control. So there's more work to do, not only on diabetes, but also many other diseases like Alzheimer's and cancer.

That's why Lilly consistently invests 25 percent of our total revenue into research and development—$7.1 billion last year and $8.5 billion budgeted this year. That enables us to introduce new medicines—19 in the last decade, including the first Covid antibody therapy, and more medicines in the pipeline. Just last week, we shared exciting results from a study on a promising new Alzheimer's medicine, which followed approximately $8.5 billion in research and development for Alzheimer's and other neurodegenerative afflictions and literally decades of work, including previous late-stage failures of three other potential Alzheimer's medicines.

Of course, new medicines do no good if people can't access them. That's why I'm proud that we've led the industry in making insulin affordable. Because of our efforts, people pay an average of $20.48 for a month's supply of Lilly insulin—less than 75 cents per day—and that was before we recently announced a new series of actions that will drive that average even lower.

We began this effort years ago. Lilly hasn't raised the list price for any of our insulins since 2017, the year I became CEO. In fact, we've only cut them. In 2016, we launched the first follow-on biologic basal insulin in the U.S., Basaglar, at a discount to the original brand. In 2019, we launched Lispro, a nonbranded copy of our leading insulin Humalog, at a 50 percent discount, then later a 70 percent discount, and now only $25 per vial. And when we saw the insurance system was not always working for people who need insulin, we were the first and still only company to cap what people pay at $35 per month for all of our insulins—which is now automatic wherever possible—even when patients have no insurance or when their insurance would have forced them to pay much more. Our efforts are making a real impact—saving people with diabetes over $185 million last year and, so far this year, we're helping over 100,000 people save $20 million *each month*.

Lilly has led the way on affordability against the headwinds of a healthcare system that now incentivizes others to prefer higher list-price medicines. Higher list prices allow for higher fees and rebates, which can increase patients' out-of-pocket costs while benefiting insurance companies, employers, and people who don't need medicines.

Lilly's Lispro is just one of many examples. Unfortunately, many other actors still prefer the higher-priced Humalog (with its higher fees and rebates) to the lower-priced Lispro (with its lower fees and rebates). Today, only one in three people has access to Lispro through their insurance despite the fact that it cost 70 percent less and is identical to Humalog.

A lot of attention has been focused on increases in the list price for insulins over time. But even before our recently announced price reductions, our net price for Humalog—what Lilly receives after paying fees and rebates—was about the same as when we launched it in 1996, adjusting for inflation. List-price increases in the past went almost entirely to paying ever-increasing fees and rebates. Last year, about 80 percent of our insulin list prices went to paying fees and rebates to companies who didn't invent, develop, manufacture, nor study the medicine. Lilly got the remaining 20 percent. And with that 20 percent, Lilly not only covered the cost of making and distributing insulins—including supporting 4,000 high-paying manufacturing jobs with full benefits and pensions here in America—but we also paid for our out-of-pocket cap commitments and poured 25 percent of all of our revenues back into research and development for new medicines.

Reforms are needed. We need a system that incentivizes both world-leading innovation and lower out-of-pocket costs for Americans. Those reforms must help patients at the pharmacy counter, while also maintaining the incentive for U.S. com-

panies to continue to invest world-leading amounts into research and development—an incentive that results in Americans having access to more and newer medicines than any other country. We're ready to continue to do our part, and we're confident that policy solutions that will address the real underlying problems are possible and relatively simple. We look forward to continuing this important dialog.

A. Embracing the Next Century of Innovation

Innovation is woven into Lilly's fabric. In 1923, we introduced the world's first commercially available insulin, which was animal based and crude by modern standards. In the decades that followed, we helped pioneer significant advancements to enhance the purity, concentration, and delivery of insulin. In 1982, we launched Humulin, the first genetically engineered human insulin (and the world's first medicine created using recombinant DNA technology), ending concerns about whether there would be enough animal-based insulin to serve the growing number of people with diabetes. In 1996, we launched a new genetically engineered insulin, Humalog, which provides tighter blood sugar control with a lower risk of hypoglycemia. And we've continued to innovate throughout the last decade, including launching the rapid-acting mealtime insulin Lyumjev in 2020, which begins working faster than other mealtime insulins.

But our work is not done. Only one in three people living with diabetes has control over the disease. That's why we are not satisfied with treating people in the future with only the medicines available today. We are actively investing and working on new solutions for people with diabetes, that if successfully developed and approved, could make a significant impact. This includes a glucose-responsive insulin that can sense sugar levels in the blood and automatically activate as needed, and Basal Insulin Fc, a once-weekly basal insulin injection.

We outpace our competitors by consistently investing 25 percent of our total revenue in research and development. We invested $7.1 billion in 2022, and we plan to invest $8.5 billion this year. We employ more than 5,000 people in the U.S. in pharmaceutical research and development activities, including a substantial number of physicians, scientists holding graduate or postgraduate degrees, and highly skilled technical personnel. These are good-paying American jobs for people doing really good things. Over the last decade, we introduced 19 new medicines, and we hope to launch several more by the end of this year.

Lilly's investments cut across many major diseases like Alzheimer's, cancer, diabetes, and autoimmune diseases. Our neurodegeneration pipeline, for example, reflects thirty years and billions of dollars spent developing potential medicines for Alzheimer's and related afflictions—$8.5 billion in the last 15 years alone. We were proud to report, just last week, the exciting results of our Phase III clinical study for donanemab, our potential new Alzheimer's medicine, which will hopefully be approved by the FDA and covered by CMS soon. At 18 months compared to placebo, study participants on donanemab had a 40 percent less decline in their ability to perform activities of daily living, and participants on donanemab experienced a 39 percent lower risk of progressing to the next stage of disease. There's finally real hope on the horizon for patients and families ravaged by Alzheimer's.

Lilly's new Alzheimer's medicine is a testament to American ingenuity and American capitalism. Without our market-based system, Lilly's efforts to find a solution for Alzheimer's would never have been possible. Along this multi-decade project, Lilly proceeded to extraordinarily expensive late-stage clinical trials with three other drugs that, unfortunately, ended in failure. But we persevered and continued to pour resources into the effort motivated by the promise of filling this vast unmet medical need, which finally led to the success for the field and for people living with Alzheimer's that we reported last week. And we hope that all Americans who need it—including those in Medicare—will benefit from it, if approved. Under a system of socialized medicine that some advocate—where the government imposes artificial price controls, and it guides, directly or indirectly, the direction of medical research—Lilly's Alzheimer's efforts would have not been possible.

This experience is not unusual in the pharmaceutical industry. As with donanemab, all our groundbreaking medicines inevitably occur alongside exploration, trials, and billions of dollars in investment that do not result in FDA-approved medicines. The average cost to discover and develop a new medication is $2.6 billion, and the average length of time from discovery to the introduction of a new

medicine is 10 years.[1] 90 percent of drug candidates fail. But we believe those costs and struggles are worth it: they yield newer and better medicines that once were inconceivable for diseases that were once untreatable. They save and improve the lives of the patients we exist to serve.

Compared to those living in other countries, Americans benefit in unique ways from our market-based economy. Studies have shown that nearly 90 percent of new medicines launched are available to people in the United States,[2] and Americans get access to those new medications within 4 months of a medicine's launch[3]—rates that far exceed any other country. For example, Canadians typically wait 17 months to get access to new medicines and then only have access to about half of the newer branded medicines.

We should aspire to have a system that incentivizes *both* world-leading innovation *and* lower costs for patients. The U.S. market-based system produces the best results for patients because it efficiently allocates resources to accomplish breakthroughs that people need to survive and lead better lives. Alternative systems like socialized medicine starve innovation because price controls drain the incentive to make big and necessary investments, not to mention more intrusive tendencies to dictate research priorities.

Simply put, new medicines and scientific breakthroughs like donanemab would not be possible under any other system. And experience elsewhere tells us these other systems don't work. As trends in Europe toward socialized medicine increased, research and development spending there migrated to the United States. For example, Lilly alone will likely spend about the same on research and development this year as the entire country of Germany, which had a gross domestic product of over $4.2 trillion. We should protect the current system that continues to support that level of investment into the next generation of medicines that many so desperately need—and we can do it while enacting reforms that protect patients at the pharmacy counter.

Lilly prioritizes keeping as much of our research and development and manufacturing work in the United States as possible. We are proud to be a U.S.-based company—headquartered in Indianapolis for nearly 150 years—with nine production, distribution, and corporate administrative sites in the United States, and research and development facilities in five different states. Over the past 3 years, Lilly has invested $6.4 billion in U.S.-based manufacturing sites to deliver medicines to people worldwide. In 2022, we committed to invest more than $2 billion in new facilities in Indiana to manufacture existing and future medicines and more than $1 billion in a new facility in North Carolina to manufacture medicines and devices. Just last month, we committed to investing an additional $1.6 billion in our new Indiana facilities to support the manufacturing of several medicines. Lilly is also the only major insulin manufacturer that has end-to-end supply chain capability for insulin within the United States.

We are also proud of our research, development, and manufacturing to help Americans during the COVID–19 pandemic. We tested an existing medicine and developed new antibodies in record time, receiving Emergency Use Authorization for three COVID–19 therapies. Our manufacturing teams boosted Lilly's production of our COVID–19 antibodies from zero doses to nearly one million by the end of 2020—all while maintaining high quality standards. And we experienced no supply disruptions across our portfolio of medicines, despite unprecedented challenges.

B. Insulin Affordability—$35 Insulin and Lilly's Industry-Leading Solutions

We are tremendously proud of the work we have done to make Lilly's insulins affordable for everyone. Lilly led the way earlier this year in announcing we were reducing insulin prices, launching a new lower-priced biosimilar, and enhancing our efforts to ensure that all people have affordable access, regardless of their insurance status. We announced we are cutting the list price of Humalog and Humulin, our two most-popular insulins, by at least 70 percent. We embraced competition by launching Rezvoglar, a biosimilar to, and interchangeable with, a competitor's basal insulin (Lantus), at a 78 percent lower price. We also lowered Lispro's list price again, now to $25 per vial, making it the lowest list-priced mealtime insulin avail-

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[1] Eli Lilly and Company, *Key Facts* (2023), *https://bit.ly/3Fy2lNl*.

[2] *"New analysis shows that more medicines worldwide are available to U.S. patients*," PhRMA, June 5, 2018, *https://catalyst.phrma.org/new-analysis-shows-that-more-medicines-worldwide-are-available-to-u.s.-patients*.

[3] *Research and Development in the Pharmaceutical Industry*, Congressional Budget Office, April 2021, *https://www.cbo.gov/publication/57126*.

able and less than the price of Humalog in 1999. And we enhanced our efforts to cap out-of-pocket costs for all our insulins at $35 per month—a program we first introduced in 2020—by making it automatic for most people. That's $35 for all our insulins, regardless of the number of pens or vials someone needs in a month.

Our commitment to ensuring people have affordable access to insulin is not new. Over 25 years ago, in 1997, Lilly began supporting a separate charitable organization called Lilly Cares, which provides free Lilly medicines to people who qualify. Eligible people with a household annual adjusted gross income of up to 400 percent of the Federal poverty level, which for a family of four means an annual income of about $120,000, can receive insulin for free. [4]

Lilly has also introduced competition and lower list price insulins. In 2016, we launched the first follow-on biologic basal insulin, Basaglar, at a significant discount to Sanofi's Lantus, which created competition in the long-acting insulins market. In 2019, we introduced more competition, this time competing with ourselves, when we introduced Lispro. We launched Lispro at half of Humalog's list price, and then cut Lispro's list price again to 70 percent less than Humalog. Effective May 1 of this year, we further reduced Lispro's list price to $25-per-vial, which is *less* than the list price of Humalog in 1999.

Unfortunately, lower list prices don't necessarily translate to lower costs for people because the lower-priced medicines are not always available to insured patients due to their insurance plan design. Lilly has taken the lead in helping those left with high out-of-pocket costs. In early 2020, we introduced the Lilly Insulin Value Program. Under this program, people who have commercial insurance or no insurance at all can visit InsulinAffordability.com, click two checkboxes, and within seconds receive a savings card to fill their entire monthly prescription of any Lilly insulin for $35. And those without internet access can get the $35 card by calling the Lilly Diabetes Solution Center at 1–833–808–1234. Our $35 program does not require any application, waiting period, identifying information, or income thresholds. We made this solution even easier earlier this year by automating the $35 cap wherever possible for people with commercial insurance, so they no longer need to present the savings card to their pharmacist or even know the program exists. Whatever their insurance company would have charged them for their monthly supply of Lilly insulin, we buy it down to $35 automatically, with no action needed by the person filling the prescription.

We also partnered with the Centers for Medicare and Medicaid Services several years ago to pioneer the Medicare Part D Senior Savings Model, expanding our $35 solutions to Medicare. Under this program, seniors in participating plans can fill their insulin prescriptions for no more than $35 per month. This program is now the law of the land, as Congress has made Lilly's $35 monthly cap permanent for seniors in Medicare Part D. Congress can go further. We encourage Congress to make the same $35 monthly cap—which Lilly already provides—permanent for people with commercial insurance or no insurance at all, too.

Our programs work. Last year, our commitment to cap insulin costs saved people with diabetes over $185 million (which Lilly covers). And so far this year, each month, it saves 100,000 patients about $20 million. Lilly regularly supports these people at a loss—paying rebates *and* paying down someone's prescription at the pharmacy—sometimes losing hundreds of dollars on a prescription to ensure someone doesn't have to pay over $35 at the pharmacy counter. Because of our efforts over the past few years, in 2022, people paid an average of $20.48—less than 75 cents per day—for their entire monthly supply of Lilly insulin, and we expect that number to decrease further this year.

C. Insulin Highlights the Broader Structural Change that Is Needed

Unfortunately, one company alone cannot ensure everyone has affordable access to the medicines they need. Our healthcare system creates an incentive for other actors to prefer higher list prices. This incentive then shifts healthcare costs onto people with chronic illnesses to support lower overall premiums for those fortunate to be healthier—the opposite of how insurance is supposed to work. This isn't right. Until we address those underlying structural issues, we will not fix the problems at the root of high out-of-pocket costs.

Let me explain why. The vast majority of people have insurance coverage. They pay premiums, and their insurance is supposed to cover the cost of their medicines.

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[4] For more information about Lilly Cares, including available products and eligibility requirements, see *LillyCares.com*.

But often it doesn't. People increasingly need to pay for more of their medicines out of pocket, especially when they have a high deductible health plan, until they hit their deductible.

At the same time, Lilly wants to ensure that people have access to our medicines by including our medicines on formularies—the list that determines whether a person's medicines are covered by insurance at all. Getting on formulary is the best way to ensure most people can access our medicines affordably—once again, that's how insurance is supposed to work. But that requires manufacturers to pay ever-increasing rebates and fees, which can place upward pressure on medicines' list prices. If we cannot offer competitive rebates, our medicines may be excluded from formularies, and people cannot access them. Last year alone, to ensure our medicines were covered, Lilly paid more than $12 billion in rebates for all our medicines, and $1 billion in fees.

Last year, about eighty cents of every dollar spent on our insulins went to pay rebates and fees. Only 20 cents of each dollar went to Lilly, even though we create insulin and employ thousands of employees in the United States, who receive good salaries and benefits (including pensions) and work 24 hours a day to manufacture it. Our net price for insulin—again, what Lilly receives after paying increasing rebates and fees—is about the same today as when we launched Humalog in 1996 after adjusting for inflation. List price increases, which have not occurred after 2017, went to increases in rebates and fees to make sure as many people as possible had access to our insulin through their insurance.

This system does not help people who rely on our medicines. Some say that most of the rebates are passed on to health plans. We don't have the visibility to verify that, but either way it's one step short. Not enough of those savings are passed along to people at the pharmacy counter who are prescribed the rebated medicine. Instead, others in our healthcare system say they often use those dollars to lower overall premiums. In the case of chronic medicines like insulin, where people's prescriptions are generating rebates that don't help them at the pharmacy counter, this dynamic effectively "transfer[s] financial resources from sick patients to healthy premium-paying beneficiaries—the opposite of what insurance is supposed to do."[5] The chronically ill need our system's support; they cannot be responsible for subsidizing the healthy.

Some say manufacturers like Lilly should simply lower their list prices on insulin. We tried. But our experience proves that won't solve the problem. Again, in 2019, we launched Lispro, a nonbranded version of our most popular insulin, Humalog, for half the list price, and later further dropped its list price to 70 percent below Humalog and now only $25 per vial. We hoped others would be eager to make this lower-priced option available to people because it would reduce their out-of-pocket costs in the deductible phase of a high deductible health plan. Unfortunately, they did not. Today, only one in three insured Americans has a policy that covers Lispro, leaving patients with only higher-priced options. That's because Lispro's lower list price means other actors receive lower rebates and fees—fees tied to a percentage basis to the list price—even though the net cost to the health plan should be the same (or lower) regardless of whether they choose the high-or low-list price version *of the same medicine*.

Our experience refutes the argument some have made that our recent decision to reduce insulin prices shows we could always have done so without risking access for people with diabetes. In fact, it proves we were right to be worried. While many factors went into our recent decision, we saw an opportunity to accomplish our long-standing goal of delivering lower list-price insulins due to changes in market dynamics that we hoped might reduce the risk that our inability to offer high rebates would result in exclusion of our medicines from formularies. Still, in leading the way, we took a risk that lower prices would result in exclusion. We hope that doesn't happen.

The preference for high list prices is not unique to insulin or to Lilly. The link between rebates and higher list prices has played out with many other medicines, and this dynamic has been documented by recent government reports discussing

[5] *Testimony of Erin Trish, Ph.D.*, Senate Committee on Commerce, Science, and Transportation (Feb. 16, 2023).

medicines that treat asthma[6] and hepatitis C.[7] Earlier this year, for example, Amgen launched a Humira biosimilar at two different prices: 5 percent and 55 percent discount off of Humira's list price—the exact same medicine at two prices.

It was widely reported that other actors would likely favor the higher-priced option—just like they favored Humalog over Lispro.[8] These examples show that, while some say they want lower list prices, their actions show they often deny or limit coverage of lower-cost medicines, including generics and biosimilars.

D. We Can Achieve Meaningful Solutions through Simple Fixes

As these dynamics show, the affordability solutions that Lilly has implemented are a band-aid on a much larger problem. But fixes are not complicated, and we can have a system that incentivizes both world-leading innovation and lower costs for Americans. Reforms that target—and eliminate—the incentive for high list prices are necessary and can help provide long-term solutions for patients' out-of-pocket costs. That is why we advocate for policies that untether fees from list prices, ensure rebates for a medicine go directly to the people who use it, and increase transparency in the healthcare system.

Delink Fees and Price. We support removing the incentive for high prices by delinking other actors' revenue streams from a medicine's list price. Fees, rebates, and other payments in the healthcare system are often calculated as a percentage of list price. Higher prices mean they make more money, but the same services are performed whether a medicine is $10 or $100. We can fix that problem by ensuring that payments are based on the services actually provided, not a medicine's list price.

Ensure People Benefit from Rebates. No one should have to pay more for their medicine than their insurer pays. Payer negotiated discounts are typically passed fully to patients for all healthcare services, but not for medicines. Lilly believes any rebate it pays should be passed through to people at the pharmacy counter to offset the cost of their medicines, not to support someone's bottom line or to subsidize the healthy. Some states have already implemented this rule by requiring that rebates for any specific medication directly reduce out-of-pocket costs for the people using that medication. This approach would enable manufacturers' price concessions to flow directly to people and lower their costs at the pharmacy counter. Lilly has long supported this approach to reducing out-of-pocket costs, including in the context of the proposed rebate rule that was proposed 4 years ago and then legislatively delayed.[9]

Cost-Sharing Reform. Lilly supports reforming the cost-sharing structures in insurance plans. This could take the form of expanding the preventive medication lists on insurance formularies to include insulin, which would reduce the amount that people spend on insulin in the deductible phases of their plans and eliminate any risk that they may be exposed to the full list price for their medications. Today, many plans exempt insulin from the deductible requirement by including it on a preventative medicines list, which is an important step toward a more sustainable model that mitigates potentially high out-of-pocket costs that people with chronic illnesses may face. Finally, Lilly also supports legislation like the Affordable Insulin Now Act, which would cap the monthly out-of-pocket costs of all insulins at $35—a Federal solution that would make permanent part of what Lilly has already done on its own. Access to $35 insulin should not depend on whether the person has Medicare, commercial insurance, or is uninsured.

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[6] Medicare Payment Advisory Committee (MedPAC).Analysis of Part D Data on Drug Discounts and Rebates (Sept. 30, 2022), *https://pink.pharmaintelligence.informa.com/-/media/supporting-documents/pink-sheet/2022/10/medpac-slides-29-sept-2022.pdf-rev-293b80c5a8634f4985d4b69437b33593&hash-5BE40A6DF109D4432E1E09852C46DC7F*.

[7] Office of the Inspector General, HHS. *Part D Plan Preference for Higher-Cost Hepatitis C Drugs Led to Higher Medicare and Beneficiary Spending* (Aug. 2022), *https://oig.hhs.gov/oei/reports/OEI-BL-21-00200.pdf*.

[8] Silverman, Ed. *Amgen pricing for its Humira biosimilar may benefit PBMs and insurers more than patients* (Jan. 31, 2023), *https://www.statnews.com/pharmalot/2023/01/31/amgen-humira-biosimilar-pbm-rebates-insurers/*; *see also* Brennan, Zachary. *Amgen launches the first US Humira biosimilar at two different list prices* (Jan. 31, 2023), *https://endpts.com/amgen-launches-the-first-us-humira-biosimilar-at-two-different-list-prices/*.

[9] *See* HHS, Proposed Rule *Fraud and Abuse; Removal of Safe Harbor Protection for Rebates Involving Prescription Pharmaceuticals and Creation of New Safe Harbor Protection for Certain Point-of-Sale Reductions in Price on Prescription Pharmaceuticals and Certain Pharmacy Benefit Manager Service Fees*, 84 Fed. Reg. 2340 (Feb. 6, 2019).

Increase Transparency. We support additional transparency in the system. We commend legislation like the Pharmacy Benefit Manager Transparency Act of 2023, which encourages fair and transparent practices that benefit local pharmacies and consumers.

We at Lilly appreciate that the Committee shares our commitment to insulin affordability, and we will continue to do our part. We stand ready to work with this Committee—and all other actors and policymakers who share this goal—to find lasting and meaningful solutions.

Thank you for the opportunity to be here today. I look forward to your questions.

The CHAIR. Mr. Ricks, thank you very much. Our next witness is Mr. Paul Hudson, who is the Chief Executive Officer of Sanofi. Mr. Hudson, thanks for being with us.

STATEMENT OF PAUL HUDSON, CHIEF EXECUTIVE OFFICER, SANOFI, PARIS, FRANCE

Mr. HUDSON. Chairman Sanders, Ranking Member Cassidy, Members of the Committee, thank you for the opportunity to be here today. I am here to talk about what I hope is our shared goal, to deepen our understanding about how the health care system works and what can be done to improve it for patients. It is also an opportunity to dispel some misconceptions.

For example, insulin is sometimes described as a 100-year-old drug, but much like the cars bear little resemblance to the Model T, today's insulins are the result of years of research that have delivered significant improvements to patient outcomes and quality of life.

At Sanofi, delivering transformative medicines for patients is our strategic imperative, and it is the role that we, and the innovative biopharmaceutical industry, uniquely play for society. Shortly after I arrived at Sanofi, I committed to refocus our research and development on medicines with the potential to deliver first in class and best in class treatments across areas of unmet need.

Today, I am very proud of the progress we made in support of these goals. Earlier this year we announced positive results from a phase 3 study in COPD, the third leading cause of death worldwide. If approved, this medicine will be the first innovation for patients suffering from this disease in over a decade.

This fall, we anticipate the approval for the first immunization against RSV disease for all infants. With this immunization, the burden of RSV on providers and its toll on families may never happen again. Finally, we also recently launched Tzield, the first medicine proven to delay the onset of type I diabetes.

Over the next 50 months, we will learn the results of another 36 clinical studies, each with the potential to become a first or best in class medicine or vaccine. But these advances mean nothing if patients can't get the medicines they need. This is why I am equally proud of Sanofi's long-standing commitment to affordability.

We are transparent about our approach to pricing, including limiting our price increases, making medicines affordable through our patient assistance programs such as capping out-of-pocket costs on insulin at $35 for the uninsured, and launching low price versions of our insulins.

We recently announced our decision to reduce the list price of Lantus by 78 percent. This was not the first time we have offered a low-priced medicine to the system. Unfortunately, each time these medicines have received very limited coverage, resulting in limited benefits to patients. Because the system is largely driven by the financial structure that links rebates and fees to the list price.

For all the focus on the price of insulin, the list price is not the amount the system pays. In 2022, 84 percent of our gross insulin sales were returned to the system as rebates and fees—$0.84 on the dollar. In fact, since 2012, the average price of Lantus for commercial insurance and Medicare Part D plans has dropped by over 50 percent.

Yet out of pocket costs for people in these plans has increased by 45 percent. Today, the average amount the system pays for Lantus is lower than it was when it launched in 2001. Simply stated, while competition is working to drive down insulin prices for the system, those savings aren't reaching many patients.

Why aren't patients benefiting from the lower prices at the pharmacy counter? Well, today there are just three players in the system that cover 80 percent of American lives. These consolidated entities encompass pharmacy benefit management, health insurance, specialty pharmacies, and group purchasing organizations.

This vertical integration gives these corporations near-total control over the products that the patients can access and the price they have to pay. And each of these integrated entities benefits from the selection of high-priced products on formularies because the rebates and fees they receive are calculated as a percentage of the list price. I know the Committee is actively looking at solutions.

We welcome changes that will make the system work better for patients, while protecting the innovation ecosystem that allows new miracles to be developed and delivered to patients.

We have contributed in the past and we are willing to do so again. It starts with a holistic approach that fixes the misaligned incentives that drive the system's preference for high list prices. Specifically, delinking fees from the list price, and requiring rebates to be used to lower prescription drug costs for patients at the pharmacy. Otherwise, I simply worry that policy reforms will do little to help patients.

Thank you again. I look forward to answering your questions.

[The prepared statement of Mr. Hudson follows.]

PREPARED STATEMENT OF PAUL HUDSON

Chairman Sanders, Ranking Member Cassidy, and Members of the Committee, thank you for the opportunity to appear before the Senate Committee on Health, Education, Labor, and Pensions to discuss issues related to pricing, affordability, and patient access to insulin in the United States. I am Paul Hudson, the Chief Executive Officer of Sanofi.

I am here today to have an open discussion about the current system for pricing and accessing insulins in the U.S., the actions we have taken to improve patient access and affordability to our insulins, and, most importantly, what more can be done to make the system work better for patients and ensure every patient has affordable access to insulin.

I. Chasing the Miracles of Science to Improve People's Lives

At Sanofi, we work passionately to prevent, treat, and cure illness and disease, understand and solve health care needs of people across the world, and transform the practice of medicine. Our focus spans therapeutic areas, including immunology, oncology, rare diseases, rare blood disorders, neurology, diabetes, and cardiovascular diseases, as well as vaccines.

We employ approximately 14,000 professionals in the U.S. in a broad range of critical roles, including research and development, manufacturing, and business operations. Our most significant U.S. presence is in Massachusetts, where we are one of the largest employers in the life sciences industry, and in New Jersey. We also have major research and development (R&D), manufacturing, and business operations in Pennsylvania and Tennessee.

Last year, Sanofi spent more than $7 billion globally on R&D, reflecting our commitment to pursuing first-in-class and best-in-class medicines and vaccines that have the greatest potential to transform the practice of medicine, improve peoples' lives, and protect public health. With a strong focus on difficult-to-treat diseases and immunization, our R&D pipeline includes 84 clinical-stage projects, 26 of which are in phase 3 or have been submitted to regulatory authorities for approval.

Today, I am very proud of the progress we've made. Earlier this year, we announced positive results from a Phase 3 study in COPD, the third leading cause of death worldwide. If approved, this medicine will be the first innovation for patients suffering from this disease in over a decade. This fall, we anticipate approval for the first immunization against RSV disease for all infants. With this immunization, the burden RSV placed on providers and its toll on families may never happen again. Finally, we also recently launched Tzield, the first medicine proven to delay the onset of type 1 diabetes.

These treatments directed to meet unmet patient needs serve as an important reminder of the importance of fostering a policy environment that makes these breakthroughs possible.

Our responsibility includes demonstrating the value of our medicines through clinical data and real-world evidence, assuming massive risk to discover, develop, and deliver the medicines and vaccines that solve meaningful health problems for patients, and to enable continued investment in the innovation cycle.

II. Evolution in Insulins

Sanofi's innovations in diabetes, and, specifically, for insulin, have been significant. Much like modern cars bear little resemblance to Ford's Model T, the variety of insulin products available for diabetes patients today reflects years of research that have led to significant improvements over early formulations.

The earliest insulin preparations were limited by their short duration of action, requiring patients to inject themselves multiple times a day and wake up at night for injections to control blood glucose levels.

We are proud at Sanofi of our innovation history in insulin and the meaningful ways in which this has transformed the standard of care for patients, from the introduction of Lantus, which provided significant improvements in basal insulin levels, to the introduction of Toujeo®, a next generation basal insulin that more closely mimics the body's endogenous insulin secretions, among others. In addition to delivering meaningful innovation in the types of insulin available to patients, we are proud of the role we have played in transforming the patient experience through the development of devices to ease the daily burden of insulin administration, allowing for fewer injections and, in some cases, fewer refills and related patient copays.

Today, our goal is to transform diabetes care by treating not just symptoms but addressing the underlying disease. We are attempting to understand and disrupt the immunological triggers for the development of diabetes through several partnerships, including the recent launch of a groundbreaking medicine TZIELD, which is approved in the U.S. as the first and only therapy to delay the onset of Stage 3 type 1 diabetes in adults and pediatric patients aged 8 years and older with Stage 2 type 1 diabetes.

III. Sanofi's Commitment to Responsible Pricing

Pharmaceutical innovation brings value to patients, our society, and our health care systems. Our responsible approach to pricing reflects our medicines' value, and

our commitment to patient access and to minimizing our contribution to health care inflation.

In May 2017, Sanofi announced our commitment to sustainable pricing through our progressive and industry-leading principles. This commitment includes transparency to help stakeholders understand our pricing decisions and to advance a more informed discussion regarding our approach to pricing our medicines. [1]

We hold ourselves to a rigorous and structured process, that includes consultation with external stakeholders, when we set the price of a new medicine. Our approach considers the following factors:

- **A holistic assessment of value**, including (1) clinical value and outcomes, or the benefit the medicine delivers to patients, and how well it works compared to standard of care treatments; (2) economic value, or how the medicine reduces the need—and therefore costs—of other health care interventions; and (3) social value, or how the medicine contributes to quality of life and productivity. Our assessments rely on a range of internal and external methodologies, including health technology assessments (HTAs) and other analyses that help define or quantify value and include patient perspectives and priorities.
- **Similar treatment options** available or anticipated at the time of launch, in order to understand the landscape within the disease areas in which the medicine may be used.
- **Affordability**, including the steps we must take to promote access for patients and contribute to a more sustainable system for payors and health care systems.
- **Unique factors** specific to the medicine at the time of launch. For example, we may need to support ongoing clinical trials to demonstrate the longer-term outcomes of our medicines, implement important regulatory commitments, or explore opportunities to improve care management/patient experience and help decrease the total cost of care.

When evaluating whether to change the list price of any of our medicines, including our insulin products, we consider four factors:

- Our ambition to chase the miracles of science to improve people's lives and ensure patients have access to the medicines they need now and in the future;
- Patient affordability;
- Government policies, including inflation penalties enacted under the Inflation Reduction Act; and
- Evolving trends in the marketplace.

In 2020, 2021, and 2022, Sanofi did not increase the list price of any of its insulin products. [2]

The table and graph below demonstrate how our responsible approach to pricing has been put into action, with limited list price increases resulting in an average aggregate net price decline every year since Sanofi started reporting data in 2017—even as consumer inflation has increased prices on other goods and services:

The net price paid to Sanofi for our products has declined for seven consecutive years:

Year	Average Aggregate List Price	Average Aggregate Net Price
2016	4.0 percent INCREASE	42.1 percent DECREASE
2017	1.6 percent INCREASE	8.4 percent DECREASE
2018	4.6 percent INCREASE	8.0 percent DECREASE
2019	2.9 percent INCREASE	11.1 percent DECREASE

[1] For more information on our Responsible Pricing policies and initiatives, please see our "Sanofi 2023 Pricing Principles Report," at *https://www.sanofi.us/dam/jcr:356cc1f592dd47a19770-ba60dfdfab1e/Sanofi2023-Pricing-Principles-Report.pdf*.

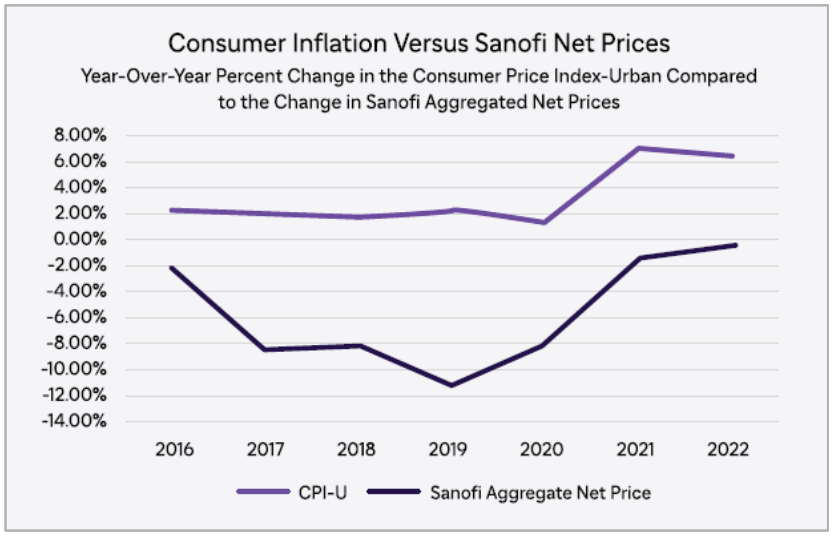
[2] Price increases on Sanofi's combination product, Soliqua®, have been within the National Health Expenditures (NHE) growth rate, a measure of medical inflation.

The net price paid to Sanofi for our products has declined for seven consecutive years:—Continued

Year	Average Aggregate List Price	Average Aggregate Net Price
2020 [3]	0.2 percent INCREASE	7.8 percent DECREASE
2021	1.5 percent INCREASE	1.3 percent DECREASE
2022	2.6 percent INCREASE	0.4 percent DECREASE

[3] Price increases or reductions that are taken mid-year may have an impact in two calendar years. In our 2019 pricing report, Sanofi announced that it took a price reduction on Admelog® (insulin lispro injection) 100 Units/mL in July 2019. The 2020 carryover impact of that change is not included in the 2020 Average Aggregate List Price above. If included, the 2020 Average Aggregated List Price change vs. 2019 would have been effectively zero percent, and the Average Aggregate Net Price would decrease by 8.0 percent.

U.S. Portfolio Annual Aggregate Price Change from Prior Year [4]



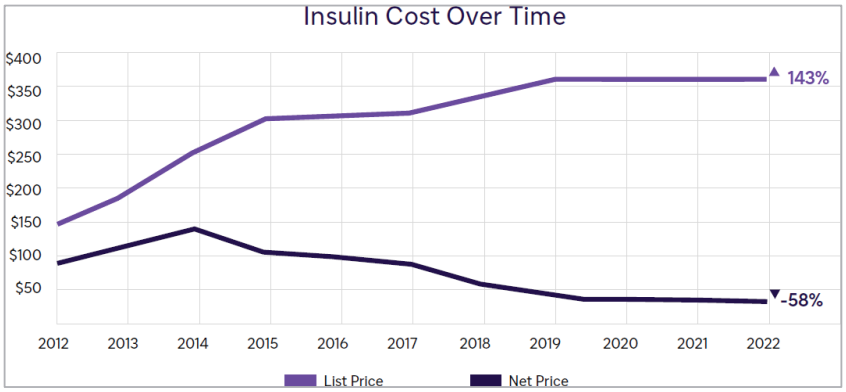
A. List Prices versus Net Prices

While list price often receives the most attention, it simply reflects the initial price Sanofi sets for a medicine. It is not the amount Sanofi receives, nor the price typically paid by government and commercial insurers, employers, pharmacy benefit managers (PBMs), or patients. Manufacturers, including Sanofi, pay significant discounts, rebates and fees—often as a percentage of a medicine's list price—to different stakeholders across the health care system with the goal of ensuring our medicines are available to patients at affordable prices. Payors, including their PBMs and government and private insurance plans, ultimately decide which medicines to make available to patients through their plans in part based on the discounts and rebates we give them for each of our medicines. **In 2022 in the U.S., across all insulin medicines, Sanofi returned 84 percent of our gross insulin sales to payors as rebates**.

Due to increased competition, including from biosimilars, the growth of rebates for insulins has been significant. Sanofi is committed to making transparent both the average aggregate list and net price changes across its portfolio to help illustrate how revenue accrues to Sanofi versus other parts of the pharmaceutical supply chain, highlighting our discrete role in the broader U.S. health care environment and enabling a better-informed discussion on solutions to improve patient access and affordability. Between 2012–2022, the net price for commercial insurance and Medicare Part D plans for our most prescribed insulin, Lantus®, has fallen by 55

[4] Aggregated across Sanofi's prescription portfolio.

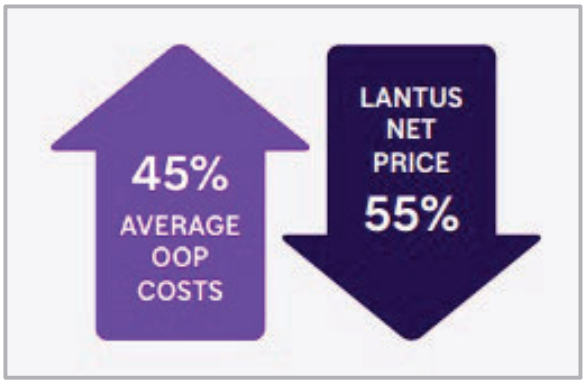
Medicare Part D plans for our most prescribed insulin, Lantus®, has fallen by 55 percent. **In fact, the average net price of Lantus® is lower today than it was in 2004**.



B. The Growing Disconnect Between Net Prices and Patient Out-Of-Pocket Costs

Unfortunately, there is a growing disconnect between net prices and patient out-of-pocket costs.

Indeed, despite the significant decrease in net price, the average out-of-pocket costs for Lantus® for patients with commercial insurance and Medicare have risen approximately 45 percent since 2012. Although PBMs frequently pass rebates on to their plan clients, health plans are placing more of the cost burden on patients through benefit designs that include high deductibles, coinsurance, and multiple cost-sharing tiers—often coupled with narrower drug formularies offering fewer choices in covered medicines.



For individuals on health plans provided by employers, average patient spending on deductibles has increased by 61 percent from 2012 to 2022.[5] Such high cost-sharing, particularly for highly rebated therapies like insulin, creates a financial barrier for patients, making it difficult to obtain essential treatments without the manufacturer's financial assistance programs. Rather than lowering out-of-pocket costs for medicines, plans often use rebates to subsidize premiums or other costs. As a result, the chronically ill in this country subsidize insurance costs for the healthy.

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[5] Kaiser Family Foundation (KFF), *2022 Employer Health Benefits Survey* (Oct. 27, 2022), *https://www.kff.org/report-section/ehbs–2022-summary-of-findings/*.

At the same time, there has been significant consolidation across the system. As a result, PBMs, insurers, wholesalers, specialty and retail pharmacies, group purchasing organizations, and, more recently, provider groups, are now increasingly under common corporate ownership, with three consolidated entities now covering 80 percent of American lives.

In addition to rebates, many of these intermediaries require manufacturers to pay fees, and other payments based on a percentage of a medicine's list price which are increasing in scope and amount. Today, we pay administrative fees, data fees, and GPO fees, among others, to ensure access to our medicines. Over the past 10 years, both the scope and quantity of these fees have grown and are an increasing source of revenue for the various intermediaries in the system [6].

Can the system do more to use the value extracted from manufacturers to lower costs for all patients at the pharmacy counter? We believe the answer is yes. We support policies requiring all fees to be calculated based on a flat payment, otherwise the incentive in the system of high list prices will continue.

C. Sanofi's Lower List Price Insulins

Sanofi's recent announcement regarding lowering the list prices of Lantus® and Apidra® is just the latest in a series of actions we have taken to introduce lower list price products. Sanofi has previously launched two insulin products at prices well below other available therapies, but as described below, our experience demonstrates that the current incentives in the system led to limited uptake of our lower list price options.

In 2018, Sanofi launched Admelog®, a follow-on biologic to Eli Lilly's Humalog®, at a list price that was 15 percent lower than the reference product. In July 2019, Sanofi reduced the list price of Admelog® by 44 percent and then again by another 25 percent in January 2022. Despite Admelog® launching at the lowest list price among mealtime insulins and subsequent list price cuts, we continue to see very limited coverage of Admelog® by PBMs and health plans.

Similarly, in June 2022, we launched the unbranded biologic Insulin Glargine Injection 100 Units/mL (U–100)—an insulin identical to Lantus®—at a list price 60 percent less than the 2022 list price of Lantus®. As with Admelog®, commercial and Medicare coverage for our unbranded Insulin Glargine Injection has been limited, with less than 25 percent of commercial and 5 percent of Medicare Part D plans choosing to cover the lower list price version in 2023, even though we offered this version at a similar net price to Lantus.

It appears that the reason these low-priced options have not had broad uptake in the system stems from the precise issues outlined above: because many intermediaries in the pharmaceutical supply chain require manufacturers to make payments based on a percentage of a medicine's list price, rather than as a flat fee, they generate more revenue from high list price medicines. These perverse incentives drive the system's preference for higher cost medications, even if some patients have to pay more out-of-pocket. Until there is a commitment by the full supply chain to make the system work better for patients or policies are enacted to remove these perverse incentives, the reality is that lower list prices will have limited benefit for patients and may lead to reduced coverage and access for lower-priced products.

IV. Sanofi's U.S. Affordability and Access Programs and Initiatives Related to Diabetes and Insulin

A. Sanofi's Affordability Programs and Initiatives

As stated above, systemic reform is necessary so that patients can access lower costs at the pharmacy counter. But these challenges have not stopped Sanofi from doing our part: within the confines of the system, we have developed and evolved a suite of innovative and patient-informed savings programs to help people reduce their prescription medicine costs, regardless of their insurance status or income level. Each of our programs is tailored to a specific population and designed within the parameters of U.S. legal and regulatory requirements. We broadly inform patients and providers about the availability of these programs through a number of different avenues and continue to look for additional ways to educate the public about their availability so that all eligible patients have access to them.

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[6] *https://wendellpotter.substack.com/p/unitedhealth-cvsaetna-cigna-pulled*.

We are proud that our actions to improve access and affordability have benefited millions of patients, but we are not satisfied stopping here—we are continually listening to patients, patient advocates, caregivers, and others to better understand additional actions we could take to address ongoing and/or emerging access or affordability challenges. As we have done several times in the past, Sanofi will continue to review and evolve these programs to better serve and improve affordability for our diabetes patients.

1. Copayment Assistance Programs

Sanofi offers copayment assistance programs for its insulins and other products covered on commercial formularies. These programs aim to lower out-of-pocket costs for commercially insured patients regardless of income level, and eligible patients can enroll online or over the phone in only a few minutes.[7] Through these programs, in 2022, the majority of participating patients paid $15 or less for their diabetes medicines. Beginning January 1, 2024, all commercially insured patients who fill their Lantus® prescriptions at participating pharmacies will be auto-enrolled in this program and will not pay more than $35 for a monthly supply.

In 2022, across Sanofi's diabetes medicines, patients used a Sanofi copay assistance card more than 582,000 times at the pharmacy counter, saving more than $70 million.

2. Insulins Val*you* Savings Program

In 2018, Sanofi launched the Insulins Val*you* Savings Program to lower out-of-pocket costs for uninsured patients who pay cash for their insulin. This program helps patients, regardless of income level, who are exposed to high out-of-pocket prices at the pharmacy counter and who do not qualify for Sanofi's free drug or other patient assistance programs. In June 2019, Sanofi expanded this program to provide eligible patients with a predictable and affordable monthly out-of-pocket cost for any combination of Sanofi insulins, regardless of the quantity they need.

Today, our Insulins Val*you* Savings Program allows uninsured patients with a valid prescription to buy any combination and amount of Sanofi insulins (Lantus®, Insulin Glargine Injection, Toujeo®, Admelog®, and Apidra®) for $35 per 30-day supply[8] Eligible patients can enroll online or over the phone in only a few minutes.

In 2022, patients used the Insulin Val*you* Savings program more than 98,000 times, resulting in savings of almost $44 million.

3. Sanofi Patient Connection Free Drug Program

Sanofi Patient Connection is a patient assistance program (PAP) that provides free Sanofi medicines, including insulin,[9] to low-and middle-income patients earning greater than or equal to 400 percent of the current Federal Poverty Level (in 2023, $120,000 for a family of 4), including Medicare beneficiaries, who meet eligibility criteria.

In 2022, more than 53,000 patients received free diabetes medicines through the PAP, valued at more than $185,000,000.

B. Sanofi's Efforts to Promote Awareness of its Affordability Programs

Sanofi has taken steps to increase awareness of these affordability programs so that as many eligible patients as possible may benefit from them. Sanofi includes

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[7] U.S. Department of Health and Human Services' Office of the Inspector General (HHS-OIG) has issued guidance stating its view that, under the Federal Anti-Kickback Statute, manufacturers cannot offer co-pay support through manufacturer-sponsored programs for prescriptions covered by Federal healthcare programs, such as Medicare and Medicaid. *See* HHS-OIG, "Special Advisory Bulletin: Pharmaceutical Manufacturer Copayment Coupons" (May 2014), *available at https://www.oig.hhs.gov/fraud/docs/alertsandbulletins/2014/SAB-Copayment-Coupons.pdf*. Consistent with this guidance, Sanofi does not make its co-pay card programs available to patients covered by Federal healthcare programs. Sanofi supports policy changes that would expand these financial out-of-pocket support programs to all patients who might benefit from copay assistance.

[8] Additionally, through the Soliqua® co-pay card, uninsured patients can pay $99 per box of pens for up to two boxes of pens for a 30-day supply.

[9] Sanofi Patient Connection provides eligible patients with access to free supplies of Admelog®, Apidra®, Lantus®, Soliqua® 100/33, and Toujeo® SoloStar®, among other Sanofi medicines and vaccines.

descriptions about how to enroll in applicable affordability programs on each medication's website and on the Sanofi Patient Connection website. We also promote these assistance programs directly to patients through social media platforms and syndicated, direct-to-consumer advertisements in local newspapers and radio stations. Sanofi shares program information with patient advocacy groups which then publish that information on their websites and otherwise share program details with their members. Specifically, Sanofi meets with more than a dozen advocacy stakeholders at least quarterly to share information and updates about Sanofi's programs and other information that may benefit patients and to obtain feedback about affordability and access barriers.

Sanofi also has partnered with other organizations to disseminate information about its affordability programs. For example, Sanofi's affordability programs are included in the Pharmaceutical Research and Manufacturers of America's (PhRMA) Medication Assistance Tool (MAT), a search engine designed to help patients, caregivers, and healthcare providers locate patient assistance resources offered by biopharmaceutical manufacturers. Information about Sanofi's affordability programs is also available at *GetInsulin.org*, an online tool created by the patient advocacy organization Beyond Type 1 to connect diabetes patients in the U.S. with insulin access and affordability options, as well as other resources to support diabetes care and management that match a patient's particular circumstances. Last, information about Sanofi's affordability programs are accessible through GoodRx's platform and Optum Store's digital pharmacy platform.

C. Participation in the Part D Senior Savings Model

Before the Inflation Reduction Act (IRA) capped insulin out-of-pocket costs in Medicare, Sanofi worked with the Centers for Medicare and Medicaid Services (CMS) Innovation Center to support the creation of the Medicare Part D Senior Savings Model. Launched in January 2021, the Senior Savings program enabled Medicare beneficiaries to access insulins at a maximum $35 copay for a month's supply. Based on CMS's estimates, beneficiaries who used insulin and enrolled in a plan that participated in the Model could see an average out-of-pocket savings of $446 or 66 percent annually, funded in part by an estimated additional $250 million in discounts from manufacturers over the 5-years of the model.

V. Market-Based Policy Solutions to Address Patient Access and Affordability

Sanofi is committed to working with Congress and other stakeholders to identify market-based policy solutions that will incentivize a high-value and sustainable healthcare system that improves the affordability of innovative medicines in the U.S. and in which the patient truly benefits. By establishing policies that encourage competition and align incentives so the value driven by competition accrues to patients, we can accomplish our shared goal of lowering drug prices and patient costs, while also protecting and cultivating the entrepreneurial risk-taking necessary for pharmaceutical manufacturers to continue to discover, develop, and bring to market life-saving new medicines.

Reducing out-of-pocket costs for patients should remain a top priority, but as we have experienced, limiting launch prices or reducing the list price of medicines alone is not sufficient to solve this problem. We support Congress' recent reforms to the Medicare Part D benefit that cap patient out-of-pocket costs and allow beneficiaries to spread their payments across the benefit year. There are a number of additional policy options that could effectively reduce out-of-pocket costs for patients, including:

- Requiring at least a substantial portion of the discounts and rebates paid by manufacturers to be used to reduce costs for patients at the pharmacy counter (not simply passed through to plans, which is common today), such as requiring any coinsurance amounts be based on the net price and not the list price.
- De-linking fees (e.g., wholesaler and retailer fees, and PBM and group purchasing organization (GPO) administrative fees) from list price, which would remove the perverse incentives that sometimes feed the cycle of higher list prices paired with higher rebates and fees and create impediments to patient access to lower list price medicines.
- Prohibiting commercial health insurance plans from misappropriating patient-directed savings through accumulator, maximizer, and alternative funding programs, and requiring commercial payers to designate all cov-

ered drugs as "essential health benefits" and count manufacturer copay coupons toward any plan deductible and/or out-of-pocket limit.
- Prohibit the use of spread pricing to save money and ensure everyone is getting the best deal possible.
- Let people get the medicines their doctors prescribe at a pharmacy that is most convenient for them, not one that makes the middleman more money.

Our shared goal of lowering drug costs while maintaining the innovation engine of the U.S. to bring novel, beneficial medicines to patients will not be fully realized if policies are enacted that solely target the list price of medicines. Without a holistic approach that addresses current system incentives favoring higher list prices, as well as common-sense patient protections paired with continued incentives for innovation, U.S. health system challenges, including access and affordability of medicines, will not be adequately addressed. For our part, we will continue to listen to patients, patient advocates, caregivers, and others to better understand additional actions we could take to address access and affordability.

* * *

I look forward to having a productive conversation about the complexities of the current system and policy solutions to improve affordable patient access to medicines.

Thank you for the invitation to speak with you today. I welcome the opportunity to work with you on this important issue.

[SUMMARY STATEMENT OF PAUL HUDSON]

Sanofi is committed to pursuing first-in-class and best-in-class therapies and vaccines that have the greatest potential to transform the practice of medicine, improve peoples' lives, and protect public health. In particular, Sanofi is proud of our innovation history in insulin and the meaningful ways in which our products have transformed the standard of care, from Lantus®—which provided significant improvements in basal insulin levels—to Toujeo®—a next generation basal insulin that more closely mimics the body's endogenous insulin secretions. Today, our goal is to transform diabetes care by treating not just symptoms but addressing the underlying disease.

However, these scientific advances mean nothing if patients cannot access or afford the medicines they need. For this reason, Sanofi is equally committed to increasing patient access and affordability through responsible and transparent approaches to pricing.

- We also have a suite of innovative and patient-informed savings programs to help people reduce their prescription medicine costs, regardless of their insurance status or income level, as well as launched low-priced insulins.
- In May 2017, Sanofi announced our progressive and industry-leading pricing principles to help stakeholders understand our rational for pricing decisions. [1]

But we cannot solve patient affordability challenges on our own. Broader systemic reforms are needed to address the perverse incentives in the system that favor higher list price products and ensure patients benefit from the robust competition driving down net prices.

Manufacturers negotiate with plans through their pharmacy benefit managers (PBMs) to obtain affordable health plan coverage for their products. In recent years, there has been significant consolidation across the system creating three players. These entities also have integrated with other intermediaries in the supply chain.

- As a result, PBMs, insurers, wholesalers, specialty and retail pharmacies, group purchasing organizations, and, more recently, provider groups, are now increasingly under common corporate ownership that covers 80 percent of American lives.

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[1] For more information on our Responsible Pricing policies and initiatives, please see our "Sanofi 2023 Pricing Principles Report,"*https://www.sanofi.us/dam/jcr:356cc1f5-92dd-47a1-9770-ba60dfdfab1e/Sanofi-2023-Pricing-Principles-Report.pdf*.

While medication **list price** often receives the most attention, it is not the price that Sanofi receives for its medicines, nor the price typically paid by the system.

- With the goal of ensuring our medicines are available to patients at affordable prices, Sanofi pays significant rebates and fees—often as a percentage of a medicine's list price—to different intermediaries across the healthcare system. Across all insulin medicines, **Sanofi returned 84 percent of our gross insulin sales to payors as rebates in 2022**.
- In fact, since 2012 the **net price**—the amount Sanofi actually receives—of Sanofi's insulins has **declined by 58 percent**.
- The average **net price** of Lantus® is lower today than it was in 2004.

Unfortunately, patients do not always benefit from falling net prices. In fact, benefit plan design increasingly places greater cost burden on patients through high deductibles and copays—often coupled with narrower drug formularies offering fewer choices in covered medicines.

- For example, between **2012–2022, the average net price** for commercial insurance and Medicare Part D plans for our most prescribed insulin, **Lantus®, has fallen by 55 percent**
- Over that same period, **the average out-of-pocket costs for Lantus** patients with commercial insurance and Medicare **have risen approximately 45 percent**.

In addition to rebates, Sanofi also pays fees to intermediaries based on a percentage of a medicine's list price. Thus, these intermediaries generate more revenue from higher list-price medicines. These perverse incentives drive the system's preference for higher cost medications, even if patients have to pay more at the pharmacy counter.

Sanofi has experienced these perverse incentives first hand, with the system expressing little interest in our lower-cost insulins. For example, in June 2022, Sanofi launched Insulin Glargine Injection 100 Units/mL (U–100), an unbranded version of Lantus, at a list price 60 percent less than the 2022 Lantus list price. Despite the lower price offered at a similar net price, commercial and Medicare coverage has been limited, with less than 25 percent of commercial and 5 percent of Medicare Part D plans choosing to cover the lower list price version in 2023.

Future policy solutions must put patients first and include contributions from across the entire healthcare system. Sanofi supports:

- Requiring at least a substantial portion of the discounts and rebates paid by manufacturers to be used to reduce costs for patients at the pharmacy counter, such as requiring any coinsurance amounts be based on a medicine's net price and not the list price; and
- De-linking supply chain payments to intermediaries in the supply chain from list price, which would remove the perverse incentives to favor higher list price products when lower list price options are available.

The CHAIR. Mr. Hudson, thank you very much. Our next witness is Mr. Lars Jorgensen, who is the President and CEO of Novo Nordisk. He is going to be speaking to us virtually from, not sure, Denmark is that where you are now? Yes. All right.

Mr. JORGENSEN. Yes, that is correct.

The CHAIR. Thank you very much, Mr. Jorgensen, for being with us.

STATEMENT OF LARS FRUERGAARD JORGENSEN, PRESIDENT AND CHIEF EXECUTIVE OFFICER, NOVO NORDISK, BAGSVAERD, DENMARK

Mr. JORGENSEN. Chairman Sanders, Ranking Member Cassidy, and Members of the Committee, thank you for the opportunity to speak today on behalf of Novo Nordisk. Our mission is to pioneer scientific breakthroughs and ultimately cure the diseases we re-

search. We share the Committee's concern that too many people fall through the cracks of the U.S. healthcare system.

We hope today's conversation will lead to meaningful action. But I should begin by briefly introducing myself. I grew up in small rural town in Denmark. My sisters and I helped my parents around the family farm. That early experience taught me to take responsibility and to work hard not only for myself but also for others.

I joined Novo Nordisk almost 32 years ago and went on to work for the company in the Netherlands, the U.S., and Japan, before I returned to headquarters in 2004. By then, my father had been diagnosed with diabetes, so I know the disease both professionally and personally. I am humbled to serve as CEO of a company that always keeps the patient at the center of everything we do.

Our company was born out of a love story between two Danish scientists, August and Marie Krogh. When Marie developed diabetes, the company embarked on a path to find a cure. This journey is where Novo Nordisk's commitment to treat and defeat diabetes began.

Today, Novo Nordisk is comprised of more than 55,000 colleagues worldwide. It is not well-known, but our majority shareholder is the Novo Nordisk Foundation. Just last year, the Foundation awarded almost $1 billion worldwide.

Some of these projects support research partnerships between industry and academia here in the United States, while others focus on cutting edge innovations around quantum computing and drug resistant bacteria. We are proud of our company's financial success, and it fuels the Foundation's work.

As we have worked to treat and cure diabetes for over a century, I would like to address an often missed—often repeated misconception that insulin is still the same as it was back in 1921. Nothing could be further from the truth.

100 years ago, patients were supplied with large, reusable needles, glass syringes, and a whetstone to keep the needle sharp. They boiled the needle between uses and insulin had to be injected repeatedly throughout the day and night.

Early insulin saved lives, but it was difficult to use and came with serious risks. While the advancements in insulin may seem minor or insignificant to those of us who do not have diabetes, patients tell us how our inventions have meaningfully improved their lives.

We also know that no matter how pioneering a drug might be, it can only help patients when it is accessible and affordable. No one who needs insulin should have to ration or go without it because they cannot afford it. That should never be the case. Novo Nordisk has worked hard to fill the gaps of the U.S. healthcare system, but we know that the problem remains.

That is why we are all here today. Patients too often find themselves trapped by a healthcare system with a misaligned economic incentive. It is a system where more and more dollars float to insurers, the newly created subsidiaries, so-called group purchasing organizations, and the PBMs, but not to patients.

We now pay on average, $0.75 of every dollar of medicine we sell. And this money goes back to the middlemen to ensure that our medicines remain available to patients. Every day we ask ourselves, what more can we do for patients. What we can do is to try to fill the gaps for those the system has left behind.

For example, we provide an immediate one-time supply of free insulin to any patient who will face rationing. We provide a long-term supply at no cost for Americans in need whose household make less than 400 percent of the poverty line. That is $120,000 for a family of four. And we supply insulin for patients through Walmart and other pharmacies that is sold for $25 for one vial.

We work hard to ensure these programs help as many patients as possible. We would like to do more and work with you today. Now is the time for all participants in the healthcare system to work for solutions that are for the patients first. I look forward to your questions. Thank you for listening to me.

[The prepared statement of Mr. Jorgensen follows.]

PREPARED STATEMENT OF LARS FRUERGAARD JORGENSEN

Chairman Sanders, Ranking Member Cassidy, and Members of the Committee, thank you for holding this hearing and for giving me an opportunity to speak today on behalf of Novo Nordisk.

At Novo Nordisk, our mission is to pioneer scientific breakthroughs that improve patient care and to ultimately cure the diseases we research.

We share the Committee's concerns that too many people continue to fall through the cracks of the U.S. healthcare system. We hope today's conversation will lead to meaningful action and changes that benefit patients. I will share some additional thoughts, but first, I'd like to briefly introduce myself.

I grew up in a tight-knit family in a small rural town in Denmark. Together with my three sisters, I helped my parents run our family farm. That early experience taught me to take responsibility and work hard, not only for myself, but also for others.

It also taught me the importance of finding solutions that are sustainable—back then it was about balancing the interests of the family, the business, the environment, and the community we were a part of.

I joined Novo Nordisk as a Finance Graduate almost 32 years ago, having just returned from studies in the U.S., and I went on to work for the company in the Netherlands, the U.S., and Japan, before I returned to Danish headquarters in 2004. By then, my father had been diagnosed with diabetes, so I know the disease not only professionally, but personally.

I am incredibly humbled and honored to find myself in the position of being the CEO of a company today that always keeps the patient at the center of everything we do.

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While many patients and healthcare professionals know of Novo Nordisk, some people in this room may not. So, I'd like to also briefly introduce the company.

Our company was born out of a love story between two Danish scientists, August and Marie Krogh. When Marie developed diabetes, the couple embarked on a path to find a cure. This journey is where Novo Nordisk's commitment to treat and defeat diabetes began.

While our company has grown to employ more than 55,000 colleagues around the world with 16 production sites in nine countries, and to expand our research and development into several new therapeutic areas, many people are surprised to learn that our majority shareholder is a foundation—the Novo Nordisk Foundation.

This means our company cannot be acquired. It also means our articles of association's commitment that we "conduct [our] activities in a financially, environmentally, and socially responsible way" cannot be weakened or altered.

In fact, our Board of Directors evaluates me and the entire executive team on how we deliver on all of these factors.

Moreover, the Novo Nordisk Foundation is the largest charitable foundation in the world. Just last year, the Foundation awarded almost $1 billion in grants around the world. Some of these projects combat hunger, poverty, and public health in developing countries; while others support research partnerships between industry and academia here in the United States; and still others focus on cutting-edge innovations around quantum computing and fighting anti-microbial resistant bacteria.

Thanks to our unique structure with the Novo Nordisk Foundation, we can be proud that our business successes not only mean bringing innovative medicines to patients around the world, but also ensure our dividends help fuel the Foundation's investment in additional scientific and humanitarian causes.

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As a company committed to defeating diabetes for over a century, I'd like to address a serious misconception that has taken on a life of its own.

Too often, it is repeated that insulin has been on the market for a hundred years. This implies that nothing has changed since insulin was discovered in 1921.

Nothing could be further from the truth.

When insulin was discovered, patients were supplied with a large reusable needle, glass syringes, a whetstone to keep the needlepoint sharp, and sterilizing equipment for boiling the needles and syringes between use.

Early insulin had to be injected repeatedly throughout the day and night. Patients also commonly suffered severe allergic reactions and considerable medical complications.

The reality is, while the insulin of the 1920's saved lives, it was difficult to use, and tight control was demanded to prevent blindness, amputations, and kidney failure.

Even today, patients with diabetes exist on a razor thin line balancing their blood sugar.

This means that while advancement in insulins—such as going from animal to human and from human to analog fast-acting or long-acting—may sound insignificant to those of us who don't live with diabetes; in reality even small steps forward can meaningfully improve a patient's life.

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At Novo Nordisk, we know that no matter how pioneering a drug may be, it can only help patients when it's accessible and affordable.

No one who needs insulin should have to ration or go without because they cannot afford it.

This should never happen.

Novo Nordisk has aggressively worked to fill gaps in the U.S. healthcare system for people taking insulin, but we know there are still problems that need to be addressed.

That is why we are all here today.

Patients who struggle to afford insulin too often find they are trapped by an integrated insurance system full of misaligned economic incentives.

It is a system that is driven by increasing the dollars going to insurers, their Group Purchasing Organizations, and their Pharmacy Benefit Managers—or "PBMs," instead of patients living with diabetes.

Over the years, these middlemen have added more and more fees, discounts, points, and rebates across the supply chain—siphoning more money out of the system.

From every dollar of medicine we sell, Novo Nordisk pays back an average of 75 cents—and for insulins, it is often higher—to these middlemen to ensure our medicines remain covered by insurance companies and remain available to patients.

Every day we ask ourselves: what more can we do for patients?

Over the last several years, we've implemented many new programs to help ensure that no American living with diabetes goes without insulin, and we are constantly evaluating what more can we do.

Today, patients have access to a suite of affordability options that provide Novo Nordisk insulins at low or no cost.

We provide an immediate, one-time supply of free insulin to patients who face rationing.

Our Patient Assistance Program provides a steady supply of free insulin to patients in need whose households fall below 400 percent of the Federal Poverty Line. That's $120,000 for a family of four.

We have made human insulin available at Walmart and other pharmacies that is sold for approximately $25 a vial for all patients regardless of income and insurance coverage status.

We are working hard to ensure that these programs reach and help as many patients as possible.

We want to work with this Committee and Congress to lower patients' out-of-pocket costs.

Now is the time for all participants in the healthcare system—including insurers, their PBMs, their Group Purchasing Organizations, and, of course, manufacturers—to work for solutions that put the patient first.

Thank you. I look forward to your questions.

The CHAIR. Mr. Jorgensen, thank you very much. We have heard from representatives of the three major drug companies. Now we are going to hear from representatives of the three major PBMs.

Our next witness is Mr. David Joyner. He is the Executive Vice President and President of Pharmacy Services for CVS Health. Mr. Joyner, thanks very much for being with us.

STATEMENT OF DAVID JOYNER, EXECUTIVE VICE PRESIDENT AND PRESIDENT OF PHARMACY SERVICES, CVS HEALTH, WOONSOCKET, RI

Mr. JOYNER. All right. Thank you, Chairman Sanders, Ranking Member Cassidy, and Members of the Committee. Thank you for the opportunity to discuss our work—Okay. Thank you for the opportunity to discuss the work. We make health care more affordable, accessible, and ultimately to improve the health outcomes in this country.

Our goal as the PBM is to remove as many drug pricing challenges as possible for our clients and their members. When people can't afford their medications like insulin, they are more likely to adhere to the prescribed therapies. Adherence means better outcomes. Better outcomes mean the health care system will spend far less on complications and hospitalizations.

In order to make medications more affordable, our job at CVS Caremark is to go head-to-head with the drug manufacturers to negotiate the lowest possible prices. The last 2 years have been challenging for millions of Americans as inflation surged and strained household budgets.

A recent 2023 study by the IQVIA Institute examining drug costs found, over the last 5 years, list prices have increased at a rate of 7.4 percent. Over the same time period, the PBM industry has helped clients hold increased spending to just 4.5 percent and kept member cost growth to just 1.4 percent.

Specifically for CVS Caremark clients and for the sixth consecutive year, we have reduced patient costs at the pharmacy counter with an average member out-of-pocket cost below $9 for a 30-day supply.

Today, it is important to note that more than 90 percent of all prescriptions dispensed are generic, and they represent just a little bit more than 18 percent of the total spend. By using competition in the generic categories, generic prices have been deflationary over the last decade.

Now we are securing affordability for the final 10 percent of the name brand drugs, and that is our focus. Competition in the branded marketplace is critical, and we use this competition to deliver discounts to our customers. By negotiating rebates and discounts, we lower costs for our clients and their members where competition exist.

Not surprisingly, many drugs without competition are the high list price medications without discounts and account for much of our client spending today. We encourage the Committee to focus its efforts here and support—and we support the three bills addressing competition that the Committee will consider in its markup.

Drug manufacturers claim rebates are the reason for price increases, but the facts show otherwise. Government study after Government study has concluded that price increases are not the result of rebates or discounts.

Now, we also understand there are questions about the level of transparency we provide to our clients. The trust of our clients is critically important to us, and the trust is built on this transparency.

Transparency starts at the beginning of our client contracting process and is a cornerstone of our approach throughout. Using sophisticated third-party consultants, clients negotiate transparent contracts in granular detail and understand how their health care dollars are spent.

We have always prioritized bringing transparent offerings to the marketplace, and today we passed more than 98 percent of all the rebates back to our clients. We also provide them with regular detailed updates on drug spending and utilization, prescription claims process, cost savings achieved, and also the manufacture rebates that we receive.

Our clients choose how to use those discounts or rebates by either reducing the out-of-pocket costs and or delivering lower overall premiums at the point of sale for the medications. I began by highlighting the importance of adherence and reducing complications and hospitalizations.

That is why we create and maintain preventative drug lists. This allows our clients to offer members $0 copays, including for insulin to treat diabetes and many other medications that are actually treating chronic conditions outside of the deductible. At CVS Health, we use this program to help our 200,000 employees stay healthy.

We have made tremendous progress on insulin affordability through negotiations by inducing competition and encouraging clients to adopt plan designs that lower the out-of-pocket costs for their members.

We have reduced the insulin cost on average 7 percent per year for the last 5 years, and our clients and plan members paid one-

third less on average for a 30-day supply of insulin in 2022 than they did in 2017. At CVS Caremark, the average member costs for a 30-day supply of insulin was less than $25.

For those using the preventative drug list, again, it is zero. We also launched Reduced Rx, a program for the uninsured and underinsured patients with high out-of-pocket costs, providing insulin at just $25 per vial. We proudly provide pharmacy benefits to over 110 million people and improving their health every day.

We will continue to improve and innovate on our model and help clients provide affordable coverage for the medications their members need to stay healthy. I look forward to answering your questions.

[The prepared statement of Mr. Joyner follows.]

PREPARED STATEMENT OF DAVID JOYNER

Chairman Sanders, Ranking Member Cassidy, and Members of the Committee, thank you for the opportunity to discuss our work to make health care more affordable, accessible, and ultimately, to improve health outcomes in our Country.

Our goal is to remove as many drug pricing challenges as possible for our clients and their members. When people can afford their medications, like insulin, they are more likely to adhere to prescribed therapies. Adherence means better outcomes; better outcomes means the health care system will spend far less on complications and hospitalizations.

In order to make medications affordable, our job at CVS Caremark is to go head-to-head with drug manufacturers to negotiate the lowest possible prices.

The last 2 years have been challenging for millions of Americans as inflation surged and strained household budgets. A recent 2023 study by the IQVIA Institute examining drug costs, found over the last 5 years, list prices have increased at a rate of seven-point-four percent.[1] Over that same period the PBM industry helped clients hold increased spending to just four-and-a-half percent and kept member cost growth to just one-point-four percent.[2]

Specifically for CVS Caremark clients and for the sixth straight year, we have reduced patient costs at the pharmacy counter with an average member out-of-pocket cost below nine dollars for a 30-day supply of medication.[3]

Today, more than 90 percent of the prescriptions dispensed are generics and represent a little more than 18 percent of total spend.[4] And by using competition, generic prices have been deflationary over the last decade.

Securing affordability for the final 10 percent of name brand drugs is our focus. Competition in the branded marketplace is critical and we use this competition to create discounts for our customers. By negotiating rebates, or discounts, we lower drug costs for our clients and their members where competition exists. Not surprisingly, many drugs without competition are high list price medications without discounts and account for much of our clients' drug spending. We encourage the Committee to focus its efforts here and we support three of the four bills that the Committee will consider in its markup.

Drug manufacturers claim rebates are the reason for price increases. The facts show otherwise. Government study after government study has concluded that price increases are not the result of rebates or discounts.[5]

We understand there are questions about the level of transparency we provide to clients. The trust of our clients is critically important to us, and trust is built on this transparency.

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[1] IQVIA, The Use of Medicines in the U.S. 2023, *https://www.iqvia.com/insights/the-iqvia-institute/reports/the-use-of-medicines-in-the-us-2023*.

[2] Ibid.

[3] CVS Health 2022 Drug Trend Report, *https://insightslp.cvshealth.com/download-the-2022-drug-trend-report.html*.

[4] Association for Affordable Medicines, 2022 U.S. Generic and Biosimilar Medicines Savings Report, *https://accessiblemeds.org/resources/reports/2022-savings-report*.

[5] U.S. Department of Health and Human Services Office of Inspector General, Rebates for Brand Name Drugs in Part D Substantially Reduced the Growth in Spending from 2011 to 2015, *https://oig.hhs.gov/oei/reports/oei-03-19-00010.asp*.

Transparency starts at the beginning of our client contracting process and is a cornerstone of our approach throughout. Using sophisticated third party consultants, clients negotiate transparent contracts in granular detail and understand how their health care dollars are spent. We have always prioritized bringing transparent offerings to the marketplace and today we pass more than 98 percent of all rebates back to our clients. We provide regular, detailed updates on drug spending and utilization; prescription claims processed; cost savings achieved; and manufacturer rebates received.

Our clients choose how to use those rebates, including reducing out-of-pocket costs at the point-of-sale and to lower overall premiums.

I began by highlighting the importance of adherence in reducing complications and hospitalizations. That is why we create and maintain preventive drug lists. This allows any client to offer members zero-dollar copays, including for insulin to treat diabetes and other medications for many other chronic conditions, outside of the deductible. At CVS Health, we use this program to help 200,000 of our employees stay healthy.

We've made tremendous progress on insulin affordability through negotiation, inducing competition and encouraging clients to adopt plan designs that lower out-of-pocket costs.

We've reduced insulin costs an average of 7 percent per year for the past 5 years. Clients and plan members paid one third less on average for a 30-day supply of insulin in 2022 than they did in 2017. At CVS Caremark, the average member cost share for a 30-day supply of insulin was less than 25 dollars. [6]

We also launched ReducedRx, a program for the uninsured and underinsured patients with high out-of-pocket costs, providing insulin at $25 per vial.

We proudly provide pharmacy benefits for over 110 million people, improving their health every day. And we will continue to improve and innovate our model, and help clients provide affordable coverage of the medications their members need to stay healthy.

I look forward to answering your questions.

The CHAIR. Mr. Joyner, thank you very much. Our next witness is Dr. Adam Kautzner, President of Express Scripts. Dr. Kautzner, thanks for being with us.

STATEMENT OF ADAM KAUTZNER, PRESIDENT, EXPRESS SCRIPTS, ST. LOUIS, MI

Dr. KAUTZNER. Chairman Sanders, Ranking Member Cassidy, and Members of the Committee, thank you for inviting me to testify today. My name is Adam Kautzner. I grew up in rural Missouri outside of Saint Louis and began my career as a pharmacist in a regional hospital.

After working in nuclear pharmacy, I began my career at Express Scripts, just over 15 years ago. I am proud of our work to deliver affordable access to lifesaving medications. This cause is personal to me.

I was diagnosed with stage four melanoma in my early 30's. That experience strongly shaped how I approach our work to advance pharmacy care and lower prescription drug costs for patients and employers.

As a business leader, I am guided by my experiences as a father, cancer survivor, rural American, and a pharmacist. Express Scripts believes all patients should have access to the medications they need at affordable prices. For decades, we have taken on one of the toughest challenges, negotiating with pharmaceutical manufactur-

[6] Internal CVS Caremark book of business data, 2017–2022.

ers to lower costs for employers, health plans, Federal and State Governments, and, most importantly, patients.

We exist to help solve the challenges you are exploring here today. Our company has been at the forefront of introducing solutions to address the insulin crisis. In 2019, we launched a program capping patient cost for insulin to $25 or less.

These lifesaving medications also have been extended for additional savings for cardiovascular diseases as well. We are constantly evolving and improving our services. This includes working to shield patients from exposure to high list prices at the pharmacy counter, to shield our clients from exposure to crippling drug costs, and to provide multiple transparent contracting options, ensuring our clients have complete control and flexibility to choose their benefit design, network, and pricing structure, and are provided robust financial disclosures.

Our solutions for driving lower drug spending for patients and the broader health care system are working. Each year, Express Scripts saves more than $30 billion for employers, the public sector, and the patients we serve. This is driven by effective drug negotiation to medical management and to targeted clinical support programs.

The savings are passed on to our clients at their direction, which benefits Americans in the form of lower premiums, reduced out-of-pocket costs, and expanded coverage. In 2022, savings negotiated by Express Scripts helped keep out-of-pocket average costs to less than $15 in the commercial market, less than $18 for patients using high deductible health plans, less than $9 in Medicare, and less than $1 in Medicaid.

None of this means the system cannot be improved. Drug manufacturers seek the highest price point possible and exploit the patent system and marketing practices to maintain monopoly status for their brands. For employers sponsoring high deductible health plans, restrictions prevent lowering costs for patients before meeting their deductible.

Rebates have been characterized by some as the mechanism for increasing list prices and thus increasing costs for patients. This claim is false. Rebates are discounts we negotiate to lower prices.

More than 95 percent of our rebates are passed to Express Scripts clients, which benefits Americans in the form of lower premiums, reduced out-of-pocket costs, and expanded coverage. Without the ability to use this negotiating tool to achieve lower drug costs, healthcare spending would be much higher.

Drug competition is ultimately what drives rebates, lower list prices, and lower net costs. We applaud recent efforts in Congress to speed the availability of generics and biosimilars, and address abuses of the patent system that work to delay competition and maintain high drug prices.

We recognize there are questions regarding the transparency and availability of pharmacy benefit services. Express Scripts is committed to be transparent to our clients and our beneficiaries. We provide robust disclosures which include principal revenue sources

and information on rebate arrangements, fees, and pharmacy claims.

We strongly caution against prohibiting contracting options entirely. These are options, not mandates, within contracts that are serving many of our clients today. Overall, our beliefs, our business model, and our orientation is geared toward, one, providing innovative solutions that enable access to medications at affordable cost with improved health outcomes.

Two, providing clients with choices to enable them to deliver accessible, affordable pharmacy benefits. And three, by providing additional levels of transparency about the value we create. Express Scripts will continue innovating to address drug pricing challenges and to respond to the needs of patients.

I appreciate this opportunity to address the important questions raised about our role and how the value we create reaches patients. I look forward to your questions. Thank you.

[The prepared statement of Mr. Kautzner follows.]

PREPARED STATEMENT OF ADAM KAUTZNER

Introduction

Chairman Sanders, Ranking Member Cassidy, and members of the Senate Health, Education, Labor, and Pensions (HELP) Committee, thank you for inviting me to testify at this important hearing.

My name is Adam Kautzner. I grew up in rural Missouri outside of St. Louis and began my career as a pharmacist for a regional hospital. After working as a nuclear pharmacist, I joined Express Scripts over fifteen years ago. I am proud of the work we do to deliver affordable access to life-saving medications – and this cause is personal to me. I was diagnosed with stage 4 melanoma in my early thirties, and that experience has strongly shaped how I approach the work we do to advance pharmacy care and lower the cost of prescription drugs for patients and employers. As a business leader, I am guided by my experiences as a father, cancer survivor, rural American, and a pharmacist.

Express Scripts believes that all patients should have access to the medications they need at affordable prices. For decades, Express Scripts has taken on one of the toughest challenges in health care: negotiating with large pharmaceutical manufacturers to lower the cost of drugs for employers, health plans, federal and state governments, and most importantly, patients. **We exist to help solve the challenges you are exploring here today, delivering both improved affordability and access to American patients. We appreciate the opportunity to contribute to this important discussion.**

As President of Express Scripts, I work directly with our clients, including self-insured employers, commercial health plans, union plans, state employee health plans, and plans serving Medicare and Medicaid beneficiaries to develop customized solutions that provided affordability and access for them as payers and for all of the patients we serve. These sophisticated purchasers demand value and drive innovation from Express Scripts every single day. Our industry-leading supply chain negotiators, specialized clinical experts, and product design leaders are focused on making sure patients get, and are able to stay on, the medications they need at prices they can afford.

I believe our role has never been more important, for the patients of today and as the promise of additional, life-changing breakthrough therapies become a reality.

The Role of Pharmacy Benefit Managers

Prescription drug coverage is the most frequently utilized health care benefit; on average, a pharmacy benefit is used approximately 11 times a year.[1] Recent health policy debates on drug pricing have led to important questions about the role of pharmacy benefit managers (PBM) and how the value created by PBMs reaches patients using their pharmacy benefits. PBMs play a vital role in delivering prescription affordability and access, developing clinical-first formularies that help

[1] Express Scripts, 2022 data

ensure patients have access to effective medications at the most affordable prices. The savings negotiated by pharmacy benefit managers (PBM) are passed on to employers and health plans which benefits Americans in the form of lower premiums, reduced out-of-pocket costs, and expanded coverage.

We are continually evolving to respond to the needs of patients. This means constantly testing, learning, and then launching new solutions to allow employers and health plans to offer broad access and affordable prescription drug coverage. When patients with high-deductible health plans started to experience exorbitant out-of-pocket costs before they reached their deductible, we introduced Inside Rx℠, which provided direct savings for prescriptions, including insulins, at the pharmacy counter for both under-insured and uninsured patients.[2] When high list prices started to impact patient out-of-pocket costs for insulin, we introduced the Patient Assurance Program℠ to cap insulin out-of-pocket costs for patients at $25.[3] In 2023, Express Scripts announced the launch of the Copay Assurance Plan™ that allows employers and health plans to cap patient out-of-pocket costs across specialty and non-specialty prescription drugs.[4]

We are constantly evolving to respond to the needs of our clients. PBMs operate in an incredibly competitive environment, with approximately 70 individual companies competing to deliver cost savings to a diverse set of employers, health plans, and public sector entities. Clients generally do not establish long-term contracts with their PBMs (i.e., more than three years). This puts pressure on contracted PBMs to consistently deliver, or employers and health plans will look elsewhere for pharmacy benefits at lower costs and/or improved service offerings.

Express Scripts offers its clients multiple contracting options to support the unique needs of their populations and provides pricing predictability in the face of unpredictable list price changes and an expensive drug innovation pipeline. Express Scripts' clients have complete control and flexibility to choose their specific benefit design, pharmacy network, and pricing structure to best balance cost, coverage, and the needs of their employees and populations. Clients are provided robust financial disclosures, including Express Scripts' principal revenue sources and information on rebate arrangements, administrative fees, and pharmacy claim insights. Clients have audit rights to validate our performance and adherence to contract terms using an independent, third-party auditor, all at no additional charge. Most recently, we introduced a new contracting option, ClearCareRx™, that provides fully transparent pricing to employers and health plans.[5]

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[2] "Express Scripts and Eli Lilly CEOs on lowering drug costs with Inside Rx." CBS News, Available at: https://www.cbsnews.com/video/express-scripts-and-eli-lilly-ceos-on-lowering-drug-costs-with-inside-rx/#x

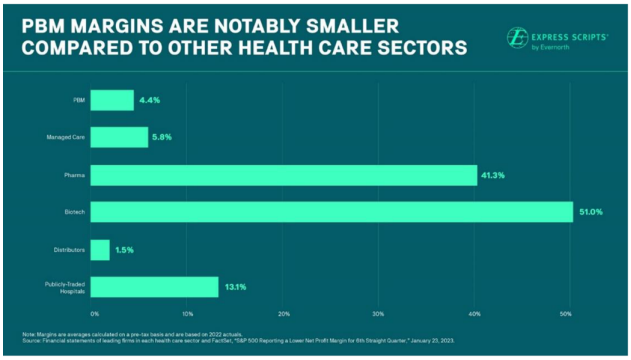
[3] Cigna Healthcare, Cigna and Express Scripts Introduce Patient Assurance Program to Cap Out of Pocket Costs at $25 per 30-Day Insulin Prescription (April 3, 2019), https://newsroom.cigna.com/cigna-and-express-scripts-introduce-patient-assurance-program-to-cap-out-of-pocket-costs-at-25-per-30-day-insulin-prescription

[4] Evernorth Health Services, Express Scripts Further Advances Transparency and Affordability for Consumers and Clients. (April 13, 2023). https://www.evernorth.com/article/pharmacy-benefits-management-pbm-affordability-transparency

[5] Ibid.

Our solutions for driving lower drug spending are working. Employers, health plans, and public sector entities *choose* to partner with PBMs because of the significant value created, and without them, pharmacy costs would be notably higher.[6] Each year, Express Scripts saves approximately $32 billion for those we serve, driven by effective negotiation, medical management, and targeted clinical support programs, resulting in high client retention rates.[7] In 2022, savings negotiated by Express Scripts helped keep average out-of-pocket costs for a 30-day prescription to less than $15 for patients with coverage in the commercial market, less than $18 for patients using high-deductible health plans, less than $9 for Medicare beneficiaries, and less than $1 for Medicaid beneficiaries.[8] For diabetes patients specifically, newly released data from the IQVIA Institute estimates the average patient out-of-pocket cost per insulin prescription, across all markets, was $21.19 in 2022.[9]

PBMs provide these benefits at a cost that is significantly lower than the benefit they bring to the health care system. In 2022, based on publicly available information, the average pre-tax adjusted operating margin of PBMs was between 4.0% and 4.5%, well below those of pharmaceutical manufacturers and many other health care subsectors, and well below the 5-year average net profit margin for the S&P 500 of 11.4%.



Pharmaceutical manufacturers seek the highest price point possible and many use loopholes in patent law to maintain monopoly status for their brands and offer coupons to steer patients towards them when generics and biosimilars do come to

[6] Casey B. Mulligan, *The Value of Pharmacy Benefit Management*, July 2022, National Bureau of Economic Research
[7] Average annual savings generated from client participation in Express Scripts' cost containment programs over the reporting periods 2018-2021
[8] Express Scripts Book of Business, 2022
[9] IQVIA Institute Report. (May 02, 2023). *The Use of Medicines in the U.S. 2023, Usage and Spending Trends and Outlook to 2027.* https://www.iqvia.com/insights/the-iqvia-institute/reports/the-use-of-medicines-in-the-us-2023

market.[10] Pharmaceutical pipelines are dominated with high-cost specialty drugs, which can command exorbitant prices and in 2022 collectively accounted for 51.5% of total drug spending, despite being used by less than 1.7% of patients.[11] At a member level, plan sponsors see an average annual cost of $38,000 to cover a patient's specialty drugs compared to just $492 for the coverage of a patient's non-specialty drug costs.[12] Additionally, for employers sponsoring Health Savings Account-qualified High-Deductible Health Plans (HSA-HDHPs), there are restrictions that prevent lowering out-of-pocket costs for patients before they meet their deductible.

Drug competition is what ultimately drives lower list prices and lower net costs for the health care system. Express Scripts will continue to innovate across the supply chain to address these drug pricing challenges. This includes working with the Senate HELP Committee and all policymakers on reforms to advance competition and protect the use of proven private sector tools to lower drug costs and improve access, while not eliminating or restricting our ability to negotiate the lowest overall cost for our clients. Specifically, we appreciate the bipartisan work of the Committee with all stakeholders to consider reforms to the transparency and availability of pharmacy benefit services in S. 1339, the Pharmacy Benefit Manager Reform Act. Express Scripts is committed to being transparent to our clients and beneficiaries. However, we continue to have concerns that the Committee is seeking to prohibit tools utilized by many of our clients, particularly smaller businesses, in risk-mitigation and pricing structure. We urge the Committee to work to ensure transparency legislation is meaningful to payers and beneficiaries and will not be a tool utilized by other actors in the drug supply chain to increase costs or a mechanism to increase the burden on employers already struggling to manage benefits.

With that context as background, our statement today is focused on the following topics:

- Express Scripts' Solutions to Help Shield Patients from High List Prices Set by Manufacturers
- Express Scripts' Efforts to Drive Lower Costs
- Delivering Clear Contracting Options for Express Scripts Clients and Price Transparency for Patients
- How Express Scripts Contracts with Pharmacies
- Public Policy Solutions for Greater Affordability, Access, and Predictability

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[10] Institute for Medicines, Access, and Knowledge (I-MAK). (September 2022). *Overpatented, Overpriced. Curbing patent abuse: Tackling the root of the drug pricing crisis*, https://www.i-mak.org/wp-content/uploads/2023/01/Overpatented-Overpriced-2023-01-24.pdf
[11] Express Scripts Book of Business, 2022
[12] Data from 2021 Express Scripts PBM client sample for plans >10k lives enrolled in multiple specialty pharmacy trend management strategies.

Express Scripts' Solutions to Help Shield Patients from High List Prices Set by Manufacturers

Insulin is essential to the health and well-being of many individuals who live with diabetes, but it doesn't work if it's priced out of reach. Whether traditional or non-insulin diabetes treatment, missing one dose of any medication can be dangerous for their health and lead to costly and complex outcomes.

The same challenges that this Committee has identified are the very ones that we as a company have been focused on for many years. The high list price of insulin and other diabetes drugs created incredible burdens on people living with the condition and increased premiums for all people with insurance. It is our job to support access to safe treatments at a cost patients and employers can afford, so we got to work.

Express Scripts has been at the forefront of introducing solutions to address this public health crisis and provide greater affordability, access, and predictability for those living with diabetes. This includes pioneering a drug discount program in 2017, Inside Rx, providing direct savings on insulins at the pharmacy counter for both under-insured and uninsured patients; in 2019, introducing the Patient Assurance Program (PAP) to cap insulin out-of-pocket costs for patients at $25; and in 2023, announcing the Copay Assurance Program to enable Express Scripts' clients to cap patient out-of-pocket costs for both specialty and non-specialty prescription drugs. More broadly, the company's diabetes care solutions are built around a whole-health integration strategy to help identify, prevent, and manage diabetes by connecting individuals to the right level of care across the health continuum – whether healthy, at-risk, or chronically ill.

Inside Rx: Discounts at the Pharmacy Counter

In 2017, Express Scripts launched Inside Rx, a program that provides millions of Americans, both under-insured and uninsured, with discounts on their prescriptions at the pharmacy counter in partnership with drug manufacturers and nearly 60,000 retail pharmacies. To develop the program, Express Scripts acted as a convener between pharmaceutical companies, pharmacies, and a technology partner, GoodRx, with the goal of providing millions of Americans with access to direct discounts for brand-name and generic prescription drugs.

Inside Rx is designed for people who are uninsured, have high-deductible health plans, or have coverage that excludes certain medications.[13] Insulins are among the brand drugs for which Inside Rx offers affordable options to those in need. Since launching in 2017, Inside Rx has helped more than 40 million patients access discounted medications. By offering an extensive network of pharmacies and leveraging our relationships with manufacturers, Inside Rx has delivered patient savings averaging more than $1 billion per year. For diabetes products in particular,

[13] While anyone with a valid prescription can use Inside Rx, there are restrictions on featured medications for individuals covered by Medicare, Medicaid, or TRICARE.

Inside Rx has been able to deliver savings of nearly 50% through 15 manufacturer partnerships. This translates to savings of more than $85 million for products ranging from insulin to glucose monitoring tools.

Patient Assurance Program : Capping Insulin Costs for Millions of Patients

This industry-first program was launched in 2019 in partnership with insulin manufacturers to provide more affordability to patients with chronic conditions by capping patient out-of-pocket costs at $25 for up to a 34-day supply or $75 for a 90-day supply of medications to treat chronic conditions, including insulin and certain oral medications for diabetes. Customers do not have to first satisfy their deductible to receive this discount, which is automatically applied at the pharmacy counter. New data from the IQVIA Institute estimates the average patient out-of-pocket cost per insulin prescription, across all markets, was $21.19 in 2022.[14]

Because diabetes management doesn't always require insulin, the Patient Assurance Program as expanded to include non-insulin diabetes treatments, including DPP-4 inhibitors, GLP-1 agonists, and SGLT2 inhibitors. In addition to capping the cost of diabetes medications, the PAP has resulted in improved adherence by addressing cost as a barrier to care.

Since the launch of PAP, Express Scripts has helped provide more affordable, predictable access to diabetes medications for close to 11 million patients. Our research shows:

- More than $18 million in patient savings at the pharmacy counter for insulin in 2022 – and more than $45 million in total patient savings since 2020.
- Total patient diabetes-related cost share decreased by 50.5% due to medical cost avoidance, or $135 million in total client savings since 2020.
    - For type 2 diabetes patients in households earning less than $50,000 per year, adherence improved by 5.7%.
    - Newly diagnosed type 1 diabetes patients, or those filling an insulin product for the first time, are 30% more likely to continue therapy when enrolled in the program when compared to those not enrolled.

Utilizing Preventive Drug Lists to Expand Insulin Affordability

Today, Express Scripts' clients who offer coverage that pairs a Health Savings Account with a High-Deductible Health Plan (HSA-HDHP) are limited by law in what products and services may be covered until a minimum deductible for that year is satisfied. However, plan sponsors offering HSA-HDHP products may cover certain preventive services pre-deductible, including those specified by the U.S. Treasury Department and the Internal Revenue Service (IRS).

In 2019, the Treasury Department and the IRS expanded the list of preventive services to include services for certain chronic conditions, including diabetes,

[14] Ibid.

recognizing that requiring patients with chronic conditions to first fulfill a deductible can result in individuals "failing to seek or utilize effective and necessary care that would prevent exacerbation of a chronic condition."[15] In addition to expanding pre-deductible coverage to insulin, other glucose lowering agents, and retinopathy screening, Treasury and the IRS also expanded coverage for products addressing congestive heart failure, osteoporosis, hypertension, asthma, depression, liver disease, and heart disease.

Importantly, this expansion allowed Express Scripts' clients to meaningfully expand the coverage of insulin and other products pre-deductible for patients in HSA-HDHP plans, alleviating a substantial cost burden for patients. However, there remain opportunities for Congress and the Administration to do more to increase HSA-HDHP flexibility and lower patient out-of-pocket costs, as discussed below.

Medicare Part D Senior Savings Model: Capping Insulin Costs for Medicare Beneficiaries

In 2021, the Centers for Medicare & Medicaid Services (CMS) introduced a pilot program in Medicare Part D, the Senior Savings Model, to offer Medicare beneficiaries new coverage that caps out-of-pocket costs for select insulins. The program's mechanics mirror, in part, how Express Scripts' Patient Assurance Program works, bringing insulin manufacturers and plans together to limit copays to $35 or less for a one-month supply of certain insulins in the initial and coverage gap phases of Part D. This year, Express Scripts participates in the model with both standalone Prescription Drug Plan (PDP) and Medicare Advantage-Prescription Drug (MA-PD) plan offerings. Our standalone PDP offerings include $0 cost-sharing for select insulins through the coverage gap phase of the benefit.

While this pilot program is expected to conclude at the end of this year due to the broader insulin out-of-pocket cap for Medicare beneficiaries included in the Inflation Reduction Act (IRA), it's important to note more than 17 million Medicare beneficiaries enrolled in the plans.[16] CMS estimated beneficiaries should save an average of $446 in annual out-of-pocket costs on insulin due to the program.[17]

One of the benefits of the Senior Savings Model is that it, like the Patient Assurance Program for individuals in the commercial market, brings insulin manufacturers and, in this case, Medicare plans together to lower out-of-pocket costs for beneficiaries. By contrast, the cap on insulin out-of-pocket costs included in the IRA, like the caps currently under debate for the commercial market, places the entire financial responsibility of capping insulin out-of-pocket costs on the Medicare plans alone. As a result, the Congressional Budget Office (CBO) estimated that the

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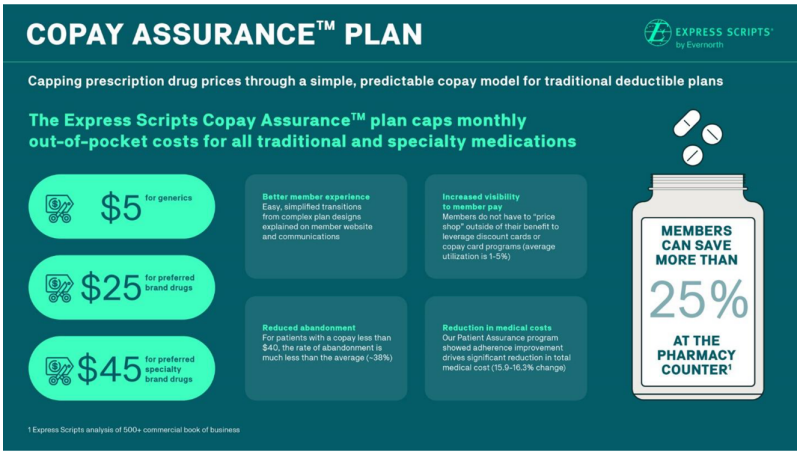
[15] Internal Revenue Service Notice 2019-45, *Additional Preventive Care Benefits Permitted to be Provided by a High Deductible Health Plan Under § 223*, https://www.irs.gov/pub/irs-drop/n-19-45.pdf
[16] Centers for Medicare & Medicaid Services. (2023). *Part D Senior Savings (PDSS) Model – Fact Sheet Calendar Year (CY) 2023*, https://innovation.cms.gov/media/document/partd-senior-sav-cy23-fs
[17] Ibid.

IRA's cap on insulin in Part D will increase federal spending by $5.1 billion over 10 years (2022-2031).[18]

Copay Assurance Plan: Capping Prescription Drug Out-of-Pocket Costs for Patients

As discussed briefly above, Express Scripts announced the launch of the Copay Assurance Plan in April 2023, which will enable Express Scripts' large clients to cap patient out-of-pocket costs under their prescription drug benefit as of January 2024. Customers enrolled in the program will pay no more than $5 for generics and specialty generics, no more than $25 for preferred brand drugs, and no more than $45 for preferred specialty brand drugs every time they fill their prescription. This will lower out-of-pocket costs for customers by an average of 27%, with higher savings for patients taking medications to manage chronic or rare conditions that require complex, specialty medications.

This program is a meaningful expansion of the Patient Assurance Program, where Express Scripts convened insulin manufacturers to drive greater savings toward patient out-of-pocket costs. The Copay Assurance Plan builds on that model for both specialty and non-specialty prescription drugs by making it easier and more affordable for Express Scripts' clients to offer a prescription drug benefit that caps all out-of-pocket costs for customers. Capping out-of-pocket costs is anticipated to meaningfully improve patient adherence and patient outcomes, which we expect will help offset the slight increase in plan costs to implement this plan.



[18] Congressional Budget Office Cost Estimate, *Estimated Budgetary Effects of Public Law 117-169, to Provide for Reconciliation Pursuant to Title II of S. Con. Res. 14*, https://www.cbo.gov/system/files/2022-09/PL117-169_9-7-22.pdf

Diabetes Care Value Program : Improving Patient Outcomes

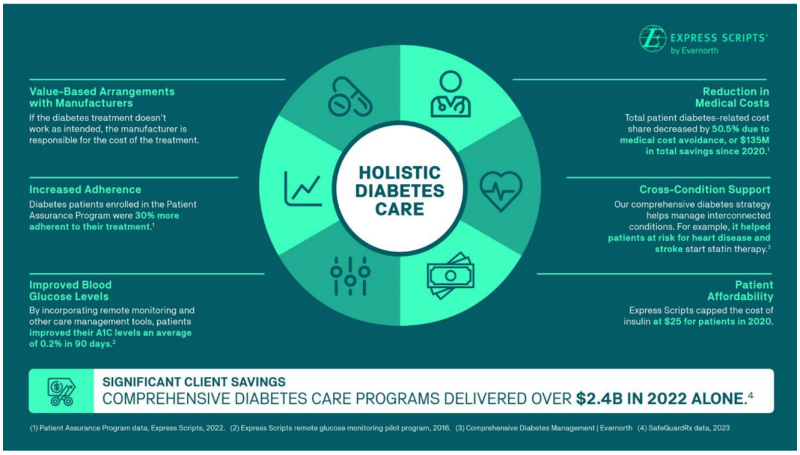
Express Scripts' Diabetes Care Value Program is part of a suite of solutions called SafeGuardRx, which offers value-based solutions to help manage chronic conditions and improve outcomes. SafeGuardRx addresses eleven complex and costly disease states, including diabetes, oncology, inflammatory conditions, multiple sclerosis, and other rare conditions. The Diabetes Care Value Program leverages proactive medication adherence monitoring, condition-specific coaching, digital health solutions, a high-quality pharmacy network, and cost management tools to help prevent diabetes for those at-risk and improve outcomes and better coordinate care for those living with diabetes. This program includes:

- **Digital diabetes prevention and obesity solution:** Individuals identified as at-risk may participate in a 12+ month virtual program that encourages a healthier lifestyle to help reduce their risk of type 2 diabetes and/or heart disease.
- **Digital care for type 1 and type 2 diabetes:** This remote monitoring solution allows clinicians to track patient blood glucose testing results, analyze trends, and offer proactive and meaningful patient interventions.
- **Preferred quality pharmacy network:** Our preferred quality pharmacies provide 90-day prescription refills to promote and increase medication adherence, close gaps in care, and mitigate unnecessary medical expenses.
- **Formulary and utilization management tools:** By using our National Preferred Formulary or Preferred Step Therapy Programs, the Diabetes Care Value Program drives use to the lowest net cost diabetes medications.
- **High-touch support from the Diabetes Therapeutic Resource Center (TRC)**: All patients, including those with diabetes and those at-risk, can receive medication education and counseling from TRC clinicians. These clinicians receive highly focused, disease-specific training that creates a better patient experience by quickly identifying issues, improving adherence, and closing gaps in care through physician outreach.

The program has created meaningful improvements in health outcomes for enrolled patients while lowering costs. In 2021:

- Digital obesity solutions saved our clients and their members nearly $20 million in medical costs by preventing diabetes for patients who are pre-diabetic and/or obese.
- Our clients saved $83 per participant per month in medical costs because of our diabetes remote monitoring tool for types 1 and 2 diabetes through LifeScan.
- 17.2% more patients began potentially lifesaving statin therapy because of TRC interactions through Diabetes Care Value. Over 20,000 heart attacks could be prevented over the next 10 years if all plans were to similarly increase statin use among their diabetes members.

- Plans enrolled experienced 2.58% lower diabetes drug trend in 2021, compared to non-enrolled peers.



Express Scripts' Efforts to Drive Lower Costs

Express Scripts applauds the recent announcements by insulin manufacturers that certain insulins will have lower list prices later this year and welcomes all manufacturers to lower their list prices so that patients can have access to safe, effective, and affordable medications. List prices are exclusively controlled by drug manufacturers. It is important to note that we believe the actions to reduce insulin list prices, while highly commendable, were likely driven by provisions in the American Rescue Plan Act which, starting January 1, 2024, will remove the existing cap on manufacturers' rebates in Medicaid, and thus increase manufacturers' Medicaid rebate obligations.[19]

Formulary Development and Client Adoption

With more than 19,000 approved prescription drugs available in the U.S., a drug formulary, or preferred drug list, is a continually updated list of medications and related products supported by current evidence-based medicine and the judgment of physicians, pharmacists, and other experts in the diagnosis and treatment of disease and preservation of health. Formularies help ensure access to the most

[19] John Wilkerson, *By cutting insulin prices, Eli Lilly avoids paying big Medicaid rebates*, STAT (March 6, 2023), https://www.statnews.com/2023/03/06/eli-lilly-insulin-medicaid-rebates/

effective medications, drive competition among pharmaceutical companies, and help combat an estimated $16 billion wasted every year on low value medications.[20]

Since our inception, Express Scripts' mission is to make drugs safe and more affordable for those we have the privilege to serve throughout the U.S. and abroad. These principles are integrally embedded in our formulary development process, which is constructed to first and foremost ensure an unbiased clinical perspective from independently practicing clinical physicians and pharmacists.[21]

Once a drug is independently determined to be clinically appropriate, if there is competition in the market, Express Scripts will harness that competition to negotiate with drug manufacturers to offer its clients and customers clinically effective, affordable solutions for delivering prescription benefits, whether that is through a negotiated rebate, a reduction in list price, or both. Financial impact to Express Scripts is expressly excluded and prohibited from consideration in the formulary development process. The financial impact to Express Scripts' clients, however, is considered, as it should be, but only after all clinical considerations have been taken into account.

Using this formulary development process, Express Scripts offers clients a variety of standard formulary options, including Express Scripts' largest standard formulary, the National Preferred Formulary (NPF), which includes roughly 600 brand-name drugs and 99% of all generics. Express Scripts also offers the National Preferred Flex Formulary, which provides clients with the ability to take advantage of authorized alternatives introduced by brand manufacturers with lower list prices. The Flex Formulary is just another example of how we champion sustainable pricing models, where manufacturers are able to do the right thing for patients, and where payers can choose a model that best helps them achieve their goals. Express Scripts' clients have secured cumulative savings of approximately $30 billion since 2014 from our formulary selections and strategies.

Express Scripts' clients, based on their own unique situation, can select a formulary that is most appropriate for their members or use existing formularies as the foundation for a custom formulary. In every instance, Express Scripts' clients define the entirety of the prescription drug plan offered to their members, including whether a patient will be responsible for a copay, and if so, how much, whether a patient will need to satisfy a deductible, or whether a specific out-of-pocket maximum applies to that patient.

Negotiating the Lowest Net Cost

When there are multiple therapies with similar clinical efficacy, like branded insulins, Express Scripts leverages competition between drug manufacturers to drive to the lowest net cost. Rebates negotiated can drive down the net, total cost

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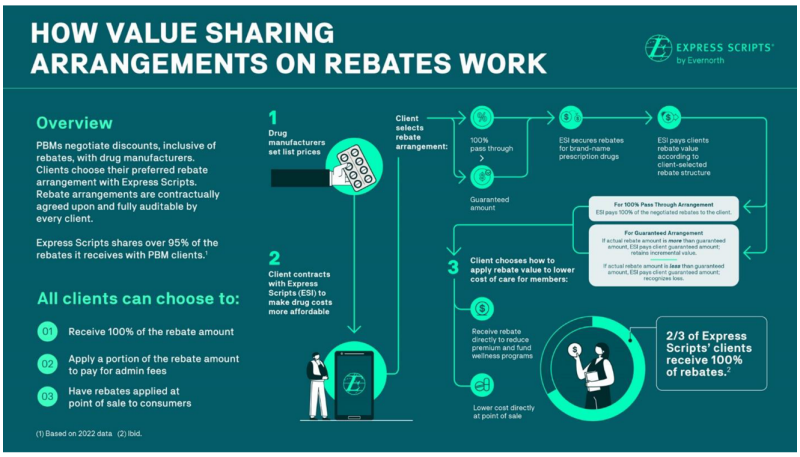
[20] Colla, Carrie H et al. "Choosing wisely: prevalence and correlates of low-value health care services in the United States." *Journal of general internal medicine* vol. 30,2 (2015): 221-8. doi:10.1007/s11606-014-3070-z

[21] Express Scripts, *Formularies*, https://www.express-scripts.com/corporate/about/formularies

of the drug, as can a low list price. The overall value negotiated from manufacturers through rebates has increased over time, as has the value shared with Express Scripts' clients. **When developing options for our clients and their members, we focus on the lowest net cost of a drug, not the rebate.**

Employers and other plan sponsors that work with Express Scripts choose how rebates are used. Some use them to lower premiums and/or cost-sharing, others choose to expand access, fund wellness programs, and/or provide discounts to their members at the point-of-sale. Employers and health plans have full control in deciding how rebates are used and how to contract with Express Scripts. They are provided robust financial disclosures, which include Express Scripts' principal revenue sources and information on rebate arrangements, administrative fees, and pharmacy claim insights. In total, Express Scripts passes 95% of rebates it receives to health plan clients and their customers.



The role of rebates has been characterized by some *as the mechanism* for increasing drug list prices, and thus increasing costs for patients. This claim is false. Negotiated rebates have increased over time specifically as a result of manufacturers raising list prices, and thus increasing costs for patients. Independent, government reports show that list prices rise irrespective of rebates and depend heavily on whether there is competition in the market:

- A 2019 U.S. Department of Health and Human Services Office of Inspector General (HHS-OIG) report found **that list prices increased faster than rebates and many drugs experienced declines in rebates at the same**

time list prices rose.[22] The report concluded that rebates insurance providers and PBMs secure for seniors in Part D led to lower Medicare premiums.

- Similarly, the Medicare Payment Advisory Commission (MedPAC) studied brand drug prices net of rebates in Medicare Part D and found that net prices more than doubled between 2010 and 2020, with net prices for single source brand-name drugs increasing by 10.2% on average annually.[23]
- MedPAC also found that in 2020, higher priced drugs with limited competition or no competition offered "fewer and proportionally smaller rebates" when compared to drugs with list prices below $700.[24] Specifically, for the 242 unique products priced over $10,000, only 15% offered a rebate.[25]

Additionally, rebates are typically not offered on generic medications, which make up the vast majority (90%) of medications by volume dispensed.

Drug competition is what ultimately drives rebates, lower list prices, and lower net costs. One insulin-specific example: The long-acting insulin pen injector Lantus was released in 2010 with a high list price and more than doubled over 2010-2014, despite very limited negotiated rebates. However, in 2015, competition

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[22] Department of Health and Human Services Office of Inspector General. (Sept. 2019). *Rebates for Brand-Name Drugs in Part D Substantially Reduced the Growth in Spending from 2011 to 2015, HHS OIG*. https://oig.hhs.gov/oei/reports/oei-03-19-00010.pdf

[23] Medicare Payment Advisory Commission. (April 7, 2022). Analysis presented at April 7, 2022 public meeting, *Initial Findings from MedPac's analysis of Part D data on drug rebates and discounts*. https://www.medpac.gov/wp-content/uploads/2021/10/MedPAC-DIR-data-slides-April-2022.pdf

[24] Ibid.

[25] Ibid.

entered the market and after that time, Lantus' price increased only modestly year-over-year from 2015-2023, and rebates substantially increased over the same time period. This underscores the studies referenced above that manufacturers can and will increase list prices to whatever the market will bear until competition is introduced.

Without the ability to use rebates as a mechanism to achieve lower net costs, health care spending would be much higher. CBO estimated that a proposal to eliminate the use of rebates in the Part D program would have cost taxpayers $177 billion in higher drug spending.[26] The delay of this regulation was a principal revenue source for passage of the IRA.[27] This reflects the value PBMs deliver through rebates to result in lower net drug costs.

Insulin Competition and Biosimilar Access

Insulins are considered highly interchangeable by Express Scripts' Pharmacy & Therapeutics (P&T) Committee, comprised of independent, practicing physicians and pharmacists reflecting a variety of specialties, including endocrinology. Many competing insulin brands contain the same active ingredient (e.g., Humulin vs. Novolin, Lantus vs. Basaglar). Manufacturers thus compete closely on list price and delivery method and aggressively seek to build brand recognition and loyalty with patients through direct-to-consumer marketing. Express Scripts makes formulary decisions based on the P&T Committee's clinical parameters, ensuring that there are preferred products for every class of insulin and limiting as much as possible any changes that would be highly disruptive to patients.

The insulin market is unique in that it has been historically dominated by branded products. Interchangeable biosimilar competition has only very recently entered the market, as a result of insulin's initial classification as a drug regulated by the Food, Drug, and Cosmetic Act (FD&C), the complexities in manufacturing insulin that prevented generic competition, and insulin manufacturers' ability to exploit imperfections in patent law to extend patent protections for their branded products.

This is poised to change. Express Scripts has advocated for years for a safe, effective way to bring biosimilars to market because they hold tremendous cost savings opportunities for patients, employers, health plans, and the entire health care system. Recognizing these issues, Congress mandated in the Biologics Price Competition and Innovation Act of 2009 (BPCIA) that insulins and certain other drugs transition to a biologic classification. Congress built in a 10-year timeline for the transition, which was effective on March 23, 2020. Appropriately, the U.S. Food and Drug Administration (FDA) announced March 23, 2020 as a "historic day and landmark moment for patients with diabetes and other serious medical

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[26] Congressional Budget Office. (2019). *Incorporating the Effects of the Proposed Rule on Safe Harbors for Pharmaceutical Rebates in CBO's Budget Projections – Supplemental Material for Updated Budget Projections: 2019 to 2029.*
[27] Ibid.

conditions."[28] The transition to a biologic classification allowed for the FDA to review applications for interchangeable biosimilar insulins, which are projected to dramatically increase competition in the market for insulin. The FDA approved the first interchangeable biosimilar insulin product on July 28, 2021.[29]

Importantly, unlike most generics, biosimilars are not automatically designated as interchangeable upon FDA approval. If a patient is prescribed a brand drug which has a generic alternative, pharmacists can generally automatically substitute the lower-cost generic at the pharmacy counter. However, for biosimilars, the pharmacist is unable to switch the patient from the brand biologic to the lower-cost biosimilar unless that biosimilar alternative is designated as interchangeable. This underscores the importance of policymaker support for not just biosimilars, but interchangeable biosimilars.

The approval of Semglee®, a form of insulin which is both biosimilar to *and interchangeable with* Lantus®, is helping pave the way for automatic substitutions in certain states, where pharmacies can automatically shift patients to the lower-cost product, but only to the extent those state's laws allow. We support continued efforts by the FDA to streamline the approval process for biosimilars and issue guidance necessary to promote greater regulatory clarity in the biosimilars marketplace, including better defined standards for interchangeability of biological products.

The introduction of new interchangeable biosimilar insulin options allows for *greater competition* between insulin manufacturers, allowing Express Scripts to leverage that competition to drive deeper discounts on the products for its clients and patients. As stated earlier, when developing options for our clients and their members, we focus on the lowest net cost of a drug, not the rebate. Express Scripts announced in October 2021 that Semglee would be available as a preferred product on our National Preferred Formulary, and we estimated cost savings for our clients of $20 million in 2022.[30]

Proposals to Statutorily Cap Insulin Copays for Patients

Express Scripts has worked hard to bring together supply chain stakeholders to develop solutions to lower insulin costs paid by insured and uninsured patients at the pharmacy counter and the net prices paid by our employer and health plan clients. Many of Express Scripts' employer clients insulate their members from paying high out-of-pocket costs based on the list price of insulins using Express

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[28] U.S. Food and Drug Administration. (March 23, 2020). *Insulin Gains New Pathway to Increased Competition*. https://www.fda.gov/news-events/press-announcements/insulin-gains-new-pathway-increased-competition

[29] U.S. Food and Drug Administration. (July 28, 2021). *FDA Approves First Interchangeable Biosimilar Insulin Product for Treatment of Diabetes*. https://www.fda.gov/news-events/press-announcements/fda-approves-first-interchangeable-biosimilar-insulin-product-treatment-diabetes

[30] Express Scripts. (Oct 20, 2021). *Express Scripts Will Unlock $20 Million in Savings for Clients in 2022 by Preferring the First Interchangeable Insulin Biosimilar*. https://www.evernorth.com/articles/express-scripts-will-prefer-first-interchangeable-insulin-biosimilar

Scripts' Patient Assurance Program, preventive care drug lists for those in HSA-HDHPs, and using negotiated rebates to set low deductibles and copays.

Many in Congress have proposed broadly capping insulin copays for patients by preventing employers and health plans from charging more than a specified amount. While this seems like a simple solution, depending on the way it is structured, it could mask the problem instead of solving it and ultimately increase patient costs through higher premiums. If patient costs are statutorily capped at the pharmacy counter, insulin manufacturers have less incentive to lower the total cost for employers and health plans, which could result in higher costs for patients. This phenomenon is present in Medicare Part D's requirements for "protected classes," whereby all drugs in the six protected classes are required to be covered in Part D. The requirements to cover these drugs have resulted in reduced negotiating leverage with manufacturers and increased costs for those specific classes when compared to other drug classes.[31]

When considering patient out-of-pocket costs, it's important to keep in mind that it only represents a portion of the total cost of a drug. According to National Health Expenditure (NHE) data, patient out-of-pocket spending (deductibles, copays, and coinsurance) represented 13.3% of all retail drug spending in 2020, with health insurance (employers, private health insurers, Medicare, Medicaid, and other health insurance programs) covering the remaining 86.7% of prescription drug costs.[32] NHE projects patient out-of-pocket spending for retail prescription drugs to decline to 10.4% by 2030.[33]

The private market solutions available today, including Express Scripts' Patient Assurance Program and Copay Assurance Program, work to bring manufacturers, payers, and PBMs together to drive down both patient out-of-pocket costs and the net cost burden absorbed by the payer. By maintaining negotiating leverage with manufacturers on the total drug price, including patient out-of-pocket cost and the larger net cost, these solutions avoid some of the challenges and unintended consequences that can come with the strictures of legislation.

We recognize there remain circumstances in which patient costs for insulin are still prohibitively expensive. Instead of enacting legislation that may ultimately result in increased costs for payers and patients, we believe there are constructive changes to HSA-HDHP arrangements that would provide more flexibility for our clients to offer lower cost options and address many of the situations in which patients may be paying higher costs at the pharmacy counter. These changes are outlined further in our testimony.

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[31] Medicare Payment Advisory Commission. (2020). *Report to Congress: Medicare and the Health Care Delivery System*. https://www.medpac.gov/document/june-2020-report-to-the-congress-medicare-and-the-health-care-delivery/

[32] Centers for Medicare & Medicaid Services. (2021). *National Health Expenditure Data: Historical*, at Table 16, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical

[33] Ibid.

Delivering Clear Contracting Options for Express Scripts Clients and Price Transparency for Patients

Express Scripts' clients have complete control and flexibility to choose their specific benefit design, network, and pricing structure to best balance cost, coverage, and the needs of their employees and populations. Because the market for client contracts is so competitive, Express Scripts is constantly innovating to bring new contracting solutions and transparency to deliver the best value for our clients and customers.

A key principle underlying Express Scripts' pricing models is client choice. Express Scripts offers employers, health plans, and public sector entities multiple contracting options to support the unique needs of their populations. Clients have options to finance Express Scripts' services using (1) administrative fees; (2) value sharing arrangements on rebate discounts; (3) value sharing arrangements on discounts negotiated with retail pharmacies; or (4) a combination of the options. To demonstrate our value and meet strict governance standards, clients receive detailed financial disclosures, including Express Scripts' principal revenue sources and information on rebate arrangements, administrative fees, and pharmacy claim insights, provided at no additional charge. Further, all Express Scripts' clients have an annual right to audit our performance and adherence to contract terms using an independent, third-party auditor.

Spread or Risk Mitigation Pricing

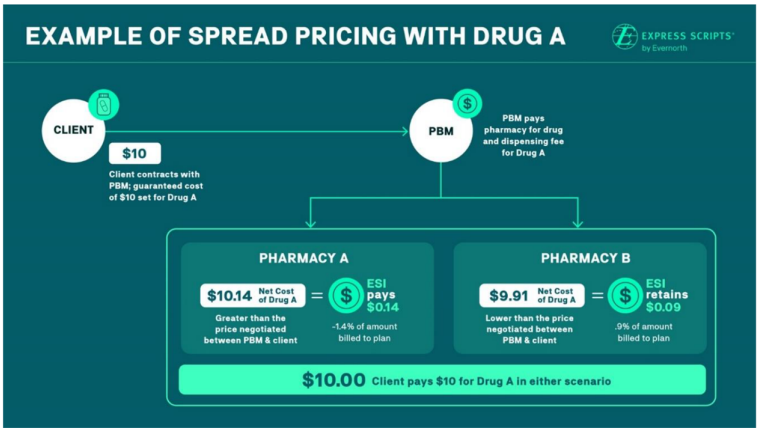
In a spread, or risk mitigation, pricing model, a client elects for more predictable, fixed pricing for prescription drugs dispensed by pharmacies and may pay reduced

fees or no fees for Express Scripts' services, like claims adjudication, network management, and formulary management. Express Scripts provides a guaranteed discount on prescription drugs dispensed, which works for many clients looking to mitigate risk and keep their monthly drug spend predictable. If prices for prescription drugs rise above the guaranteed rate, the client is held harmless, resulting in Express Scripts incurring a loss on prescription drug claims. This means employers and health plans are protected from fluctuations in drug prices.

Clients may elect to utilize a spread pricing model to offset or forgo the cost of PBM services Express Scripts provides, creating a more affordable contracting option for some clients. Incremental value retained by Express Scripts under a spread pricing arrangement represents value sharing and Express Scripts' compensation for providing services.

We recently announced efforts to provide clients utilizing spread pricing with enhanced financial and fee disclosure for Form 5500 reporting and other plan administrative functions. The Form 5500 Series is a compliance, research, and disclosure tool for the U.S. Department of Labor (DOL), other Federal agencies, Congress, as well as for plan participants and beneficiaries, and the private sector to assess employee benefit, tax, and economic trends and policies. Express Scripts will provide the same level of disclosure to its non-ERISA clients to help support them in understanding the services Express Scripts provides.

Spread pricing is not a unique arrangement to Express Scripts or PBMs. It is used across the prescription drug supply chain, from manufacturers to pharmacies, and across the broader health care industry and economy, from retail to automotives to food and beverage.



Pass-Through Pricing Models

In a pass-through pricing model, Express Scripts collects fees for the services it provides, such as claims administration, retail network management, formulary management, clinical programs, and utilization management programs. One example of pass-through pricing is Express Scripts' ClearCareRx contracting model, which offers employers the option of a transparent economic model by providing clear and predictable costs for prescription drug benefits:

- Clients pay exactly what Express Scripts pays pharmacies for a prescription.
- Clients receive 100% of the drug rebates that Express Scripts obtains by negotiating with pharmaceutical companies.
- Clients pay one simple fee to cover the administration of pharmacy benefits, PBM product services, reporting and analytics, and is 100% auditable.
- Provides guarantees that keep Express Scripts accountable to clinical and financial performance measures, including improvements in drug performance, adherence, and overall patient outcomes.

Express Scripts successfully piloted the program with several employers and health plans covering 500,000 people. Results from 2021 (full year) include:

- -3.5% drug trend
- 12% total medical cost reductions and $193 million in savings from closing clinical care gaps
- 86% of patients that were previously non-adherent to their medications improved adherence through our coaching and interventions

Value Sharing Arrangements on Rebate Discounts

Express Scripts shares in the rebate savings it generates for its clients when a client (a) elects to receive a minimum guaranteed rebate amount and the minimum guaranteed rebate amount is less than the actual rebate amount received by Express Scripts and/or (b) elects to forgo payment of administrative fees in lieu of a rebate value sharing arrangement. If a client's guaranteed rebate amount exceeds the actual rebate amount received by Express Scripts with respect to that client's utilization, Express Scripts pays the client the guaranteed rebate amount and recognizes a loss; and therefore, Express Scripts is at risk based on performance. Regardless of method selected, Express Scripts passed through over 95% of rebates it collected for its clients in 2022.

Client Choice and Proposals to Ban Spread Pricing

We appreciate the work of the Committee to consider bipartisan reforms to the transparency and availability of pharmacy benefit services. We are concerned, however, that banning practices utilized by many of our clients, particularly smaller businesses, may result in unintended consequences, including increased risk volatility for those businesses. Despite CBO indicating there are federal budgetary savings tied to provisions to increase transparency and ban spread pricing, it is unclear that the ban on spread pricing specifically is driving any of the savings to employers and may ultimately result in higher health care premiums.[34] Therefore we strongly caution against banning this option for our clients without a greater understanding of the financial implications to employers utilizing spread pricing today.

Many clients choose a combination of spread and pass-through arrangements to manage drug costs for covered members. Express Scripts and clients work together to design pricing options that work best for the client's needs. Many of Express Scripts' clients are sophisticated purchasers, and all employers are represented by brokers who bring a deep knowledge of the benefits industry, conduct analyses of the potential value provided by the PBM, and provide advisory services when selecting a PBM and negotiating a contract. Express Scripts has no financial connection to these consultants.

Express Scripts is committed to being transparent to our clients and beneficiaries, and provides clients with robust disclosures, provided at no additional charge, which include Express Scripts' principal revenue sources and information on rebate arrangements, administrative fees, and pharmacy claim insights. Further, all Express Scripts' clients have an annual right to audit our performance and adherence to contract terms using an independent third-party auditor. We urge the Committee to work to ensure transparency legislation is meaningful to payers and patients and will not be a tool utilized by other actors in the drug supply chain to

[34] Congressional Budget Office. (2019). At a Glance: S. 1895, Lower Health Care Costs Act. July 16, 2019. Available at: https://www.cbo.gov/system/files/2019-07/s1895_0.pdf

increase costs, or a mechanism to increase the burden on employers already struggling to manage benefits.

Overall, our beliefs, our business model, and our orientation is geared toward: (1) providing innovative solutions that enable access to medications at affordable costs and with improved health outcomes; (2) providing clients with choices to enable them to navigate the numerous aspects of delivering accessible, affordable pharmacy benefits to their covered populations; and (3) continuously improving, including by providing additional levels of transparency about the value we create.

Patient Price Transparency

In addition to lowering the prices of prescription drugs, providing customers with convenient access to personalized information about the cost and quality of their care has long been one of our principal priorities. Express Scripts offers industry-leading tools to help patients make informed health care decisions, including the ability to access real-time cost-sharing information for prescription drugs with individualized prices for their specific prescription at participating pharmacies nationwide. The information is personalized to the patient based on their prescription drug benefit, incorporating information on deductibles, out-of-pocket maximums, and Health Savings Account or Health Reimbursement Account information. Over 22 million patients have benefited from this service.

To enable constructive conversations between patients and their health care providers, we also make this information available to health care providers at the point of service. In 2022, we made this information available to more than 850,000 health care providers at the point of prescribing.

Starting in 2024, all prescriptions covered by Express Scripts will include an easy-to-understand digital pharmacy benefits statement for patients – sharing drug pricing information, out-of-pocket costs, and the value delivered by Express Scripts. This benefit will be implemented across all 64,000 pharmacies in Express Scripts' networks.

Express Scripts' Price Assure Program

To further assist those enrolled in HSA-HDHPs who are still in the deductible phase of their benefit, Express Scripts launched Price Assure to provide easy access to the lowest prices for medications on the market. Price Assure ensures customers pay the lowest price available when picking up their medication at the pharmacy, whether that price is their copay, the pharmacy's cash price for the medication, or the discounted price offered by GoodRx. In most cases, the best prescription medication price comes from our negotiated price within the benefit, but there are instances where cash discount pricing is lower, particularly for customers with HSA-HDHP plans where the customer is responsible for the full cost of the medication until they meet their deductible.

Price Assure doesn't require customers to take any action or price shop, providing a key benefit to those who will benefit from the discounts. Additionally, this program ensures any out-of-pocket costs contribute to a patient's deductible, which doesn't happen when an individual uses third-party discount programs. Most importantly, because the prescription is processed within the benefit, it undergoes thousands of health and safety checks for things like drug interactions and allergic reactions to ensure each patient gets the right medication at the right time. More than 10 million customers are enrolled in this program, provided at no cost to Express Scripts' clients.

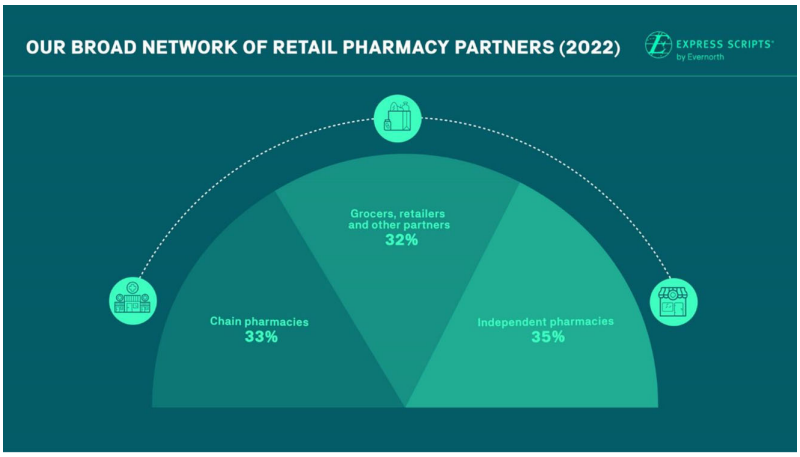
How Express Scripts Contracts with Pharmacies

PBMs build networks of pharmacies to provide consumers convenient access to prescriptions at discounted rates. Just like physician networks, pharmacy networks are designed to achieve optimal access, quality, and savings for clients and customers. A well-designed network strategy is more than just a list of in- and out-of-network pharmacies, but rather it is comprised of the right coverage to account for population size, geographic area, clinical goals, and utilization patterns.

Across the U.S., there are four types of pharmacies: (1) chain pharmacies; (2) regional pharmacies, including grocers and large consumer goods retailers; (3) independent pharmacies, of which a majority contract with pharmacy services administrative organizations (PSAOs) owned by large wholesalers; and (4) mail-order and online pharmacies, commonly known as home delivery.

Express Scripts partners with pharmacies to drive savings and access for consumers, working to make sure there is convenient access to medicines at the lowest available cost. Clients choose the pharmacy networks that work best for them and the unique needs of their employees and populations based on geography, demographics, and other key factors.

Optimizing a pharmacy network does not equate to limiting access. Express Scripts works to create flexible pharmacy network options – from large chain pharmacies to regional pharmacies to independent pharmacies and home delivery – that help ensure patients can easily access the medications they need, when and where it's most convenient. In fact, there are nearly 64,000 pharmacies in the Express Scripts national network and nearly every patient has an in-network retail pharmacy within a 15-minute drive of their home. By way of reference, that is more locations in the United States than McDonalds and Starbucks.



Pharmacies are offered competitive rates, and we contract with retail and home delivery for both traditional and specialty medications to ensure robust network coverage. Clients also have flexibility with how they pay for prescriptions dispensed to their members, including through a spread or pass-through model.

PBMs have substantial safety checks in place to review every prescription processed by every pharmacy in the network. This proactive approach is anticipated to help prevent an estimated 1 billion medication errors over the next 10 years.[35] Express Scripts continues to pioneer new ways of working with pharmacists, including launching online prescribing systems that show drug-to-drug interactions and integrate benefits into the pharmacy-provider workflow, which are designed to minimize the risk of medication errors.

Fostering Independent Pharmacy Growth

One in five Americans live in rural areas, yet less than 10% of physicians practice in those locations, creating critical access gaps. Often, independent pharmacists in those communities can close those gaps as the front lines of care, which is why Express Scripts recently launched a program to further champion and expand access to rural independent pharmacies. The IndependentRx Initiative is aimed at increasing reimbursement and health care opportunities for rural pharmacists who are on the front lines delivering health care in rural areas.

[35] "The Return on Investment (ROI) on PBM Services." Prepared by Visante on behalf of PCMA, February 2020. https://www.pcmanet.org/wp-content/uploads/2020/02/ROI-on-PBM-Services-FINAL_.pdf

Express Scripts has always offered rural pharmacies higher reimbursement, as they are an extremely valuable and necessary network partner due to lack of health care access in rural areas. The Initiative increases reimbursement to support pharmacies that prioritize pressing health care needs facing rural America.

To provide more convenient care options for patients and support our independent pharmacist partners, we're also launching efforts that increase access to certain routine, preventive, and chronic care services at independent, rural pharmacies. Within the legal limits currently in place, we will offer plan design options that would reimburse for medical services, including a variety of health screenings, tests, and clinical services (e.g., vaccine administration and influenza testing), substance use disorder education (e.g., education to administer Naloxone), and behavioral health screenings. Generally, we support the option for pharmacists to practice at the top of their licenses and encourage policies that would expand the role pharmacists play in delivering health care.

Knowing there is a lot more we can achieve together to address patient access, we also announced the creation of an Independent Pharmacy Advisory Board. By deepening our partnership with rural pharmacies, we can help remove barriers to patient care in hard-to-reach places throughout the country. We are eager to further explain this initiative and partner with policymakers to advance solutions that enable licensed independent pharmacists to play a bigger role in care delivery. In addition, all independent rural pharmacies will have increased opportunities to participate in Express Scripts' retail pharmacy networks.

These initiatives stem from a 2022 Columbia University Mailman School of Public Health study that demonstrated amid growing provider shortages, pharmacists in the U.S. are well-trusted by patients and projected to play an increasingly integral role in care management.[36] These steps build on Express Scripts' ongoing commitment to America's rural communities.

Public Policy Solutions for Greater Affordability, Access, and Predictability

Express Scripts supports public policy solutions that will advance competition and protect the use of proven private sector tools, while not eliminating or restricting the ability to negotiate the lowest overall cost. This includes:

- Providing more flexibility for HSA/HDHPs to offer lower cost options to enrollees:
    - Allowing HSA/HDHPs to offer separate deductibles for medical coverage and prescription drug coverage, provided the combined total is within the code limits (i.e., for 2022, minimum $1,400 for single coverage and $2,800 for family coverage).

[36] Press Release, Express Scripts Pharmacy. (January 12, 2022). *Pharmacists' Role to Expand Over Next Decade amid the Pandemic and Provider Shortages.* https://www.evernorth.com/articles/pharmacists-role-expand-over-next-decade-amid-pandemic-and-provider-shortages

- Amending out-of-pocket maximums so they are the same under the Affordable Care Act (ACA) by permitting separate out-of-pocket maximums provided the combined total is within the ACA limits.
- Amending inflation adjustments so that the out-of-pocket maximums for HSA/HDHPs and all other group plans are the same.
- Considering adjustments to the HSA/HDHP preventive services list.
- Increasing flexibility for HSA/HDHPs to cover high-value items and services before satisfying the deductible.

- Promoting competition by streamlining the approval process for biosimilars and issuing guidance to promote regulatory clarity, including better defined standards for the interchangeability of biological products.
- Curbing anticompetitive tactics and loopholes used by drug manufacturers to prevent or delay the market availability of lower-cost alternatives, including preventing patent "thickets" by drug manufacturers.
- Shortening the 12-year market exclusivity for brand-name biologics to seven years to promote greater price competition and earlier market availability of biosimilars.
- Ensuring health plans and PBMs retain their ability to use formularies and utilization management tools to drive utilization to lower-cost items, services, and providers in support of access to safe and reliable treatments at lower costs.
- Changes to Medicare Part D's protected class policies to offer Part D plan sponsors more flexibility in designing formularies and provide more leverage in negotiating with manufacturers, in part because the Part D program already includes strong patient protections that enable beneficiaries to gain access to any drugs subject to utilization management when clinically appropriate.
- Enhancing initiatives to increase health literacy, informing patients about where and how to access information, and encouraging the use of available information when making health care decisions.
- Building on existing private sector price transparency tools that are being iteratively improved over time, rather than cementing regulatory constructs that would limit the industry's ability to better serve patients' needs.

* * *

Thank you for the opportunity to be here today, and for the consideration of our views. We look forward to working with you and others to improve the affordability

and accessibility of insulin products. Many of the proposals highlighted in my testimony are achievable if we work collaboratively, throughout the system, to overcome the challenges facing public and private stakeholders, and the health of our nation.

I welcome the opportunity to discuss these issues with you and look forward to your questions.

The CHAIR. Dr. Kautzner, thank you very much. Our final witness is Ms. Heather Cianfrocco, who is the Chief Executive Officer of OptumRx. Ms. Cianfrocco, thanks very much for being with us.

STATEMENT OF HEATHER CIANFROCCO, CHIEF EXECUTIVE OFFICER, OPTUMRX, EDEN PRAIRIE, MN

Ms. CIANFROCCO. Chairman Sanders, Ranking Member Cassidy, and Members of the Committee, good afternoon. OptumRx, a part of UnitedHealth Group, provides essential services to our customers, which include employers, unions, health plans, and Governments.

Our team works every day to make prescription drugs more affordable and to improve health outcomes for people. We do this by conducting evidence based clinical review of medications, negotiating with manufacturers and pharmacies to bring down the cost of drugs, providing tools to help consumers and their providers use their benefits, and find the lowest cost options, supporting patients with medication adherence and disease management programs, and serving patients in our pharmacies.

Our customers pay for the medical and pharmacy care for their employees and their members. They count on us to be a counterweight to the substantial market power of manufacturers, which have the sole discretion in setting and in raising prices for their products.

We are held accountable for consistently delivering savings on prescription drugs, for lowering overall health care costs, and ensuring people have access to the medications they need. Overall, we deliver on average $1,600 in annual drug savings per person to our customers. 98 percent of our negotiated discounts pass directly to our customers, and they use these discounts to help reduce premiums to provide point of sale savings and to invest in health and wellness programs.

Without our negotiations with manufacturers, the cost of drugs would be even higher. PBMs save the system $145 billion annually. People need consistent, affordable access to insulin. In the century since insulin was discovered, it has saved and improved countless lives. But over the last decade, manufacturer's list prices for insulin have nearly doubled.

Along with leadership from Congress and others, our company has been at the forefront of efforts to make insulin more affordable. We began offering point of sale discounts on insulin and other related drugs to fully insured group customers in 2018.

Since 2019, the number of consumers we serve who pay $35 or less per month for insulin has increased by 34 percent. Millions of people now have access to insulin at reduced costs through our preventive drug list.

The 8 million people in United Health Care standard fully insured group plans now pay nothing out-of-pocket for preferred short and long-acting insulins and other lifesaving drugs, which includes EpiPens and Albuterol. And working with Sanofi, we offer a monthly supply of insulin for $35 for uninsured individuals. The standing—the standard offering we recommend to our customers

caps insulin out-of-pocket at $35 and supports affordability for patients and high deductible health plans.

As a result, our 1.7 million consumers who take insulin now pay an average of $22 per month, and our efforts are ongoing. We also welcome the recent announcement by the three largest insulin manufacturers to lower their list prices on some insulin products. And let me be clear, we support and encourage lower list prices across the board. Despite the recent progress on insulin, more can be done.

Cost sharing on a month's supply of insulin is now capped at $35 in Medicare. A similar approach in the commercial market would close the gap for Americans who still cannot consistently afford insulin. But importantly, such a cap must preserve the ability of PBMs to negotiate for lowest costs of insulin for their customers.

Because even with the welcomed list price reductions by some manufacturers on some insulins, the list price of insulin is still above $35 per prescription. Beyond insulin, broader reforms are needed to foster competition among manufacturers and to make prescription drugs more affordable for Americans and sustainable for our Country.

Reforms are needed to promote access to generics and biosimilars, including closing loopholes that enable pay for delay, product topping, and other delay tactics. A 10-year cap on a product's exclusivity should be established, regardless of the number of follow-on patents. And public policy should also support more value-based arrangements to ensure that resources are focused on the treatments that deliver the best outcome for patients.

We appreciate this opportunity to share our perspective with the Committee. Our company will continue to do our part to make insulin and all prescription drugs more affordable and to improve the health for all Americans. I welcome any questions you may have. Thank you.

[The prepared statement of Ms. Cianfrocco follows.]

PREPARED STATEMENT OF HEATHER CIANFROCCO

Chairman Sanders, Ranking Member Cassidy, and Members of the Committee:

I am Heather Cianfrocco, CEO of Optum Rx, a part of UnitedHealth Group. I appreciate the opportunity to address the vitally important topic of the cost and accessibility of insulin. While meaningful progress has been made through both private sector and government actions, more can be done to close the remaining gaps in consistent, affordable access to insulin for everyone who needs it.

Our customers—employers, unions, health plans, and governments—count on us to help them access the most effective medicines at the most affordable cost. Our team of pharmacists, pharmacy technicians, clinicians, and health care professionals works every day to improve health outcomes and simplify the health system for consumers. It is important to note that companies like ours are the only link in the drug supply chain that exists to reduce costs.

My testimony focuses on three areas:

1. How our Company makes prescription drugs more accessible and affordable and improves health outcomes for patients.

2. Actions our Company has taken to make insulin more affordable.

3. Policy solutions to make insulin and other prescription drugs more affordable for people and more sustainable for the country.

How Our Company Makes Prescription Drugs More Accessible and Affordable and Improves Health Outcomes

Our Company's role is to ensure patients have access to the prescription drugs they need while managing the cost of those drugs. Companies like ours act as a counterweight to the substantial market and pricing power of drug manufacturers, which have the sole discretion in setting prices for their products. Under loopholes in the current patent system, periods of product exclusivity can be extended by manufacturers and product competition limited for decades, amounting to government-granted monopolies. This makes our role even more critical.

Thousands of employers of all sizes rely on our negotiations and the resulting savings off of high and increasing drug list prices. Our negotiated discounts and clinical tools deliver approximately $1,600 in average annual drug savings per person. A recent paper by a University of Chicago economist concluded that without these negotiations with manufacturers, the cost of drugs would be even higher. In fact, this research shows Pharmacy Benefit Managers (PBMs) save the system $145 billion annually.[1] Our customers rely on our essential services and these material drug cost savings to control medical and pharmacy benefit costs for their employees and members. Moreover, the role we play is more important than ever with the advent of exceptionally high-priced specialty drugs, a large and growing piece of the prescription drug market in which competition is lacking, and many manufacturers offer no discounts.

Our customers recognize the value of our services, which are provided in a highly competitive market. As of 2021, there were 70 companies that offered a full range of pharmacy benefit services in the U.S. market.[2] We must compete day in and day out to win and retain our customers. We face competition from pharmacy benefit companies of varying sizes with different value propositions—some of which are growing disruptors in the market. We are constantly innovating to drive costs lower and meet the unique needs and demands of current and prospective customers.

We compete for business on our clinical capabilities, patient support programs, drug trend analytics and insights, but most importantly on our ability to lower drug costs for our clients, regardless of list price. This squarely aligns the interests of pharmacy benefit companies with our clients and our consumers, not with the manufacturers that set the prices for prescription drugs.

Optum Rx plays four essential roles in serving customers and consumers.

First, everything we do begins with a clinical foundation. Our work is anchored by clinical data and starts with our independent Pharmacy & Therapeutics (P&T) Committee, which applies significant clinical rigor and provides unbiased, evidence-based review and appraisal of new and existing drugs and their place in therapy. Our P&T Committee is made up of physicians, nurses, and pharmacists who are not affiliated with Optum Rx and operates in a highly transparent manner. Our customers are welcome to observe the P&T Committee's clinical decision-making process.

Second, once we have completed our clinical assessment, we aggressively negotiate with drug manufacturers to secure the lowest net cost for our customers to enable them to control costs for their members. Although more than 90 percent of prescriptions are for low-cost generics, often without rebates,[3] negotiated discounts are the only check on manufacturers' pricing power for most branded drugs (the remaining 10 percent of prescriptions). While negotiating for discounts on these expensive branded drugs is a vital role, it is only one of the ways we work to ensure people have access to the most affordable medicines. We offer our customers a wide range of formularies, which enables them to choose the solution that best fits their needs and meets their affordability, predictability, and transparency expectations.

Third, we provide a range of options for providing the prescription drug benefit that meets the needs of our diverse employer, union, health plan, and government customers. While our customers ultimately determine their medical and pharmacy benefit design, we offer benefit plans that balance their health care cost affordability with patient out-of-pocket cost protections, such as our $35 insulin and critical drug affordability program. We also offer our customers choice in how they compensate

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[1] Casey Mulligan. "The Value of Pharmacy Benefit Management." July 2022. Available at: *https://bfi.uchicago.edu/wp-content/uploads/2022/07/BFI-WP-2022-93.pdf*.

[2] PCMA. "The Highly Competitive PBM Marketplace." April 2021. Available at: *https://www.pcmanet.org/highlycompetitive-pbm-marketplace/*.

[3] Food and Drug Administration. "Office of Generic Drugs 2021 Annual Report." Available at: *https://www.fda.gov/drugs/generic-drugs/office-generic-drugs-2021-annual-report#::text=Currently%2090%20%E2%80%949%20out,they%20are%20on%20the%20market*.

us for the savings we generate and reimburse us for pharmacy claims administered by our pharmacy network. Some customers choose to compensate us for the savings we generate and the services we provide by opting for us to retain a small fraction of the discounts we negotiate with pharmaceutical manufacturers. Other customers prefer that we pass along to them 100 percent of the savings we negotiate and instead compensate us via administrative fee. Some reimburse us for pharmacy network claims through a predictable, aggregate payment and some choose a per claim or "pass through" reimbursement. Our clients are provided options and they each make the choice that best meets their needs. On average, Optum Rx passes through 98 percent of the discounts and the pharmacy rates we negotiate to our customers. These savings enable them to reduce premiums, provide point-of-sale discounts, and invest in population health and wellness programs.

A key underpinning of this process is Optum Rx's ability to achieve the lowest net cost for our customers for the benefits they provide—through a combination of negotiating both discounts with manufacturers and reimbursement with a network of pharmacies where members fill their prescriptions. The essential value we deliver is validated by each of the employer, union, health plan, and government customers who have selected us as their PBM. For this service, our fees equate to 2 percent of these savings, which covers the administrative functions of negotiation, formulary management, pharmacy network management, credentialing, payment, auditing, and reporting. After performance of these functions—and all the clinical, claims, client, provider, and patient related benefit administrative functions, our Optum Rx margin was roughly 4 percent in 2022.

Fourth and finally, we deploy innovative clinical support programs to actively support the patients we serve at each stage of their health care journey, as well as tools to drive affordability. Our PreCheck MyScript tool enables health care providers and patients to see how much a prescription will cost—and if there are any lower cost alternatives—before leaving a provider's office. Our Price Edge tool ensures patients pay the lowest cost in the market for their prescription and has already saved patients more than $4 million since the program launched in January. We also offer condition-specific medication adherence programs to make sure patients stay on therapy once prescribed. All these tools help people cut through the complexity that can be a barrier to accessing affordable, high-quality care.

Actions Our Company Has Taken to Make Insulin More Affordable

Diabetes is the eighth leading cause of death in the United States.[4] More than 37 million people, or 11.3 percent of the U.S. population has diabetes.[5] Diabetes leads to decreased life expectancy and higher health care costs. The appropriate management of diabetes may encompass a range of interventions for patients, including insulin for those who depend on it.

Insulin was discovered more than a century ago and it has now been 23 years since long-acting insulin was first made available to patients.[6] Since that time, little significant clinical advancement has been made, but insulin manufacturers have continued to raise prices due to pricing power and insufficient competition.

Loopholes in U.S. patent law enable pharmaceutical manufacturers to continue extending patent protection for a drug well beyond its original date through tactics such as product hopping, where manufacturers attempt to switch patients to new formulations of their products before losing exclusivity. This action results in higher prices that directly impact patients. As another example of efforts to delay competition, one insulin manufacturer accumulated more than 70 secondary patents to block biosimilar competition.[7] Only after significant litigation and a change in the approval pathway for insulin biologics were competitors able to come to market. Moreover, as noted in the Senate Finance Committee's 2019 Report on the insulin market, many of the secondary patents filed for insulin are related to mechanisms

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[4] Centers for Disease Control and Prevention, National Center for Health Statistics. Available at: *https://www.cdc.gov/nchs/fastats/leading-causes-of-death.htm*.

[5] Centers for Disease Control and Prevention. "National Diabetes Statistics Report: Estimates of Diabetes and Its Burden in the United States." Available at: *https://www.cdc.gov/diabetes/data/statistics-report/index.html*.

[6] Food and Drug Administration. "100 Years of Insulin." Available at: *https://www.fda.gov/about-fda/fda-history-exhibits/100-years-insulin*.

[7] Initiative for Medicines, Access and Knowledge (I-MAK), "Overpatented, Overpriced, Special Edition: Lantus." October 2018. Available at: *http://www.i-mak.org/wp-content/uploads/2018/10/I-MAK-Lantus-Report-2018-10-30F.pdf*.

for delivery (e.g., pens and auto-injectors)—not the medicine itself.[8] This finding raises important questions about what kind of innovation current patent law is encouraging.

The Senate Finance Committee Report also found insulin manufacturers raise prices in lockstep with one another—a practice known as "shadow pricing." This practice has resulted in a lack of price differentiation and high insulin list prices with no connection to the rate of health care inflation or the cost of goods. This historical insulin pricing serves as a case study for harmful manufacturer pricing strategies. Shadow pricing exists because of manufacturers' sole control of the price of their products and a lack of meaningful competition in the insulin market.

In the last several years, with leadership from Congress and action in the private sector, meaningful progress has been made in making insulin more affordable in Medicare and the commercial market. Last year, UnitedHealthcare was the first to implement zero-dollar cost sharing for insulin for its fully insured members. The Medicare Part D $35 monthly out-of-pocket cap on insulin that went into effect this year is providing certainty to all seniors in Part D. The recent announcements by some drug manufacturers that they will lower their list prices on some insulin products in advance of the approaching removal of the cap on Average Manufacturer Price rebates in Medicaid was a welcome development and confirms that drug manufacturers alone have the power to set and raise prices. They also have the power to lower them when it is in their interests to do so. Policies that discourage list price increases help reduce drug costs to customers and consumers.

We know that when patients have reliable, consistent, and affordable access to needed medications, including insulin, they are better able to adhere to their medications as prescribed, which leads to better health outcomes. Our company has been at the forefront of efforts to improve access to affordable insulin and provide comprehensive care to patients with diabetes:

- Optum Rx negotiates discounts from manufacturers on behalf of our customers and on average passes 98 percent of the discounts through to them, which allows them to keep premiums low, improve benefits, or lower out-of-pocket costs for patients.
- We began offering point-of-sale discounts on insulin and other rebated drugs to fully insured group customers in 2018.
- As part of the company's initiative to make critical and life-saving drugs more affordable, in July 2022, UnitedHealthcare eliminated out-of-pocket costs in its standard fully insured group plans for preferred short-and long-acting insulins as well as EpiPens, Albuterol and Naloxone.[9] Offering these preferred drugs at $0 cost share builds on our previous actions, including point-of-sale discounts, that have delivered millions of dollars of savings directly to consumers at the pharmacy counter.
- We have placed insulin on our Preventive Drug List, given the important role insulin plays in preventing the development of additional health conditions. These drugs are available at a reduced out-of-pocket cost to patients with preventive drug benefits through their health plans. This action is particularly important for patients enrolled in high-deductible health plans in the commercial market and has driven more than $14 million in patient out-of-pocket savings on drugs in the first quarter of 2023 alone.
- In addition, for new clients, our standard recommended benefit caps out-of-pocket costs for the preferred insulin at $35, and for customers in high-deductible plans, our plan clients have the option to bypass the deductible and apply their rebates to the customer's co-insurance obligation at the point of sale.
- We were active partners in the CMS Medicare Part D Demo Model that piloted $35 insulin. The program rolled out to all Part D beneficiaries in 2023.
- Through our integrated pharmacy and clinical care services, we provide comprehensive chronic care management to patients with diabetes. Pa-

[8] See footnote 4, U.S. Senate Committee Finance. "Insulin: Examining the Factors Driving the Rising Cost of a Century Old Drug." January 2021. Available at: *https://www.finance.senate.gov/download/grassley-wyden-insulin-report*.

[9] "UnitedHealthcare To Eliminate Out-of-Pocket Costs on Several Prescription Drugs, Including Insulin, for Eligible Members." July 2022. Available at: *https://newsroom.uhc.com/news-releases/uhc-eliminate-out-of-pocket-costs.html*.

tients have access to pharmacists and pharmacy technicians—24 hours a day, 7 days a week—who provide face-to-face or virtual consultations and coaching to help patients manage diabetes and other chronic conditions. More than half of the patients in our Diabetes Management Program experienced improved A1C levels.

- Working with Sanofi, we offer a monthly supply of insulin for $35 for uninsured individuals.
- As a result of these efforts, our 1.7 million consumers who take insulin now pay an average of $22 per month—and our efforts are ongoing.

Manufacturers have blamed companies like ours, along with health plans and hospitals, for high drug prices. They contend that the discounts we negotiate with them are the root cause of the problem. However, drug prices are rising fastest on specialty drugs, where manufacturers are less willing to negotiate discounts due to the lack of clinical alternatives or other meaningful competition. It is no surprise, then, that CMS reported that in 2016 and 2017, prices increased the most for drugs with only one manufacturer.[10] Additionally, economist Alex Brill concluded that list prices of rebated and non-rebated drugs have been increasing at comparable rates—dispelling the myth that discounts negotiated by companies like ours are responsible for the list prices set and raised unilaterally by drug manufacturers.[11]

Policy Solutions to Make Insulin and Other Prescription Drugs More Affordable for People and More Sustainable for the Country

While progress has been made in promoting insulin affordability, more can be done. Our company strongly supports policy solutions that will fill in gaps, increase competition among manufacturers, and ensure all patients—regardless of their coverage situation—can access this lifesaving medicine.

As mentioned earlier, under Federal law cost sharing for covered insulins in Medicare is now capped at $35 for a month's supply. A similar approach in the commercial market would close the gap for Americans who still cannot consistently afford insulin. Importantly, such a cap must preserve the ability for pharmacy benefit companies to negotiate for the lowest cost of insulins for our customers. Even with those welcomed list price reductions by some manufacturers on some insulins, the list price of insulin is still above $35. Taking this approach in the commercial market would protect patients at the pharmacy and ensure employers, plans, unions, and governments can still obtain the lowest net cost for insulin.

Beyond insulin, broader reforms are needed to make all prescriptions drugs more affordable for people and sustainable for the country. This starts with creating more competition in drug manufacturing.

We are most effective in negotiating with manufacturers to achieve savings when competition exists. To that end, public policies are needed that both encourage competitors to enter the market and end the widespread use of manufacturer practices that actively prevent competition and extend patent protections for medicines far longer than originally intended.

Congress should address abuses of the patent system that prolong a drug's market exclusivity and delay the entrance of generic and biosimilar therapies. While patents play an important role in ensuring manufacturers earn a return on a successful drug, current law allows manufacturers to exploit loopholes and extend these protections for no other purpose than greater profit. Manufacturers' ability to build "patent thickets" around products and engage in pay-for-delay and product hopping schemes should be prohibited. To prevent these and other abuses, a 10-year cap on a product's exclusivity should be established—regardless of the number of patents associated with it. Additional support should also be given to the Patent and Trademark Office to ensure it has tools to identify and invalidate weak or superfluous pharmaceutical patents in a timely manner.

Finally, we continue to support efforts to expand value-based arrangements between payors and pharmaceutical manufacturers. The flexibilities offered by these models can speed access to new therapies, ease budgetary pressures on health systems, and ensure health care dollars are spent on treatments that work. The Federal Government can advance these goals by adopting more modernized price report-

[10] Sarah Karlin-Smith, Sarah Owermohle, and Janie Boschma. "Drugs with a single manufacturer drive Medicare, Medicaid, spending increases, CMS says." Politico, March 2019.

[11] Alex Brill. "Understanding Drug Rebates and Their Role in Promoting Competition." March 2022. Available at: *https://www.affordableprescriptiondrugs.org/app/uploads/2022/02/CAPD-Brill-Report-FINAL.pdf*.

ing requirements in Medicare and Medicaid and allowing greater flexibility in the Medicare benefit to enable cost sharing structures that reflect value-based pricing arrangements.

In conclusion, we appreciate the opportunity to share with the Committee the meaningful steps we have taken and will continue to take to make insulin more affordable for patients we serve. We are committed to doing our part to make insulin and all prescription drugs more affordable and to improve health outcomes while enhancing the consumer experience.

[SUMMARY STATEMENT OF HEATHER CIANFROCCO]

Optum Rx appreciates the opportunity to address the vitally important topic of the cost and accessibility of insulin. While meaningful progress has been made through both private sector and government actions, more can be done to close the remaining gaps in consistent, affordable access to insulin for everyone who needs it.

My testimony focuses on three areas:

1. How our Company makes prescription drugs more accessible and affordable and improves health outcomes for patients.

- Companies like ours are the only counterweight to the substantial market power of drug manufacturers, which have the sole discretion in setting drug prices.
- Our negotiated discounts and clinical tools deliver approximately $1,600 in annual savings per person.
- Across the sector, research has found that PBMs save the health care system $145 billion annually.
- Optum Rx plays four essential roles in serving customers and consumers:
  - Developing a drug formulary with a strong clinical foundation.
  - Negotiating with drug manufacturers to drive toward the lowest net cost for medicines.
  - Developing a range of options for our customers to compensate us for providing the prescription drug benefit.
  - Deploying innovative clinical support programs that lead to affordable, high-quality care.

2. Actions our Company has taken to make insulin more affordable.

- Our company has taken many actions to improve access to affordable insulin and provide comprehensive care to patients with diabetes, including:
  - We pass 98 percent of the discounts we negotiate with drug manufacturers through to our customers, allowing them to keep premiums low, improve benefits, or lower out-of-pocket costs for patients.
  - We began offering point-of-sale discounts on insulin and other rebated drugs to fully insured group customers in 2018.
  - UnitedHealthcare eliminated out-of-pocket costs in its standard fully insured group health plans for preferred insulins.
  - We placed insulin on our Preventive Drug List making insulin available at a reduced out-of-pocket cost to patients with preventive drug benefits. This is particularly important for patients enrolled in high-deductible health plans in the commercial market.
  - Working with Sanofi, we offer a monthly supply of insulin for $35 for uninsured individuals.
  - As a result of these efforts, our 1.7 million customers who take insulin now pay an average of $22 per month—and our efforts are ongoing.

3. Supportive policy solutions to make insulin and other prescription drugs more affordable for people and more sustainable for the country.

- A cap on insulin cost sharing in the commercial market could help those Americans who still cannot consistently afford insulin. However, such a cap must preserve the ability for PBMs to negotiate for the lowest cost of insulin for our customers.

- We also support efforts to create more competition among manufacturers, promote access to generic and biosimilars therapies, close patent loopholes, and facilitate greater adoption of value-based arrangements.

The CHAIR. Ms. Cianfrocco, thank you very much. We are now going to begin questioning, and I will begin it. Let me start off by saying if somebody in the real world is watching this hearing, they have heard every single person from the drug companies and from the PBMs say we are working tirelessly to lower the cost of prescription drugs, just knocking our brains out.

Yet at the end of the day, 1.3 million Americans are rationing their insulin. People have died. People end up in the hospital. And you are working night and day to lower the cost. And all over the world, people are paying a fraction of the price, not only for insulin, but for other products, drugs, than we are paying.

I am going to—and I would appreciate very brief answers because we don't have a whole lot of time up here. So let me start off with Eli Lilly, and I am going to go down the line here. Mr. Ricks, since 1996, Eli Lilly increased the price of Humalog 34 times from $21 to $275 bucks—same exact product.

I am told that it costs $5 to manufacture this product, and the story is not different for the products produced by Novo and Sanofi. So, my question to you, and to the other drug companies, will you commit to this Committee today that you will not increase the price of any insulin product again? Mr. Ricks.

Mr. RICKS. Thank you, Chairman, for the question. As I mentioned in my comments, all we have done——

The CHAIR. Be brief——

Mr. RICKS [continuing]. Is reduce the prices since I have been CEO. So, I am comfortable saying, we will leave our prices as they are for the insulins on the market today.

The CHAIR. All of your products?

Mr. RICKS. Yes. In fact, we have been cutting them, is the point I am making.

The CHAIR. All right. You are not going to raise—Mr. Hudson.

Mr. HUDSON. We have said before, we have a responsible and sustainable pricing approach. We have had it since 2017 and that price has continued to fall, and the net price for insulin today for Lantus is lower than it was in 20—when it was launched in 2001.

The CHAIR. I am hearing from you that you will not increase the price of any insulin product again?

Mr. HUDSON. To repeat myself, we have a responsible pricing policy standard in the——

The CHAIR. Yes or no would be the better answer.

Mr. HUDSON. We have a responsible pricing policy. We have set that since 2017.

The CHAIR. All right. Mr. Jorgensen.

Mr. JORGENSEN. Yes, sir. Thank you. Senator, we are committed to limit the potential price increases to a single digit. We have not taken any for the past many years. In fact, we see double digit decline in the price of insulin for the past 6 years.

Our price, our net price today is lower than when we launched our products. So, we see a dramatic, dramatic fall in price, for instance, in the U.S. market.

The CHAIR. Okay. Let me ask the drug companies another question before we go to the PBMs, and that is there are a number of newer insulin products that all three of you have brought forth to the market.

Do all of these insulin products still cost more than $300? Will you commit to doing to those products what you have done to your other insulin products and substantially reduce the price of all insulin products? Will you make that commitment to us?

Mr. RICKS. Senator, we have capped the cost for the consumer at $35 for every Lilly insulin.

The CHAIR. That means, I may be mispronouncing it, Lyumjev—how do you pronounce it?

Mr. RICKS. Lyumje.

The CHAIR. Lyumjev—wasn't close. All right. That is going to be sold for $35?

Mr. RICKS. The patient will pay no more than $35 in the United States for that product.

The CHAIR. Okay. Mr. Hudson, your product is Toujeo, is that what it is?

Mr. HUDSON. Yes, and it is equal for us that it would be less than $35. If I could just add one quick thing. Our most recent launch was Atlanta's at 60 percent lower list price that was not accepted by the system.

The CHAIR. Okay. And Fiasp is sold by Novo Nordisk. Mr. Jorgensen?

Mr. JORGENSEN. Yes. And I can also confirm that we have availability of insulin that is below $35 for all arrangements for patients, if they want that support from us.

The CHAIR. All right. Let me ask—thank you. Let me ask the PBMs a question. It is a simple question, and I would appreciate a yes or no answer. Will you commit today that your companies will put insulin products on your formularies with the lowest list price? Mr. Joyner.

Mr. JOYNER. We will commit to put the lowest cost product on our formulary—net of discounts and rebates. So, whether it be the low list price or the high list price, our job is to deliver the lowest net cost, post discounts. Discounts off of high and, or lowest price.

The CHAIR. Dr. Kautzner.

Dr. KAUTZNER. Thank you for the question, Senator Sanders. We will commit to putting the lowest net cost product on formularies. However, we also have other formularies that are other choices for our employers to choose from which do have low list price products also available. So, we offer multiple different choices to our employers.

The CHAIR. Ms. Cianfrocco.

Ms. CIANFROCCO. We commit to always providing the lowest cost option to our clients, to the lowest cost, and other products that are available to other clients through other formularies.

The CHAIR. Thank you. All right. Let me go back to Mr. Ricks. Mr. Ricks, Eli Lilly charges $196,000 in the United States for Cyramza, a stomach cancer drug. That same drug can be purchased in Germany for just $54,000. Would you commit to this Committee to lower the price of Cyramza in the United States to the same price that you are selling in Germany, 54,000? Yes, no?

Mr. RICKS. Respectfully, Senator, that product has been on the market for a while. We do expect biosimilar entry. That is the primary mechanism in the U.S. where the price will fall when that occurs. I am sure there will be competition and the price will fall.

The CHAIR. But what you are telling me is that the American people will have to pay four times more than Germans do for the same product that you manufacture? Okay. Mr. Hudson, Sanofi is a French company.

In France, Sanofi sells a thyroid cancer treatment, Caprelsa, for $30,000 a year. Sanofi sells the same drug in the United States for $203,000 a year. It is nine times as much.

Will you commit to lowering the price of Caprelsa in the United States to $30,000, the same price as it is sold in France?

Mr. HUDSON. Over time with the introduction of competition and other biosimilars, etcetera, you will see the price fall.

The CHAIR. The answer is no. Mr. Jorgensen——

Senator CASSIDY. Mr. Chairman.

The CHAIR. Yes.

Senator CASSIDY. I hate to interrupt, but we are now—you are at 7 minutes——

The CHAIR. You will have the same amount of time.

Senator CASSIDY. Does every Member have that?

The CHAIR. Absolutely. Mr. Jorgensen, in Denmark, Novo Nordisk sells a diabetes treatment, Ozempic, for $2,000 per year. That is six times more—you charge six times more to Americans. Will you reduce the cost of Ozempic in the United States to what it is in Denmark?

Mr. JORGENSEN. [Technical problems]—the amount you mentioned for the U.S. is before rebates. So, on average we pay 75 percent in rebates in the U.S., and for Ozempic, we actually see price going down, only the prices going down, year over year. So, we get a low price already.

The CHAIR. All right. Answer is no.

Senator Cassidy.

Senator CASSIDY. I defer to Senator Paul.

Senator PAUL. The great thing about capitalism is that supply and demand intersect, and you get the largest supply at the least cost when you allow capitalism to function. Now, capitalism doesn't function very well in drug markets because Government has been involved for a long time.

But prices need to be based on supply and demand. A publicly traded company to promise to base their prices on bullying from a politician would actually be in breach of their fiduciary duty.

I mean, it is actually illegal to say, I am going to make all the prices go down in my company. But it would also be irrational because if you did and there was no profit margin, the companies would be gone, and they would no longer exist.

Mr. Ricks, if a patient has a co-pay of $50, would the rational decision be then to choose Lispro over Humalog?

Mr. RICKS. In the case where they were buying one unit, yes, they pay $25, not $50.

Senator PAUL. Right. So, if the patient had a co-pay of $25 and Lispro is $25 and Humalog is $100, but I am only going to pay $25, is there any rational reason why I would want to buy the least expensive one? I would want to buy the more expensive drug at that point.

Mr. RICKS. Well, they are identical. In that case, they would be indifferent because they are paying $25 out of pocket either way.

Senator PAUL. Right. So here is the interesting thing. The lower the co-pay, the less the consumer cares about the price.

You can mandate lower and lower co-pays, but you might actually get the opposite. You might actually drive consumers toward something that is actually more expensive. So, for example, under Obamacare, we made birth control have no co-pay, so there is no co-pay for birth control.

But if you look at the price of birth control as it became free, the demand became enormous or greatly enhanced, and so the prices went up. From 2013 to 2019, you had a threefold increase in the price of birth control. So, the most important thing, as we think things through.

We all want lower prices, but if you want to mandate lower co-prices for things, you may well get the opposite because you are taking away the consumer from the equation.

Now the consumer is only involved in drug prices through the co-pay or the deductible, and so much of healthcare, 80, 90 percent of it is beyond that. And so how do we lower co-prices, or we lower prices for drugs?

People hire an intermediary. Dr. Kautzner, does anybody hire you, who, what businesses, labor unions, because they want higher prices?

Dr. KAUTZNER. Absolutely not, Senator.

Senator PAUL. If you didn't provide lower prices, would they hire either another PBM or do it on their own?

Dr. KAUTZNER. We exist in a highly competitive market. So, if we didn't deliver the value that we commit to our clients, they would certainly go elsewhere.

Senator PAUL. It is quite confusing. We want to blame PBMs for everything, but why do people hire them? No one is forcing anybody to hire them.

As I understand, the companies represented here represent tens of thousands of businesses who voluntarily come to you and hire you. And they pay you and you make a profit.

Your profit, is it exorbitant? Is your profit—Ms. Cianfrocco, is your profit greater than the drug companies somehow?

Ms. CIANFROCCO. Senator, our profit is—our margin is 4 percent, roughly 4 percent for the services we provide to all of our clients.

Senator PAUL. That is about like Wal-Mart. I mean, I am surprised we don't have Wal-Mart here today to beat up on Wal-Mart. We are all unhappy, but we have to be rational about what we are doing.

Spread pricing, everybody is like, oh, this terrible spread pricing. Dr. Kautzner, do you offer spread pricing and also pass through pricing?

Dr. KAUTZNER. Yes, Senator. We offer both options to our clients today. Roughly one-third choose spread pricing. Two-thirds choose a pass through type of model. They choose spread pricing in order to have predictability on their pharmacy benefit.

We shield them from incremental costs because we effectively provide them with a guarantee or a lock in on price.

Senator PAUL. Which is more expensive, spread pricing or pass through pricing when you offer it?

Dr. KAUTZNER. We are agnostic to the type of pricing that we offer. It is more for the client to make that decision.

Senator PAUL. No, but there is a price. One—is spread pricing cheaper or more expensive than pass through pricing if I am a customer.

Dr. KAUTZNER. Generally, they are going to be roughly equal in price or cost. There may be——

Senator PAUL. Ms. Cianfrocco, same question.

Ms. CIANFROCCO. You are referring to spread pricing as the mechanism where a client pays one price for all the pharmacy claims adjudicated. It offers predictability, and often cases, it offers controlled pricing and can be less expensive than if they pay every claim on a pass through model. But both are offered to our clients.

Senator PAUL. This needs to be pretty clear, and people need to think through. We have a bill before us to ban spread pricing. So at least one of the companies, and I think others have said this, spread pricing is less expensive than pass through pricing.

We are going to ban the cheaper form of buying your drug insurance. Why would we ban the cheaper form? It sounds like if you ban the cheaper form, you might get the opposite result of what you are intending.

You might actually get higher prices. Not to mention why we should be banning any of this but is there a possibility you ban spread pricing and then they, people decide to add more of a fee on the pass through pricing because, see, their obligation is to their stockholders, and they are legally bound to make a profit.

If you tell me can't make a profit here, wouldn't they have to try to make a profit somewhere else if they are going to please their stockholders. But the thing is, we haven't thought this through. We are angry. Everybody is angry. I am angry. I have gone to the drugstore before and seen something for $1,600, an acne cream.

We are angry. But why is it so obscure? Why is it different than electronics? Why is it different than buying a car? Why is it different than a lot of expensive things? Because we have made it

opaque through all of these different things that we have mandated. In the 1930's, we passed antitrust law, the Robinson Patman Act, and we made it illegal to pass through discounts based on volume.

Then we had a court case that now says you have to move market share and all these complicated things to get these rebates. But the bottom line is, in a free society, rational thinking, labor unions, and businesses, and health organizations are choosing a PBM. Why are they choosing a PBM?

Do you think they want higher prices? And if a PBM is gouging them, why don't they go to another PBM? There is like 70 some odd PBMs, and yet we have got in our heads somehow, we are going to forbid this.

In the Lispro example, Dr. Kautzner, so what happens to that, if we have a $25 co-pay and you got $100 Humalog and you got a bigger rebate, and you are going to make more profit on the rebate? Are you keeping Lispro off of your list or can I get Lispro if I am a business and I have people who are diabetic in my business?

Dr. KAUTZNER. Thanks for the question, Senator. So, our focus is on lowest net cost of the product. And so that is where we are focused the most. And as we all know, all insulins are not created equal. We actually separate insulins into three different categories as well. But our focus is lowest in the cost to patients——

Senator PAUL. Let's say they were equal. You have Humalog and Lispro, it is the same thing, and Lispro is $100 bucks, and you get a $75 rebate to make it $25.

Now we are equal price to the business you are selling your plan too, but there is more rebate. Does that mean you are excluding Lispro from a list, that I—if I am a business, is it somehow working that way to exclude cheaper generics is my question.

Dr. KAUTZNER. Our focus is on where lowest net cost is available for products.

Senator PAUL. I think there is a possibility, and I think that might be one complaint. There is a possibility of this. However, here is the rub. They are still giving you the lowest net price.

If you say, well, gosh, the generic, I would rather the generic, it is underneath the copay, so it is outside of what the negotiation is, and so that is the only way it's going to make a difference to the consumer. But actually, I think that in the long run, as we look at it, the net cost is still what we are looking at.

When everybody shakes their hands, oh, the net cost, the list price—the list price means absolutely nothing the same way they mean nothing in medicine. But the thing is, we got this complicated thing. This isn't capitalism.

We got this because of antitrust laws in the 30's. We got this from a court case based on the antitrust law in the 90's, and we have this complicated system. But instead of trying to unravel the complications we put on the market, what we are asking is to ban certain contracts.

I think what you are going to have in the end is you are going to have the unintended consequences of doing something, trying to do to make things better, and actually make the situation worse.

The CHAIR. Senator Paul, thank you.

Senator Baldwin.

Senator BALDWIN. Thank you, Mr. Chairman. Thank you to our witnesses today. In preparation for this hearing, I was reflecting back a few years when this very Committee had held several hearings on drug prices, and we had panels not totally unlike the one we have today with representatives from PBMs and representatives from drug companies, and a lot of finger pointing.

I remember a few weeks after those hearings, having then Secretary of HHS, Alex Azar in front of us, who was formerly associated with a pharmaceutical company as an executive. And I was reading a letter that I got from a constituent. It was a father, two sons, both with juvenile diabetes.

He was talking about just how much the family had to spend each month to keep his sons healthy. And at the end of sharing that letter, I said to Secretary Azar or asked, what should I tell my constituent about why these costs are so high? And he said, it is complicated. That is what he said. It is complicated.

That is not an answer I can provide to my constituents who struggle with this. And there was just a discussion by one of my colleagues about opaqueness and lack of transparency. I find that basically an issue of the industry not being transparent.

When I ask questions like help me follow the dollars, if you double the price of a drug, help me figure out who is pocketing that extra price. And I get, it is complicated as an answer. If we are going to make good policy, we have to have more transparency, and it is why I am glad this Committee is working on measures to achieve that.

But one thing I can say when we look at people versus profits is greed is not complicated. Prescription drug manufacturers tell us they invest significant resources in research and development.

PBMs tell us they invest significant resources in making drugs more affordable and accessible to patients. But both industries are also working overtime for profits and self-enrichment. Mr. Ricks, yes or no, did Eli Lilly conduct $1.5 billion in stock buybacks in the year 2022?

Mr. RICKS. I believe that is approximately the number.

Senator BALDWIN. Mr. Joyner, yes or no, did CVS Health conduct $3.5 billion in stock buybacks in 2022?

Mr. JOYNER. I am not sure.

Senator BALDWIN. If I had the consolidated statement or consolidated financial statements in front of me that indicated such, would you agree that is the figure?

Mr. JOYNER. I would.

Senator BALDWIN. Okay. Dr. Kautzner, yes or no, did Express Scripts parent company, Cigna, conduct $7.6 billion in stock buybacks in 2022?

Dr. KAUTZNER. I believe that is accurate, Senator, yes.

Senator BALDWIN. Ms. Cianfrocco, yes or no, did UnitedHealth Care, which owns OptumRx, conduct $7 billion in stock buybacks in the year 2022?

Ms. CIANFROCCO. Yes, that is about correct for UnitedHealth Group.

Senator BALDWIN. Mr. Jorgenson, yes or no, did Novo Nordisk conduct $24 billion in Danish krona, worth roughly $6—or $3.6 billion worth of stock buybacks in 2022?

Mr. JORGENSEN. I believe that is approximately incorrect. We have majority ownership in the Novo Nordisk Foundation who gets the money and award money back to society for social and scientific purposes.

Senator BALDWIN. Mr. Hudson, yes or no, did Sanofi conduct a 497 million of stock buybacks in 2022, or roughly equivalent to $544 million USD?

Mr. HUDSON. That is correct, Senator.

Senator BALDWIN. Thank you. We are taking, Mr. Chair, some steps in the right direction, Mr. Ranking Member, in the legislation that we will be working on tomorrow in this Committee. And I am hopeful that we are able to specifically tackle insulin prices later this year.

But we can't ignore the business practices of the companies that have come before us today. Part of how we tackle drug prices relates to that need to get transparency and that need to take on the aspect of greed.

The CHAIR. Thank you very much, Senator Baldwin.

Senator Cassidy.

Senator CASSIDY. I will go ahead and take my questions now. I agree with some of my colleagues, Senator Paul said regarding the adverse kind of paradoxical effect of decreasing rebates, but I differ with them on spread pricing.

Now, Mr. Kautzner, looking at your testimony, I noticed that you were not, as you know, kind of hesitated when you ask if it is cheaper to do spread pricing versus a fee.

Looking in your testimony on page 20, you speak about your pass through pricing models, and you say, clients pay exactly what Express Scripts pays pharmacy for a prescription, in this particular model.

Clients receive 100 percent of the drug rebates that the Express Scripts gets, and clients pay one simple fee. And in this, the pilot program from 500,000 people was a –3.5 percent drug trend, a 12 percent total medical cost reduction, $193 in savings from closing clinical care gap, and I really like this as a doctor used to take care of uninsured patients, an 86 percent of patients that were previously non-adherent to their medications, improved adherence through your coaching intervention. That is a good thing.

A –3.5 percent drug spend. So, it is pretty clear from your testimony that banning or not using spread pricing actually decrease cost by 3.5 percent. So, but I think it raises the issue of what is actually the spread. Mr. Joyner, can you tell us on those contracts with which you have spread pricing, what is a typical spread?

Mr. JOYNER. I do not know the average spread per client because it varies based on the performance of the network.

Senator CASSIDY. Mr. Kautzner?

Dr. KAUTZNER. Senator, I don't have the exact amount of where the profitability is.

Senator CASSIDY. Ma'am.

Ms. CIANFROCCO. Senator, I can't speak to the specific per claim. On some claims there is a difference by claim. I can tell you we passed through the 98 percent of the discounts, not just the rebate, but from the spread.

Senator CASSIDY. I have limited time. I am sorry, I don't mean to be rude. Thank you. By the way, I appreciate everything you are doing. I have an article that was sent to me today from first author is Mattie Lee, Understanding Spread Pricing, How Doctors Flow Through the Pharmaceutical Company for High Utilization Generic Drugs in Medicare Part D.

This is Part D. Now the spread here, Medicare Part D paid an average of $22.50. $3.80 went to the pharmacy. $2.71 went to the wholesaler. $6.73 went for the manufacturer, and 41 percent or $9.18 went to the PBM.

That was their spread. Now, this is generic drugs and Medicare Part D. It is a pretty good spread. 41 percent of the Medicare payment for generics is going for spread pricing. Now, I spoke to someone in the—I don't have this in an academic article, but I spoke to someone who has looked at the commercial market and they have found the average spread is $11.50.

Now, I agree with Senator Paul. It should be transparent that someone says, well, wait a second, here we have got a 3.5 percent decrease if we have full pass through. 3.5 percent decrease if we just pay a fee.

Why don't they just do it? One thing we have been hearing from manufacturers is they have a really hard—excuse me, from the employee sponsor. They have a really hard time getting this. Now, in you all's testimony, you say that a third-party auditor can look at this, but that is a third-party auditor for a Fortune 500 company, for the local kind of 200 people employee, they don't have those assets, so I am told.

They are more likely to be fully insured. And the fully insured product is where it is more likely to have spread pricing. I talked to Southern Scripts in Natchitoches, Louisiana, and they charge a fee-based claim with 100 percent pass through of everything, and it is $8.50 per paid claim. Now in Medicare Part D, it is a $9 something spread and with some retention of some percent of the rebates.

Here one is purely a per fee claim. It is $8.50. So, it strikes me both from your data and from this and from anecdotal data that the employer is doing better. It is just difficult to figure it out if you are a smaller employer.

Now, Mr. Joyner, or one of you, I apologize, in your testimony, you speak about how the average person in a high deductible health plan only pays $18.60 for her prescription. But we know that in a high deductible health plan, you have got an initial de-

ductible of $3,000. Let's just pick that number. And then through the course of the year, you have got continued drug spend.

What is unclear to me is that when you are paying list price for a drug, not insulin, because apparently you guys have done a good job of some of these drugs trying to lower it for the person. And I think I spoke to you, Mr. Kautzner, and you, ma'am, about how you lower it. Hats off, just thank you.

But for other drugs, they are paying the full list price when they are in their deductible. It may be $18.60 on the average, because through the remainder of the year they pay a lower price. Have you looked at—and I think I know that 34 percent of employees nationwide are in high deductible health plans.

What is the average cost of a drug when someone—list price of a drug when someone is in her deductible? Do you all have that data? Because it is $18.60 on the average through the year, but when she is in her deductible, that is where I have a concern.

That is where, if the insurance company knows where the deductible is and that is what has been negotiated with the plan sponsor, and now she is going to have to pay full freight for that list price because the rebate does not pass to her.

The spread pricing is fully operative. She is just paying full freight. Do we have a sense of what that average drug cost is during that period? Mr. Joyner.

Mr. JOYNER. I don't have the exact average, but I will say that most of our clients with high deductible plans understand the first dollar coverage and the fact that they want to provide an affordable benefit.

In categories that are attached to the preventative drug list, in many of the cases, the members are paying zero. And then there are many of our customers that choose to pass the discounts through the point of sale, meaning that at the counter they are getting the discounts.

Senator CASSIDY. You have a percentage of the customers that would do that relative to the number of patients?

Mr. JOYNER. We have over 10 million of our lives in the high deductible plans that are doing that today. So, it is a meaningful number.

Senator CASSIDY. 10 million of the—10 million employees who have high deductible plans would get a point-of-sale rebate?

Mr. JOYNER. Exactly. On average, we—our average insulin cost per month——

Senator CASSIDY. No, but that is insulin. I am sorry, that is insulin. I was just talking about drugs in general.

Mr. JOYNER. On average, the average out-of-pocket expense for our members are less than $9 a month.

Senator CASSIDY. Again, I am talking about specifically——

Mr. JOYNER. I understand.

Senator CASSIDY. Ms. Cianfrocco, let me ask you on something different. You mentioned the margins being 4 percent. Does that—is that net of expenses? I assume it is.

Ms. CIANFROCCO. Yes, Senator. Final margin for roughly 4 percent.

Senator CASSIDY. Now, what I have learned is there is a lot of vertical integration where there is a GPO or rebate aggregator, others providing data analytics, etcetera, but they are all vertically integrated within the same insurance company, the same pharmacy benefit manager.

If you pay the GPO a fee for whatever they do, and the rebate aggregator a fee, etcetera, one, they may retain a little bit of it, but on the other hand is, are you subtracting—is that is a business expense and you do not include that in the margin?

Ms. CIANFROCCO. Senator, for Optum, our affiliated group purchasing organization does not cost the client anything and it is——

Senator CASSIDY. No, but is that—but is your margin net of that or include that?

Ms. CIANFROCCO. Our margin is straight margin. It is net of everything.

Senator CASSIDY. Okay.

The CHAIR. Senator Kaine.

Senator KAINE. Thank you. To my colleagues, I have some good news for you. In Virginia, there is a company called Civica. It is a nonprofit pharmaceutical company that has taken over a closed pharmaceutical manufacturing company and reopened it as a nonprofit to bring both low prices but also transparency to prescription drugs.

Last year, Civica announced that they will manufacture and distribute affordable insulin products that are interchangeable with most popular brand names currently on the market, Lantus, Humalog, Novolog. Civica's insulins will be available to consumers at no more than $30 per vial or $55 for five pins.

No rebates, no opaque discounts. A price everyone can count on. I am grateful that this innovative nonprofit has stepped in to increase competition in the market, ensure people have access, bring more transparency.

I would like to ask to my PBM representatives, Mr. Joyner, Mr. Kautzner, and Ms. Cianfrocco, will you commit to offering such low-cost biosimilar insulins as tier 1 products with $0 or low-cost copays?

Mr. JOYNER. We will certainly—we are certainly open to adding any drug that comes with the low net cost and lower drug price. What I can't commit to is the benefit design because that is the decision that our plan sponsors, employers, unions, etcetera, decide.

Senator KAINE. Dr. Kautzner.

Dr. KAUTZNER. Senator, we actually, in 2020, already capped the cost of insulin in partnering with manufacturers that are here today at no more than $25. We saved patients last year over $18 million with that solution, and now are offering a new flat dollar co-pay plan designed for our plans, which also will cap preferred brands at $25, and specialty generics at just $5.

Senator KAINE. It sounds like a no, but I will go to Ms. Cianfrocco.

Ms. CIANFROCCO. Senator, in addition to all the things we have talked about to lower the cost of insulin, I want to be very clear that any insulin offering that is clinically effective can be delivered with support to our patients at scale and is available list price or net price. As long as it is the lowest cost and it is competitive, it is offered, and it will be offered.

Senator KAINE. Let me move to my pharmacy execs, and I had a question. I have heard so often from pharmacies—pharma companies that you tried to develop a low-cost product that you offer to patients, but the PBMs turn you down. They don't let you have access to the system.

I have heard many in your industry say because they would prefer products with high list prices, because they gather fees and the fees are a percentage of the list price, not of the net price. And that, if I am right about that in that sense, to Dr. Paul, that Senator Paul said the list price is meaningless.

It is meaningless maybe to a patient. I don't think it is meaningless in the industry because I think the PBMs collect a percentage of list price, even when the negotiated price is much lower.

Mr. Hudson, you said something a few minutes ago that perked my ear up. You talked about trying to offer a low-cost insulin product that was, "not accepted by the system." That is too opaque for us slow Senators to understand exactly what you mean by that.

Can you go into more detail what it means, that Sanofi had a low-cost insulin that you wanted to provide to more patients, but it was, "not accepted by the system"?

Mr. HUDSON. Yes, of course, Senator. You know, Lantus has been around over 20 years, and we have tried to bring lower cost alternatives. Biosimilars have been available, not used in any great detail since 2016.

Last year in August, we launched Lantus—an unbranded Lantus made in the same factory by the same excellent people with a 60 percent discount to the list price, it was just not listed on the health plans.

Senator KAINE. What was the reason for that?

Mr. HUDSON. Well, it is complicated for me to try and be precise because the conversation will, I am sure, be between the PBM and the health plan, not between me and the PBM.

We tried to bring a much lower cost, Lantus, a lot much lower priced Lantus to the table. Of course, there will be less rebate associated with that——

Senator KAINE. But when you say it wasn't accepted by the system, and we have heard there is all kinds of competition among PBMs, you couldn't find any of the major PBMs that would accept this insulin product that had a dramatically lower list price?

Mr. HUDSON. That is correct.

Senator KAINE. Can I ask that Mr. Ricks and Mr. Jorgenson, have your companies had similar experiences, whether it is in insulin or something else, of bringing a pharmaceutical at a dramatically lower list price that had capacity to really help people and to

be told that, no, these would not be available on formularies? And if I go to Mr. Ricks first and then Mr. Jorgensen.

Mr. RICKS. Yes, thanks for the question, Senator. We have, as I mentioned, and I brought two boxes of the Humalog product. We make them both. Once is called Lispro, once is called the Humalog.

They are made in the same factory by the same hardworking people. And after 4 years, the Lispro product, which is the copy and now cost $25, which is available on about one out of three formularies in America. So, I think it is clear that the lower price is not preferred.

Senator KAINE. The PBMs who make the decisions, if it is a higher list price, they like the higher list price better than the lower list price.

Mr. RICKS. That is what the data tells us, based on the market share, the poor performing lower cost——

Senator KAINE. Mr. Jorgensen, how about your company. Have you had a similar experience?

Mr. JORGENSEN. Yes. So, Senator, we have a similar experience. We have also launched an unbranded version, which is exactly the same product from exactly the same factories, and it has around one-third of the access as the higher list priced products.

Senator KAINE. Are you told why the lower list price offering is not being accepted on formularies by PBMs you deal with, Mr. Jorgensen?

Mr. JORGENSEN. No, I am not aware of that specifically. I can say that in general we keep increasing our rebates and they go into the PBMs, and obviously, I understand they do not decide on the plan designs, but this is the Bermuda triangle where things get lost.

Patients are paying more, and we are paying more in rebates. And somehow in the middle, that is something that is not really working.

Senator KAINE. All three of our pharmaceutical—pharma company who are here today have had the experience of trying to put drugs with lower list prices out available for patients but been told they would not be offered on formularies, even so that somebody could make a choice.

I mean, if something is on a formulary, it doesn't have to be the product that is chosen, but it is not even getting to the formulary. To our PBM witnesses, do you collect fees based on a percentage of the list price of the drug or a percentage of the negotiated actual price of the drug?

Mr. JOYNER. Every client contract is different, but we generally either have a fixed fee and or a PM, meaning that we kind of collectively manage the expenses across the population. If I could go back to the——

Senator KAINE. Let me just though, so you do not have any fee structure in your company where you collect a fee based on a percentage of the list price?

Mr. JOYNER. We certainly may have a few in our client base——

Senator KAINE. Dr. Kautzner, how about you? Do you, do you collect fees based on a percentage of the list prices of drugs that are on the formulary that you manage?

Dr. KAUTZNER. Senator, we have a mix of both, where some are percentage fee, some are a flat fee. But as we have been on the record before, we welcome manufacturers that continue to lower their list prices on all their products, not just on some new products that they are bringing out that are copies of other products. We have been asking for them to do that for years.

Senator KAINE. I yield back, Mr. Chair.

The CHAIR. Senator Collins.

Senator COLLINS. Thank you, Mr. Chairman. In 2018, I chaired a hearing of the Senate Aging Committee on why the costs of insulin was so high. And Mr. Chairman, one of the witnesses was a father from Maine who was going to Canada to get insulin for his 10-year-old son.

What we found was a system of getting insulin from the manufacturer to the customer that was rife with perverse incentives, convoluted and opaque, so opaque that the witness that we had who had done the study on the system could not fully explain the chart showing all the links.

I want to put up a chart that shows insulin list price, which is the top line versus net prices from 2012 to 2021. And starting with you, Mr. Ricks, I want to find out where the money is going in that gap between the list price and the net price over 9 years' time. And as you can see that gap has gotten bigger.

You have testified that I think it was $0.80 per dollar doesn't go back to the manufacturer. Mr. Hudson said $0.84. So, similar. So, explain to us who gets that money. Because I can tell you, it is not, for the most part, going to the consumer at the pharmacy counter. Mr. Ricks.

Mr. RICKS. It is a good question. I can explain much better what are the costs that make up the bottom line, because from that, that is our revenue.

We pay our workers, we make the product, we pay to distribute it, and we invest 25 percent of that line in research and development.

The difference, there are concessions made in price negotiations with large payers like the PBMs here today. I think you have to ask them how that gets redistributed in the system.

Senator COLLINS. Mr. Hudson.

Mr. HUDSON. That is already a very complete answer. It is the same for Sanofi.

Senator COLLINS. Mr. Hudson. You would agree that this money does not find its way in most cases to the consumer at the pharmacy counter?

Mr. HUDSON. I would agree. I mean, over the last decade, the list prices increased over 50 percent, but the out-of-pocket expense, what someone is paying at the counter has increased 45 percent.

It is on average not making its way to the counter for the person who is trying to make a choice between groceries and medicines.

Senator COLLINS. I think we have a very strange system here because—to say the least, because most of us would think that the rebate, the discount that is negotiated by the PBMs, would largely benefit the consumer at the pharmacy counter. But in fact, it goes to the PBMs themselves and it goes to the plan's sponsors.

That could be an insurer, that could be a large employer with an ERISA plan, but it is not making its way down. So, the insurers will tell you that, well, we use it to moderate rates, to keep rates lower for everyone.

The problem with that explanation is insurance is based on the principle that the healthy are subsidizing the sick. What we are doing is turning this on its head. So, in order to lower the premiums for the healthy, we are not passing on the savings to the sick. Mr. Ricks, would you agree with that?

Mr. RICKS. I agree that happens frequently. And I think particularly where Senator Cassidy was going with the high deductible phase in particular, where patients are exposed to full list pricing, there is an enormous difference between what the system pays and what they have paid, and that creates a surplus that is supporting premiums or other things.

Senator COLLINS. I want to ask our 3 PBM representatives. Mr. Joyner, who owns your PBM company?

Mr. JOYNER. CVS Health.

Senator COLLINS. Isn't there a connection also to Aetna, the large insurer?

Mr. JOYNER. That is correct.

Senator COLLINS. Dr. Kautzner, who owns Express Scripts?

Mr. RICKS. Senator, the Cigna group owns Express Scripts. And if I——

Senator COLLINS. Another large insurer, correct?

Mr. RICKS. Cigna Health Care, yes.

Senator COLLINS. Ms. Cianfrocco, and I apologize, I have misspelled—if I have mispronounced your name. Who owns Optum?

Ms. CIANFROCCO. Optum is owned by UnitedHealth Group.

Senator COLLINS. Again, another large employer—another large insurer. So, to me, this is an example of the system's incentives.

If you are in fact negotiating for your clients, you are negotiating for your owners who are all large insurers, for other plan sponsors that are insurance companies, for large self-insured employers, but you are not negotiating for the customer because it is not—to be fair, it is not up to you what the people who hire you or for whom you work, decide to do with that discount.

They could pass it all on. But the evidence is overwhelming that they do not. I want to go back to an issue that Senator Kaine raised, and that is the difficulty that biosimilars have in getting on to the market and getting chosen by a PBM for a formulary. This makes no sense whatsoever to me if you care about lowering prices.

Mr. Hudson, Senator Kaine talked about the fact that when you come up with biosimilars that are cheaper than your branded product, you can't get chosen. But it is not just you.

Even when a competitor comes up with a brand—with a biosimilar that is way cheaper, and I would use Viatris as an example, which came up with insulin glargine, which was 65 percent cheaper than Lantus. It couldn't get on the formulary.

It takes the same product, relaunches it at only 5 percent lower, and guess what it gets chosen?

The CHAIR. Thank you, Senator Collins.

Senator Hickenlooper.

Senator HICKENLOOPER. This is one of the most amazing hearings I have heard. It reminds me of a long time ago when I used to be in the restaurant business. I knew a guy who, it was probably 30 years ago, had an Italian restaurant, worked very, very, very hard. And some months he just could barely make things balance—could not balance the budget at the end.

If there was a snowstorm or something, he would have to go through incredible contortions to stay in business. And he would get frustrated, and he went, and he doubled the prices of everything. It was an Italian restaurant. Pizza, spaghetti, whatever, he doubled the prices. Within 3 weeks, the number of people coming into his restaurant almost doubled. Same food. He just doubled the prices.

That shouldn't be the case. I say that because that is an aberration of capitalism, Senator Paul would say if he was here, for sure. And but that is what we are seeing here. We are seeing a case where the higher the price, the more likely a pharmaceutical company can sell their product through the PBM system.

I have got a couple of questions. The $0.84, so that means that $0.16 stays with your—with the pharma—you are roughly somewhere between $0.16 and $0.20. You are $0.16, you are $0.20, roughly in that range.

I guess we should go down the list of the PBMs and just say, how much of that, all the rest of that stays with the PBM, right, and then how much goes—is rebates to the plans or to hopefully eventually some of the consumers. Mr. Joyner, why don't we start with you.

Mr. JOYNER. Today we pass through more than 98 percent of all the rebates and discounts to our customers. And 100 percent in Medicare.

Senator HICKENLOOPER. It goes right straight to the customers.

Mr. JOYNER. It goes straight to the customers, which are the employers, unions, Governments, etcetera.

Senator HICKENLOOPER. Okay. I should have gotten Senator Collins to keep her poster up, because that is a big space up there for—98 percent sounds like a big number there. That is an awful lot of—it doesn't seem like it is going to the consumer who is purchasing it, which is that bottom line, right?

Mr. JOYNER. Yes. I think that is a perfect example of PBM competition. When you saw the price separation, it was at the point in time when we selected one insulin product.

The result was declining costs for our customers, the payers, while the manufacturer was increasing pricing. So, we are passing through 98 plus percent of that value.

Clients are using that to invest obviously in their out-of-pocket expense, $0 co-pays in many respects, and, or trying to deliver the discounts at the point of sale.

Senator HICKENLOOPER. Got it. Got it. All right. Dr. Kautzner.

Dr. KAUTZNER. Senator, for our commercial employers, labor groups, health plans, and public sector entities, we passed back over 95 percent of rebates. I would also comment on Senator Collins list price component.

That list price continued to go up in the height of extreme competition. Manufacturers are on the record of saying they control list prices. We have been asking them for years to lower their list prices. No one made them increase their list prices. They made that decision on their own.

Senator HICKENLOOPER. Seems to me the more they raise their price, just like the Italian restaurant in Boulder, Colorado, their sales go up, which is anybody put in that position would have a very difficult choice. Yes, Ms. Cianfrocco.

Ms. CIANFROCCO. 98 percent of the value of the amount of savings that we negotiate gets passed directly to our customer. They do use that for programs like the $0 out of pocket that we saw on the lifesaving drugs.

They do use it, and we always recommend that those dollars are used to protect the patient through things like the high deductible preventive drug list, which would protect patients for preventive—for drug and prescription drugs for preventive disease. For life saving drugs and chronic disease.

Senator HICKENLOOPER. Right. Okay. I am just going to throw out a fact because I was puzzled when I went home last night just because of as I looked into this, it became more puzzling, but at the same time, somehow almost symbolic of the whole health care system, the troubles we have.

This is just Googling, so this might be a little bit out of date. But you look at the Fortune 500, the Fortune 100, the Fortune 25, CVS is No. 4 in the country. Let's see, UnitedHealthcare is No. 5.

Express Scripts, you got, Cigna is number 12. So, 3 out of the 15 largest corporations in America are all significantly in this integrated vertical spectrum, which somehow finds very puzzling. If you go back and look at the top 20, there are really 8 companies in there that are health care related, or 7 for sure.

I am not sure whether you would say Walgreens is more of a retailer or a health care company. But the weight there, the preponderance of market mass, it seems inconceivable that these companies could be that large if they are pushing 98 percent through to their customers, that they would be able to do $6 billion, $7 billion stock buybacks. It doesn't sound like they are losing profitability.

Mr. Hudson, at one point you said that, or someone had said that you felt that you guys were almost like the canaries in the mineshaft. Is that some reflection of the situation?

Mr. HUDSON. Well, what I have said publicly before is that when we use the same insulin as unbranded and reduce the price 60 percent, we wanted to see whether the system in all its form would pass that on, the lower price, to patients.

We recently reduced the price, again, as you know, 78 percent, and we have some anxiety that it won't make its way to patients. In fact, patients may be taken off.

Senator HICKENLOOPER. You get—the lower you—the more you lower the price, the less patients you achieve. So that is the canary at a certain point.

Mr. HUDSON. That is, as Chairman Sanders said, that we, this Committee may look again in a year to see whether it had impacted access affordability. I think that is the key question.

When you bring the price down—remember, our net price is $21, which is often less than the co-pay across all channels, $21 a vial for Lantus. You know, that should change what is available and what patients pay.

If you come back in the year and nothing has changed but less Lantus is being used, you have to say, the system is not working.

Senator HICKENLOOPER. That is for sure. Mr. Ricks let's ask all three of the pharmaceutical companies the same question. If you, and you all lowered your prices, do you think you will have gotten your products, your insulin to more customers a year from now? Mr. Ricks.

Mr. RICKS. Well, I think it was a risk to lower prices, but one that we thought was worth taking. We were happy that competitors independently followed that, but we need to make sure that we can have our insulins stay on formularies and available.

Hopefully it would increase availability, but those decisions are in front of us—in front of them.

Senator HICKENLOOPER. Well, what is your prediction a year from now when we all have a reunion?

Mr. RICKS. Well, I hope that we will have better access to low priced insulin.

Senator HICKENLOOPER. Okay, great. Mr. Hudson, what is your sense of that?

Mr. HUDSON. Yes, look, I agree. I think we spend a lot of time talking about insulin pricing. It is really a net price conversation. It is really what money makes it to make it more affordable for patients. If in a year's time more patients can get access to more affordable insulin, then it was worth doing. I really hope that is the case.

Senator HICKENLOOPER. Right. Mr. Jorgensen, I am just going to assume you are of the same mind?

Mr. JORGENSEN. Yes, I share the same concern. We don't know yet whether we even have access to the patients we have access to today. And I can add that our net price after rebates, fees, and discounts, today is lower than when we launched the products. So again, if patients are paying more and the price has gone down, something has not worked. Thank you.

Senator HICKENLOOPER. Thank you. I am out of time, but I do—I think we can challenge the PBMs that are here represented that if you are the—if you guys are part of the 4th largest, the 5th largest, and the 12th largest companies in this country——

The CHAIR. Senator Braun——

Senator HICKENLOOPER. You can help resolve this—resolve this issue.

The CHAIR. Senator Braun.

Senator BRAUN. Thank you, Mr. Chairman. I have been wrestling with this issue across the board for at least 15 years prior to coming here. Actually, did something about it in my own company, across the board too, to make things work for my own employees. That occurred in about 2008.

I was sick and tired of hearing how lucky we were through our insurance companies that it is only going up 5 to 10 percent per year. And Senator Paul earlier talked about free markets. He and I are going to be in agreement on that mostly. But let me tell you what free markets have in common, unless it is entangled with Government like this business is even more so than most industries.

No barriers to entry, robust competition, full transparency, and here is probably the most important one, that the consumer—Senator Paul mentioned this, the consumer has no skin in the game the way it is currently constructed. They either want, when they need remediation, which is a very inelastic demand, when you get critically ill or have a bad accident, they want it done immediately.

They don't want to shop around. And they either want their employer to pay for most of it or the Government. It is a system by its nature that is about as far from free enterprise, it is more like an unregulated utility, and you are a part of it. The good news is, when I first started looking at it, hospitals were about 30 percent of the health care dollar. Practitioners were about 30 to 35 percent.

Pharma was 15. Insurance, 15. Insurance and pharma have not changed a lot, even though insurance has become this disproportionately more impactful in terms of keeping the whole system glued together the way it is.

Sadly, hospitals have grown to almost 45 percent of the health care dollar simply because so many practitioners, it would be like losing farmers in agriculture, aren't even wanting to get into the business like they used to. Used to be not only the Hippocratic Oath, but they wanted to have their own business to boot.

They are increasingly being employed by large corporate hospitals that all play into this lack of what most markets have. So, you pile all that up, you get to where Senator Sanders is. People are getting fed up with it. I got fed up with it 15 years ago. The rest of the world can buy drugs for one-fourth the price.

They have healthcare that is being tended, 12 percent of their GDP, with every developed country having outcomes as good as, if not better. And here we are at 18 percent of our GDP, and it is going up as opposed to going the other way. Nothing works like that in a true market context.

Maybe we will not get there. Let's look at pharma itself. You have got a proprietary product. It takes a long time. Investment in R&D. Pointed out that a lot of these drugs have a $5 maybe material cost yet sell for hundreds of dollars. So that means you have got very low variable cost, very high fixed costs.

That is a classic case for how you can charge things and you don't have it related to your actual cost of doing business. Sounds like maybe on PBMs, if that is accurate that you are working on a 4 percent profit margin, I assume that is on sales.

I am assuming you are getting a lot better return on equity than that, or you probably wouldn't be growing your businesses. Something has got to give. You are either going to get what Senator Sanders is proposing, where all other countries have done it because they have never found a way to address the broad issues I have mentioned.

Probably the easiest place that you could fix it would be maybe in primary health care, which never did—was insurance intended to cover scratches and dance. Never should consumers being in any market where they want someone else to pay 100 percent of it.

Those who can afford it shouldn't even be under insurance for their primary health care. Those who can't, should have that support, otherwise you never have a real market. I am going to go to the thing that struck me most kind of significantly was when I heard Senator Sanders ask, why are you selling especially—I am sure it is simple molecule drugs, as well as the biologics.

Why is this stuff selling minimally for one-quarter of the price in most other markets that you sell to and sometimes one-tenth? Obviously, you are covering your variable costs. Why are we as Americans paying the bill even though it is only 15 percent of our GDP?

If it is not working here, how are we going to get the rest of the system to work? Why is that? I never was clear, and I didn't hear a clear answer other than you are going to continue to do it. You want to start, Mr. Ricks.

Mr. RICKS. I can, yes. Thanks for the question. First, one problem with the data that is often cited is list prices in the U.S., where we get paid on net pricing after negotiation. Those numbers versus Europe are typically about 35 percent higher in the U.S. than Europe, not double or some other number.

I will admit they are higher on a net average basis. What do we get for that? We get the earliest access to new medicines of any country in the world. And in general, we have the industry here as well, which I think supports jobs and manufacturing roles, etcetera, so.

Senator BRAUN. If you are breaking the bank, the thing you got to realize is all the things that you say are attributes of our system, they shouldn't cost us 50 percent more than what health care does across the world.

In your case, since most people have a prescription as maybe their first entry into the health care system, here, you are showing us where you are charging minimally four times as much here, if not ten times.

I don't think politically that is going to get you into the next generations of where you will be like a regulated utility, and it will be the same format that all other countries have had to go to.

Mr. RICKS. With all due respect I think we get one other thing, which I wanted to mention, which is the possibility of new cures and treatments. That is funded by the more or less the premium we get in the developed world. They fund that for the world. And I think we have to strike a balance between having low-cost medicines today and future——

Senator BRAUN. What does that have to do with charging us ten times to at least four times? I mean, why can't they carry—they are the ones not even doing the work. They should be paying more.

Mr. RICKS. I mean, you raise a good point. Lilly will spend about what the entire country of Germany does on pharmaceutical research this year. So why are they not funding that? I don't know.

Senator BRAUN. Well, I think that is something you need to ask yourselves, or else I think the structure of what you are used to is not going to persist into the future because we simply can't afford it.

The other, you are in a business that has the peculiarity of uncertain outcomes. R&D, that is bona fide, but I think where you have defaulted, maybe somewhere down the line—you say you don't need PBMs.

We have had that conversation. Why wouldn't it then—why would you not need PBMs when they are making a smaller margin, and it is such a complicated system, and you are the producer of the product.

In all other industries, you have a wholesaler that buys it, distributes it across the marketplace, and—was that 7 minutes, Mr. Sanders?

The CHAIR. That is 8 minutes.

Senator BRAUN. Very good. I will yield the floor. We will have the discussion further. Thank you.

The CHAIR. Thank you.

Senator Smith.

Senator SMITH. Thank you, Chair Sanders and Ranking Member Cassidy. And thanks to all of you for being with us here today. I would like to start with going at how this system affects folks with—who don't have health insurance.

My first work in the Senate focused on this when I met my fellow Minnesotan, Nicole Smith Holt, who—and heard about her son Alec, who I believe Chair Sanders raised at the beginning, who died of ketoacidosis when he went off his parents' insurance and couldn't afford his insulin.

He rationed and he died. Now, HHS analysis tells us that uninsured patients typically pay the most for insulin, and that, of course, leads to rationing. And so, we have heard about your patient assistance programs, and you have argued today that insulin is different and better than it was 100 years ago.

Diabetic patients need different drugs, need different insulin based on their body and what works best for them. So, my first

question to the drug companies, can uninsured patients currently access each of your insulin products through all of your patient assistance programs at somewhere between $25 and $35, which I think is the range of prices?

Mr. RICKS. Want me to start? Yes, is the answer. If you are insured, it is capped at $35 for every Lilly insulin. If you are uninsured and your income is below $57,000 a year, it is free.

Senator SMITH. For all—it doesn't—whatever——

Mr. RICKS. Doesn't matter what insulin you are on——

Senator SMITH. Doesn't matter—it is all of them. Okay. Mr. Hudson.

Mr. HUDSON. The same for us. And in fact, the data is that uninsured patients use that facility over 100,000 times last year for $0 co-pay.

Senator SMITH. For all of the insulin products that you own, not just some of them.

Mr. HUDSON. That is correct. Yes. That is correct.

Senator SMITH. Okay. And Mr. Jorgensen.

Mr. JORGENSEN. Yes, Senator. We also offer a program where people can get access to free insulin and any insulin if they are in a situation where they have to ration. So, we are there for patients without insurance.

Senator SMITH. Okay. So, what I don't understand is, because I hear about patients being charged list price if they don't have insurance. So, I am having cognitive dissonance trying to understand how this all works. Why don't you just lower the list price for all of those medications, and just make it simple? Yes——

Mr. RICKS. Yes, we would like to get there, honestly. I think Senator Braun mentioned that we would be happy if there weren't rebates in the system. They don't do anything for us, and we are——

Senator SMITH. You would be willing to lower list price?

Mr. RICKS. We have been, as I mentioned in my comments.

Senator SMITH. Let me just turn to the PBMs, because the drug companies are saying they would lower list prices. You have been asking for them to lower list prices. Can we just like have an agreement today that we are going to lower list prices?

You won't charge rebates. They won't—they will lower list prices and we would be all done? Who wants to——

Dr. KAUTZNER. I can answer that, Senator. So, we have been asking for years for them to lower list prices.

Unfortunately, the lower list prices are coming far too late compared to when they could have occurred years ago. Now they are coming because of the Medicaid cap that is going away, and so they are going to be exposed, and would have to pay more.

They are actually doing this because of Government intervention, not because they just want to lower the prices. But we welcome them to lower the list prices and we will be excited to do so for the value that is going to provide to our patients.

Senator SMITH. Mr. Joyner.

Mr. JOYNER. Similar to Express Scripts, we also would applaud and enjoy the lowering of list—of drug prices.

Senator SMITH. Then this gap that Senator Collins showed on her chart, which appears to be the rebates and discounts that—then you would get rid of those?

Mr. JOYNER. Yes, I think there is two things because one is that is what the PBMs have done to date. So, the prices that have been announced on that chart is actually below the cost at the time that they have listed for coverage.

Senator SMITH. Mr. Hudson.

Mr. HUDSON. Yes, just to be clear that it was 2018, we brought a lower price analog. Nothing to do with recent policies or announcements and reduced the price of that three times to no effect.

Then it was last August that we bought, made in the same factory, as I said earlier, an unbranded Lantus at 60 percent off, long before this year's debate. So, I am a bit perplexed because they are there. They have been there—we have stepped up and done that.

Senator SMITH. I am perplexed too. Right. And to the PBM executives, what do you say to this critique that your profitability is enhanced or higher when list prices are higher?

Mr. JOYNER. I will give the Lantus example, because I think it is an important point that is being made that of a lower list price being brought to the market has not been accepted by the PBM.

Back in 2017, a biosimilar came to market by the name of Basaglar, which was generic competition in that category. We adopted that product as our preferred product. So, we lowered the list price, and we lowered the overall net cost for the customers, and we converted 97 percent of all the patients on Lantus on to Basaglar.

It was a significant savings for our customers, and we actually embraced a much lower list price than what Lantus was promising at the time.

Senator SMITH. This critique that PBMs do better when list prices are higher, does anybody—I mean, is that an unfair critique, or how do you see that?

Dr. KAUTZNER. Senator, our focus continues to be for our employer, clients, and patients that we drive to the lowest net cost, regardless of where the list price is. Lantus is an interesting example.

Lantus, when it didn't have competition between 2010 and 2014, actually doubled in price. The price didn't moderate until 2015 and beyond when competition actually entered the market. Discounts were about 3 percent. They increased to about 20 percent in the 2015 range, and then certainly have more than tripled since that point.

Just to the questions earlier on products, other products in other countries and how expensive they are. Unless there is competition in the market, and for us to drive that competition, you are going to continue to see sky high list prices by drug manufacturers.

We are going to do everything we can to bring those prices down, and that may be in the form of rebates so we can provide discounts back to our employers and our patients.

Senator SMITH. Well, so let me ask—let me just follow-up on that a little bit with you, if I could. Actually, Senator Braun and I will be mark—tomorrow we will be marking up legislation that Senator Braun and I have introduced that would basically be a bill that would help bring lower cost generics to the market more quickly.

But of course, that only benefits patients if they have access to them. This is another place where I am having cognitive dissonance because this brings me to the formularies that basically determine what medicines patients can get at what cost.

A recent study showed that in Medicare Part D, a greater proportion of generic drugs are being placed on higher tiers on formularies, which leads to increased patient cost sharing.

Another report showed similar trends forcing patients that—they actually, so they end up paying more for generics because of where what tier they are placed in on the formulary.

Can you explain how you see that? What is going on there? Why is that happening? Why are not—why does it appear that lower cost generic benefits are not getting passed on to patients like we would have expected and hoped?

Dr. KAUTZNER. Senator, we are absolutely supportive of legislation that could help to improve the accessibility to generic drugs, that will remove patent thickets, remove pay for delay, and will provide faster accessibility to more competition in the market. And we welcome anything that can help to do that.

On the biosimilar front, we also welcome reducing the patent expiration down from 12 years to 7 years to create more competition, and interchangeability rules as well on biosimilar products so that it is easier for biosimilar manufacturers to come to market and actually be competitive.

Senator SMITH. Mr. Chair.

The CHAIR. Thank you, Senator Smith.

Senator Marshall.

Senator MARSHALL. Thank you, Mr. Chairman. Ms. Cianfrocco, what percentage of Optum's rebates go back to UnitedHealthcare?

Ms. CIANFROCCO. Similarly, we pass along the majority of those rebates. 98 percent go to all clients——

Senator MARSHALL. My question is on UnitedHealthcare. What percentage of all these rebates go back to your parent company, UnitedHealthcare?

Ms. CIANFROCCO. Yes, just like the other 5,000, we pass along the 98 percent. So UnitedHealthcare is one of 5,000. We pass along 98 percent of the discounts to the client.

Senator MARSHALL. Of all the reasons we were talking—so Dr. Kautzner, maybe you can answer the question better. What percentage of your rebates are kicked back to Cigna?

Dr. KAUTZNER. Senator, the—so we passed back over 95 percent of rebates to our clients. I don't know the exact number that is passed to Cigna Healthcare, if that is the question.

Senator MARSHALL. Okay. I think that is exactly what I said. Mr. Joyner, any idea what type—percentage, your kickbacks go back to Aetna.

Mr. JOYNER. Yes, we don't pass kickbacks back to our company. We do actually pass through 98 plus percent of our rebates to our customers, retaining a little bit more than 1 percent.

Senator MARSHALL. But you won't tell me how much is going to Aetna?

Mr. JOYNER. At this point, it goes back to our parent company, CVS Health. It doesn't go to—it doesn't go to Aetna.

Senator MARSHALL. Okay. All right. Mr. Chairman, certainly I think we agree, everyone on—most everybody up here agrees America is spending too much on prescription drugs. America is spending $600 billion a year on prescription drugs.

That is almost what we are spending on the military. And I don't have to tell anybody here, but I want to make sure we understand that American spend per capita almost twice of what comparable nations spend—almost twice what comparable nations spend. Show my next one.

I think it is important to separate brand name versus generics. That brand names represent only 8 percent of prescription drugs dispensed, but 80 percent of the cost. So, 8 percent of the drugs accounting for 80 percent of the dollars. Generics account for 92 percent of prescription drugs dispensed but only 14 percent of the cost.

Eventually we need to have a conversation about what games are going on with those two types of drugs. Next, I want to talk a little bit about the history of insulin. When I think about insulin today compared to what it was 100 years ago, I think comparing the single prop airplane that Amelia Earhart flew across the Atlantic to today's F–35.

I think it is important, again, that we make sure that Americans realize the innovation that has occurred in the industry. Certainly, insulin was discovered in 1921. Was launched in 1923. Slow acting insulins were added in the 30's and 40's. We took insulin and added protamine and zinc and made them last longer. Insulin was the first protein to be synthesized in 1963, so figured out the amino acid chain.

There are some innovations going on with the gadgets, the insulin pumps. But I want to point out that synthetic insulin was not produced until 1978. That it took the industry 15 years to tease E. coli into making insulin. It was not a simple task, but then that took your industry, some of the players here another 4 years to bring it to market in 1982.

I have to highlight that FDA approved this in only 5 months' time. We go on through the history of this, there is more advancement in technology pumps, and eventually we are able to manipulate the amino acid sequence and we come up with even new and better insulins, able to more match what we are doing with our own pancreas.

It has been quite a development and we think we should share the value of what that—what has happened. If you think back to 1921, insulin dependent diabetes, and that is what I am talking

about, the type I insulin-dependent diabetes was a death sentence. Life expectancy, one or 2 years.

But once we started squeezing insulin out of the pancreas of animals, people maybe lived 5 or 10 years, but they still were 25 years below the life expectancy of other people in this general population. We continued in 1950, and there, 15 years—mortality rate is 15 years below the general population.

In 1978, it is 12 years below the general population. And then today we are sitting at about 7 years below the general population. It is not perfect, but because of these improvements, we have gained a lot of progress.

I just want to stop—Mr. Hudson, what does the future look like for you, just very briefly, as far as innovation opportunities?

Mr. HUDSON. Well, I think, and thank you for sharing the journey. I think it is important to realize the contribution, the continued improvement in innovation insulin has made. The next barrier is really to help patients protect the insulin making function that they have, treat them earlier.

We launched Tzield a few months ago, which is to try and stop the progression of the disease, trying to halt the disease, try and give young adults a chance to live insulin free for a number of years and maybe indefinitely, if the trials support that.

We don't know. But a life free from needing insulin, a life free from medicines in general is the ultimate goal. I think we would all agree with that—a normal life.

Senator MARSHALL. Well, thanks. I guess I just want to be careful today we don't throw the baby out with the bathwater.

We certainly think that the prescription drugs are too expensive, but we don't want to get rid of the innovation, if at all possible. I want to turn back to the PBMs for a second. Again $600 billion prescription spending in this country. PBMs gross revenue last year was $500 billion. $0.84 on the dollar goes to the middleman. I think, just I want Americans to see what has happened in this industry.

I think that this picture paints a thousand words. That we see the vertical integration that is occurring within this industry. Mr. Hudson, of the dollar being spent on prescription drugs, what amount of that money is going to go to the middleman?

You testified earlier. I just want to get this on record again.

Mr. HUDSON. It is $0.84 of all insulin on the dollar goes to the system or the middleman. On Lantus specifically, it is 93 percent across all channels—93 percent.

Senator MARSHALL. Mr. Ricks, would you—somewhere in that same range?

Mr. RICKS. Similar. Insulin is $0.80 on the dollar for us. For our whole portfolio, which includes newer medicines, it is about two-thirds of all gross pricing goes to the PBMs and insurance companies.

Senator MARSHALL. Okay. I think it has been pointed out earlier that these are top 500 companies. CVS is number 4, UnitedHealth number 5, Cigna is number 12. Turn to my executives from the

PBMs. You all are recently forming some GPOs. Dr. Kautzner, where is the location of your GPO? What country?

Mr. RICKS. Senator, it is located in Switzerland.

Senator MARSHALL. Ms. Cianfrocco, where is yours?

Ms. CIANFROCCO. It is domestic. It is a Delaware company.

Senator MARSHALL. Okay. And Mr. Joyner, where is yours?

Mr. JOYNER. It is here in the states as well. It is a Delaware company.

Senator MARSHALL. Okay. What is the purpose of the GPOs? Ms. Cianfrocco, what is the purpose of the GPO? And I hope you don't tell me it is to increase purchasing power.

Ms. CIANFROCCO. Well, it is a group purchasing organization, so it is designed to allow other companies, companies that negotiate with pharmaceutical manufacturers, to increase the counterweight against those high list prices and negotiate additional savings to lower the cost of drugs.

Senator MARSHALL. Okay. It feels like it is a shell game to me. That is what it feels like to me, is that we are hiding money here and there. Mr. Joyner, why don't you put some of these lesser expensive insulins on your list of drugs that you can sell, your formulary?

Mr. JOYNER. I think, as I mentioned earlier, we have. So, in the Lantus example, which is a very high-priced insulin, when the biosimilar were released——

Senator MARSHALL. You are telling me that the pharmaceutical managers are—the pharmaceutical makers don't get the story, right? They all three said that there are certainly drugs that they have for sale that you won't put on your formulary.

Mr. JOYNER. If it is not on the formulary, it is because it is not the lowest net cost in the therapeutic class.

Senator MARSHALL. Dr. Kautzner, why won't you put some of these on your formulary?

The CHAIR. Sorry.

Senator MARSHALL. Thank you.

The CHAIR. Senator Hassan.

Senator HASSAN. Thank you, Mr. Chair and Ranking Member Cassidy, for the hearing. And I want to thank all of the witnesses for being here today.

I want to start by following-up on Senator Smith's line of questioning, because I think all of us here would like a world in which your doctor writes you a prescription, and you go to your pharmacy, and the pharmacy produces the prescription at a predictable price that the drug companies tell us is their price.

I mean, that is what I would like, and I would like it to be a low price. And I think every one of us has experienced going to the pharmacy counter and being told by a pharmacist standing in front of a computer, this won't go through, or you are going to need to pay $300.

I know your co-pay for medications is supposed to be $10, but for this one, it is $300, and they can't really tell you why. And we all

know, you all know, everybody in this room knows, when you have got a child who is sick or a loved one who is sick and you have just been through a process of getting a diagnosis and getting a prescription that you hope is going to help, this is the last complication you need.

Senator Smith was asking about why not just offer, to the pharmaceutical reps here, why not just offer insulin at the price at the pharmacy counter? Eli Lilly, you recently announced, Mr. Ricks, you would have insulin for $35 or less. Mr. Hudson and Mr. Jorgensen, your companies have said you have made similar commitments.

My question is in your patient assistance plans, how does a patient go about getting this assistance if, one of you said it is a $57,000 income threshold, what happens to people who aren't on one of these plans or are uninsured in terms of getting the actual assistance that you say is available to make sure that people don't pay too much for insulin, let's say?

Mr. RICKS. Yes, I can start. Thanks for the question, Senator. It is important. I think we have all experienced the frustration you just described. It is why we have worked hard to eliminate it wherever we can.

The $35 buy down we have for anyone with a valid insurance card that covers Lilly insulin is automatic in 85 percent of the cases. The only reason we have 15 percent that aren't, are the pharmacy computer networks aren't plugged in yet, but we are working to close that gap.

If someone has no insurance, they have two options. They can go to lilly.com and in literally a few clicks qualify for the coupon and show that at sale. Or they can call our phone number and we will help them.

Senator HASSAN. Okay. Mr. Hudson.

Mr. HUDSON. It is exactly the same. If you go to value.com, you can do that. If you go to many of the patient associations websites, you can get a connection. If you are uninsured, you go, you print it off, you will get your insulin for free.

Senator HASSAN. When you say you print it off, you print off some sort of coupon or application?

Mr. HUDSON. A coupon. Yes.

Senator HASSAN. How lengthy is the application process? I mean, what kind of information do people have to provide? You can start, Mr. Hudson.

Mr. HUDSON. Yes. I mean, it is really not that complicated, and that is—and it is done—as I said, it was over 100,000 times, it was done for the uninsured. Over 600,000 times for people to reduce their co-pay. It is very straightforward.

Senator HASSAN. I think it is very straightforward for you. I am not sure it always is for patients. Mr. Ricks, and then I will get to you, Mr. Jorgensen.

Mr. RICKS. Yes. In the case of an emergency, which we have heard about, and those are terrible situations that should never occur, I think we all agree on that. If you contact Lilly today, we

will ship you a month's supply at no cost with one question, what is your address?

You then need to enroll in an annual program if you are below the low-income subsidy level, the $57,000. But that is for the next year. But in an emergency, it is absolutely simple.

Senator HASSAN. What happens if you are at $58,000?

Mr. RICKS. Yes. So, then you are eligible for the buy down to $35 at the point of sale. And in many cases, people are between insurance plans, and it is a short-term need, and $35 is reasonable. Or they can buy our $25 Lispro, which is often purchased without insurance now.

Senator HASSAN. Okay. And Mr. Jorgensen, what is the process like for patients for your company?

Mr. JORGENSEN. It is a similar process, and I don't live in the U.S., so I actually took the time to go to the U.S. and visit patients and physicians to ask about some of these pain points. And that lead to that we enhanced our—programs.

It is for a patient without insurance, it is free to go to our website and it is a few clicks, and then you can get access to all our insulin at decent prices, at some $30. Or you can go to Walmart and buy a vial of insulin for $25. That takes no paperwork whatsoever.

Senator HASSAN. Okay. Thank you. I want to turn to our representatives from the PBMs now. And this is really following-up on a point Senator Kaine was trying to make or did make. As we have heard today, manufacturers are taking steps to lower list prices and over-the-counter prices of insulin.

However, patients with insurance only benefit from these reduced prices if PBMs also step up to make sure these lower cost options are covered. So, Mr. Joyner and Ms. Cianfrocco and Dr. Kautzner, how are each of your companies ensuring that lower cost insulins, including generics, are available to patients with commercial insurance?

Mr. JOYNER. Yes. This is a very good question. And I would say we start with using competition to negotiate to the lowest net costs. So, once we do that, that passes on to our employers and Government entities, etcetera, in order to manage the benefit.

We encourage them, with the savings that are generated through the rebates and discounts, to actually offer a more affordable benefit either on a preventative drug list and or encouraging them to use the discounts at the point of sale. And so, 10 million lives, as I mentioned, is already doing the preventative drug list.

We have a large number of customers doing the preventative drug list, which is zero. So, on average, the actual average cost of insulin is $25 or less. And CVS Health, specifically on our own 200,000 employees, which we want to make the model plan, does pass the discounts at the point of sale.

We also have a preventative drug list so that our employees actually pay $0. So, we are very much in alignment.

Senator HASSAN. Dr. Kautzner, I am going to ask you to address the same thing. I am going to follow-up on, and I think it was Sen-

ator Marshall, to just say we are hearing something different from our pharmaceutical manufacturers here about their ability to list the lowest price drug, insulin on your formulary. So why don't you go ahead and address the question.

Dr. KAUTZNER. Thank you, Senator. So back in 2020, we capped the cost of insulin across all the different types of insulins and working with these manufacturers at $25.

Last year, it saved our patients $18 million in utilizing that program. We also just recently announced another co-pay assurance plan. This plan caps not just insulin, but for all employers that adopt it, all other branded products at just $25 that are not specialty drugs. So, it keeps it very, very affordable.

We also are expanding our preventative drug list as well for those employers that do have high deductible health plans or HSA accounts. I would say having additional options where today medical and pharmacy are combined in the deductible, separating those since pharmacy is the most utilized component of the benefit 11 times a year, and having a separate pharmacy deductible would be another benefit for patients.

Senator HASSAN. Thank you. And I am sorry we are not going to get to our last witness because my time is up. I do want to follow-up with you, Dr. Kautzner, on the relationships you all have with independent pharmacies, especially in rural parts of the country. Thank you.

The CHAIR. Thank you, Senator Hassan.

Senator Budd.

Senator BUDD. Thank you, Chairman. Again, thank the panel for being here. Ms. Cianfrocco, in your testimony, you said that PBMs develop formularies for the placement of prescription drugs using clinical foundations.

I would like to understand this a little bit better. As you know, this Committee is going to vote on a bill tomorrow that asks PBMs about their rationale for formulary placement. So, what do you mean by clinical foundation for formulary placement?

How does this influence a patient's ability to fill the prescription from their doctor?

Ms. CIANFROCCO. Sure. Thank you, Senator, for the question. First to be clear, our formularies have some of the drugs we have talked about today, which are rebated, but also hundreds of drugs, generic.

There are meant to be the lowest cost options for our customers on behalf of their consumers, but it all starts with your point, clinical evaluation by an independent Committee that evaluates the efficacy of those—and outcomes of those therapeutics before they can be offered on our formularies.

Senator BUDD. Okay, thank you. In North Carolina, about 40 percent of our 10 million residents live in rural areas of the state, and access for pharmacies is critical, especially for those rural patients. I have heard from North Carolinians about rural pharmacy closures, and they are concerned about them.

Mr. Kautzner, Ms. Cianfrocco, and Mr. Joyner, what steps are your companies taking to make sure that rural Americans have access to pharmacies to fill their prescriptions? Let's start with you, Mr. Joyner.

Mr. JOYNER. It is a good question, and I will just, as a reminder, the independent pharmacies, especially in the rural markets, are an essential part of our pharmacy network. In many cases—and they represent close to 40 percent of all the pharmacies in our network today.

We do negotiate generally with what I would call a PSO or a group purchasing organizations, or the independent pharmacies have come together with large wholesalers to actually contract specifically for them. So, our contracts with the PSOs, or with the group purchasing organization, is actually higher than it is for other chain and grocery store pharmacies.

We have actually reimbursed them more, trying to—they have actually aligned with large purchasing organizations to improve their purchasing. And again, it is what we believe is an essential part of our pharmacy network.

Senator BUDD. Thank you for that.

Dr. Kautzner.

Dr. KAUTZNER. Thank you for the question, Senator. As a pharmacist and a rural America, myself from Missouri, it is extremely important for our organization to ensure that patients do have access regardless of where they live in this country.

Unfortunately, today, less than 10 percent of physicians live in rural America, even though over 20 percent of the population does. So, we are working with independent pharmacies, one, and improving overall reimbursement rates for rural pharmacies on average of 10 percent.

Second, we are working with them to do things beyond pharmacy to provide improved access to care of other services, whether those be for diabetes testing, vaccines, doing components around behavioral health testing, opioids.

Those are additional services where they can provide quality of care and be accessible, where you don't have to go to your doctor where they may not be. So, we are working to enable rural and independent pharmacies so that they can be much more of a health center, so patients have access to quality care regardless of what zip code they live in America.

Senator BUDD. Thank you for that.

Ms. Cianfrocco.

Ms. CIANFROCCO. The independent pharmacies make up over a third of the OptumRx network, so they are a critical part, and their services unique.

The focus that I would point to for our community pharmacies is, No. 1, increased sort of reporting, predictability of reimbursement, and add in reimbursement that addresses their unique business model together with revenue enhancement opportunities in areas where they are uniquely qualified, such as medication adherence coaching, disease management diabetes, and most impor-

tantly, identifying barriers to things like rationing and inability to get insulin, because in many cases, they are the source of trust and access, and sometimes the only source of trust and access in a rural community.

Senator BUDD. Thank you. Thank all the witnesses. Chair, I yield back.

The CHAIR. Thank you, Senator Budd.

Senator Casey.

Senator CASEY. Thank you, Mr. Chairman. I want to thank you and the Ranking Member for the hearing. I want to thank all the witnesses for being here. I am going to be rather brief in light of the time and the vote that is going on.

I don't think I have to explain to anyone in this room. I think there is a consensus, when we go back home, we hear from people about the cost of prescription drugs. It is for a lot of families like a heavy bag of rocks on their backs every single day. And we have got to do a lot more.

I think both sides of this table have to do a lot more to lower those costs. We are happy the Inflation Reduction Act got those costs down for Medicare Part D beneficiaries. We are happy the companies took actions after that.

But my question is, why stop at insulin? So, I am going to ask first on the left side, my left side of the table, starting with you, Mr. Ricks. I want to just—just in 1 minute, you, being the first one, in 1 minute itemize for me specific steps that your company is taking right now or will take to lower the cost of prescription drugs more broadly, well beyond insulin.

Mr. RICKS. Thank you, Senator Casey, for the question. And I totally agree with the sentiment. We need to do more. We are working on a number of things. First of all, we have capped out-of-pocket costs for basically all of Lilly's branded medications, on patent medications.

Typically, it is around $25 to $35 in the United States. So, people with insurance should have a limit of what they pay no matter how much they use. That is the first step we have already taken. Increasingly, we have talked today about some of the dysfunction in the system whereby lower list price products may not be on someone's formulary, so it is not presented as an option.

But I do think I see a future where there will be more products introduced with two forms, both a high price and a low price, so that those that are in high deductible plans will have a choice that is actually cheaper for them, and that is something we can do.

The third thing I would say is, we support policies that have a system where there is a beginning and an end to patents and to intellectual property periods, and at the end competition should flourish.

We do support that system. And ultimately, I think it was shown earlier about the low-cost generics in America. That is a real success story for American health care. We have the cheapest generics in the world, and we support that world. We also support a world where we can afford to invent the product that became generic to begin with. That requires a premium for new products.

Senator CASEY. Mr. Hudson, if you can just itemize for me, that is——

Mr. HUDSON. Sure. Starting with the out-of-pocket commitment as well, in 2022, our co-pay card was used 2 million times, at a cost to us of $850 million. So, we are all in on trying to make sure we help.

We bookend a rather challenging health care system, investing in R&D at one end and trying to help patients make sure they get on drugs at the other end, and a black box in the middle. I accept as well that it may be that we have to have high and low priced equivalents of the same medicine, but we do now for Lantus.

I think it is somewhat disappointing that has to be the case. I think there has to be a better way where lower prices, lower out-of-pocket, and a reasonable fee by the way, for a service is provided along the chain. I think it needs some effort. To biosimilars, I think the biosimilar penetration in the U.S. lags the rest of the world.

I think it really should be 60, 70 percent mirroring what is happening in Europe and other places, and it isn't. And we have to look to why that is. We bring them forward, but it is not for us to choose what goes on the plan, and that is a broader conversation about how to reduce health care costs in the United States.

Senator CASEY. Mr. Jorgensen.

Mr. JORGENSEN. Yes, thank you, Senator. So, we have similar programs. So, patients who have insurance, they get co-pay support from us, so they typically pay around to $25 in co-pay. And for patients without insurance, we have patient system programs for all our products.

I would just add that I think we should be focused on what it is that the patient pays at the counter. We hear a lot about passing on rebates to clients, but it is really about the patient pays at the counter that this—should be about.

Senator CASEY. Mr. Joyner, it is a similar question, but what additional steps can you and the other PBMs take to ensure that patients can afford prescription drug costs?

Mr. JOYNER. Well, I will go back to the original premise that competition works. And so we will continue to look for competition in the therapeutic categories, lowering the cost for the plan sponsors or the employers, unions, etcetera, that actually pay and fund the other benefit, and then encouraging them to adopt benefit designs that actually allow it to be more affordable for the members, similar to what we do at CVS, which is a $0 copay for insulin.

Senator CASEY. Doctor.

Dr. KAUTZNER. Thank you for the question, Senator. We are absolutely focused on continuing to lower costs for our employer plans, our clients, but also for patients. We just introduced a new co-pay assurance plan, which is flat dollar co-pays, $5 for generics and specialty generics, $25 for preferred brands, $45 for specialty brands, that we are bringing out to our constituents.

We are also, through competition, continuing to beat the drum on biosimilar accessibility, interchangeability, and having more access, and reducing the patent life for biologics down from 12 years to 7

years to enhance that competition, which will flow through to have additional options in the biologics space.

I would also say there has been a lot of focus here on just price. Care is also a key component of what we do and what we must continue to do. So, when patients are on the drugs, they are on the right drugs, and we are able to help them with specialized care models that we have based on specific disease states like multiple sclerosis and diabetes.

You have nurses, physicians, and pharmacists that are trained and can help those patients. Through our program, over 80 percent of the patients that have specialty conditions are adherent on their medications and can have better health outcomes to live better and healthier lives.

Senator CASEY. Ms. Cianfrocco.

Ms. CIANFROCCO. Thank you for the question, Senator. I will point to three things. The first is a continuing commitment to work for lower drug costs, and that is through a negotiated savings or a list price. We are looking for lowest list prices.

As we embrace the lower list price. We welcome the lowest list—the lower list prices from the insulin manufacturers, and we request more of it. I will give you one example. Biosimilar for the most—for a highly utilized drug, Humira, new biosimilars have and are coming to market.

We are offering up to three of those biosimilars at parity with the original product so that patients, their prescribers, and the health plans and clients can select the best option for them. And where the biosimilar manufacturer offered a low list price, we are offering the low list price.

Second thing I will point to is we will continue to recommend and push for benefit designs for our clients that would use the savings that we negotiate and put those to consumer out-of-pocket costs, particularly in the high deductible plans.

The third thing is to Senator Hassan's and Senator Smith's comments that no one should be confused at the pharmacy, so additional tools that help consumers navigate their benefit, understand the best options in generic and brand drugs so that they can find the best affordable option for them. That is our commitment.

Senator CASEY. Thank you, Mr. Chairman.

The CHAIR. Thank you, Senator Casey.

Senator Mullin.

Senator MULLIN. Thank you, Chairman. I am just going to make an open comment here. I kind of feel like hell's freezing over because Chairman Sanders and I actually agree on something, and it is that something needs to be done with PBMs.

I do appreciate you having this hearing in the order that we are having it, Chairman. It is such a compliment coming from my side, if you can believe that. I want to point out this chart behind me.

This is the integration chart or start showing how PBMs have integrated themselves and they have become their own customer, which is kind of like the fox guarding the henhouse. And it is dif-

ficult when you start thinking about that Congress was—actually wanted to help stand up the PBMs to help bring down cost.

You have seen costs do nothing but skyrocket on prescription drugs. At the same time, you have seen that PBMs have become literally $1 billion industry. In the last 5 years alone, you have seen prescription drugs increase by 16 percent. At the same time, you have seen the net income of PBMs, and their integrated companies grow substantially.

Start thinking, why? I mean, if the $1 billion industry has grown up not because of taxpayer dollars. It is because it has got to be going to the drug costs. If it is going to drug cost, who is ultimately paying that price?

Well, it is the consumer, obviously. The money has got to be passed on to some place. It is just retail politics, and it is retail consumers. The price has to be made up because every one of you guys are in business for profit. And I think that is great. That is called America. We are able to do that. But I want to kind of bring down on some things that maybe need to be clarified.

For instance, when Senator Marshall was asking the question of why is it that some drugs aren't able to make it to the market, and I believe it was said that they are if they are the lowest cost.

But Mr. Hudson, when that comment was being made, you were shaking your head saying—because what Senator Marshall was asking is what prohibits drugs from coming to the market, especially competitive drugs, because everybody says competitiveness is what brings down the price.

I agree with that. But I don't think you actually agreed with—is it Joyner? With Mr. Joyner's answer when he said it is based on formula, whichever is cheapest for the consumer? And as I was noticing, just reading your body language, he was going like this. Can you explain more for your perspective, what prohibits drugs from coming to the market?

Mr. HUDSON. I think what I was perhaps reflecting was a lack of unknown, because as I said in 2018, we launched a lower price analog into the end of the market last year, a lower priced, direct equivalent made in the same factory.

You would expect if price was the answer, and perhaps we talk in slightly different terms.

The use of cost versus price, I am not quite sure what it means on both sides, but I am reflecting on the fact that if the intent of the Chair and everybody here is to lower the price of medicines, and we do, and it doesn't change for patients, I don't know——

Senator MULLIN. You brought a generic to the market and that was significantly cheaper than the other one, but it didn't reflect the patient's payment?

Mr. HUDSON. Well, it just didn't get listed in any way. If price is really the motivator, it would have been listed.

Senator MULLIN. Who prevented that from being listed?

Mr. HUDSON. I am—I was not part of that conversation.

Senator MULLIN. But I mean, but the PBMs are the ones that help bring that to market, right?

Mr. HUDSON. Well, my assumption——

Senator MULLIN. Your assumption——

Mr. HUDSON. The PBM——

Senator MULLIN. I think you are being very politically polite here, and I appreciate that. But I think we can all read between the lines on this one.

Mr. Ricks, when you are talking about rebate checks, because the comments were made earlier, because a question was asked about rebates, and our PBM officials over here, they were saying that the PBMs go to their customers, which I am curious of who the customers are, because I think the public would assume that it goes to the public, to the individual, to the person buying the drugs.

But I know I have six kids that seem to always be in the emergency room, that always seem to be getting prescription drugs of something, and I have never got a rebate check. So, who is the customers? Where do you send your rebate checks to?

Mr. RICKS. Yes. Thanks for the question. We send them to the PBMs, as mentioned.

Senator MULLIN. But where does a check actually get mailed to? Does it get mailed to someplace outside the United States—?

Mr. RICKS. We are increasing—yes, we were instructed to send them to the GPO.

Senator MULLIN. Where is the GPO at?

Mr. RICKS. I think it was asked earlier, the various organizations you have up there. I think——

Senator MULLIN. Most of your checks, what country are they mailed to? Outside the United States or—?

Mr. RICKS. There are some that go outside the United States.

Senator MULLIN. In the tune of how many? How much would—give me a guess.

Mr. RICKS. Our total rebates in the United States for commercial that was paid to the major three last year was $8 billion. It is not a third, but it is roughly that.

Senator MULLIN. A big chunk of that goes outside the United States.

Mr. RICKS. Several billion.

Senator MULLIN. Goes outside the United States. But yet these are customers for inside the United States.

Mr. RICKS. Yes.

Senator MULLIN. All right. These are rebates for customers——

Mr. RICKS. For U.S.—access to U.S. formularies, yes.

Senator MULLIN. But yet the rebate checks aren't actually staying inside the United States, the biggest chunk of them?

Mr. RICKS. Correct. Or a big chunk.

Senator MULLIN. That is interesting. That is interesting, too. I wonder why that is. And so, when we start talking about customers for the PBMs, who are your customers that you are referring to that rebates go to? Because you say the PBMs only keep 97, 98—

or you guys send out 97, 98 percent of your rebates, right. And the customers are the insurance companies, right?

Dr. KAUTZNER. Senator, the—our customers—so Express Scripts has over 2,500 customers. Many of them are employers, small middle, market employers, some large employers. Labor unions are clients, public sector entities——

Senator MULLIN. Self-employed or self-insured—and health plans, right?

Dr. KAUTZNER. Yes, self-insured.

Senator MULLIN. But also, your insurance companies, right? And the whole reason is to supposedly bring down premiums. But yet, if you look at this top line here, which says insurer, the PBMs only insurance companies, that the rebates are going to—it is self-integrated. So, you are rebating yourself.

That is just, wow, great business model. And we wonder why prices are high to our consumers. And this is why the Chairman and I actually agree on something. This isn't working for America. It is working for you all great. I mean, you guys are killing it. But if we are talking about bringing down prices, what have you all done to bring down prices?

That was the whole reason why you guys were created, to bring down prices. We have seen nothing but them increase. It is not going to the pharmaceutical companies that are making it. It is not going to the pharmacies unless you own them.

But if you own them, we really don't care if it makes it because upstream or downstream, depending on where they are in the integration chart, that is where you are getting your money back. And there—it—you wonder why you are here. Are you actually serving your purpose?

Heck no. You are not. And as I said before, it is like the fox guarding the henhouse. You have literally forced us to make the changes. And in my private company, if I have an entity that is not being effective for what their intended purpose is, I would shut them down. And that is what I think the solution here is. With that, I yield back.

The CHAIR. Thank you, Senator Mullin.

Senator Luján.

Senator LUJÁN. Thank you, Mr. Chairman. Thank you, Senator Mullin. I appreciated that line of questioning as well, sir. One thing I wanted to share with everyone as we open up today is, one thing I am very proud of is that New Mexico, as you all may know, recently moved to cap insulin at $25 for a 30-day supply.

I think we are seeing more and more attention state to state clearly here. I appreciate agreements to make insulin more affordable at $35 as well. And I am hoping that we can find some common ground here to expand upon that.

Especially when we talk about folks where this is make it or break it. And for me, that has new meaning. As some of you may know, I survived a stroke about a year ago. If folks don't get their insulin, it would be like if I didn't have a neurologist or a neurosurgeon. It is a false choice to think you can live without.

There are too many families back home that have shared with me decisions they are making on trying to make that insulin last longer than it should. Making decisions about what they are going to buy. And I join my colleagues in saying whether it is this or in other areas, not in our Country, that just—I don't want to get in the way of innovation.

I don't want to stifle research. But when we have something that can transform someone's life and save someone's life, there has got to be a better way for us to make this affordable so that families aren't having to worry about other stuff. And then they have the stress on top of whatever that insulin is going to help with.

I can tell you, that stuff doesn't help, because you could end up in the same situation that I was in. Now, while I am proud of what we did in New Mexico, as you all know also that the policy left out, public plans like ERISA and others.

There is still almost 200,000 people in New Mexico that need insulin that don't get the cap. And that is one of the reasons why I wanted to be here today. And so, Mr. Joyner, what percent of appeals for coverage are denied for the insulin prescribed and preferred by a patient's doctor?

Mr. JOYNER. I do not have that stat, sir.

Senator LUJÁN. Mr. Kautzner, do you have that information?

Dr. KAUTZNER. We can pull that for you, Senator, and get it to you.

Senator LUJÁN. I appreciate that, doctor. Is it Ms. Cianfrocco? Did I pronounce that correctly?

Ms. CIANFROCCO. Yes. Thank you, Senator. Similarly, I will have to—we can follow-up with your office with that exact—with exact number.

Senator LUJÁN. I appreciate that, because in the end here, being able to work with physicians as well and trying to better understand what happens when there is a denial. And I am hoping we are not going to see high rates here.

I won't be surprised if we do, but that is another area where we can do some work and make sure that people are getting what it is that their doctors think that they should get as well. And that is another conversation I have been having with people back home.

Now, Mr. Ricks, Mr. Hudson, and Mr. Jorgensen, your companies have made recent announcements about reducing list prices to some of your insulin products, and I very much appreciate that.

Now, what my team tells me is that according to CDC, about 16.5 percent of people in the U.S. who use insulin report rationing it because of cost. Something I was saying earlier. Mr. Jorgensen, yes or no, can you commit to keeping the price of your current and future insulin prices affordable?

Mr. JORGENSEN. Yes, we have a free option. So, people who are in a situation where they have to ration, they can get free insulin from Novo Nordisk. And last year, more than 60,000 Americans got a free insulin from our company.

Senator LUJÁN. Well, I appreciate that I heard you say yes. That is important to me as we talk about future insulin prices. Mr. Hud-

son, yes or no, can you commit to keeping the price of your current, future insulin prices affordable?

Mr. HUDSON. We can commit to that.

Senator LUJÁN. Mr. Ricks, I want to ask you the same question, and specifically should Mounjaro be approved to treat weight loss, will you commit to keeping that drug affordable?

Mr. RICKS. Yes, we will commit to that. And Mounjaro for diabetes today is already a $25 a cap for everyone.

Senator LUJÁN. I appreciate that. And last, I just want to point out that we know that these reforms work. When there was an effort to cap Medicare Part D, we saw about 9,000 New Mexicans that are going to benefit from saving $443 right off the top. $35 cap here, I am hoping because of actions that were taken and everyone involved, that we can find a way to get there.

But Congress is probably going to have to take some action here, and I am hoping that Congress is willing to do so. So that when we are talking to families, at least that is something that we can all agree on, with the work, the research, the investments that are made in these spaces, that we are going to say, yes, we can save people's lives.

When we have these incredible scientists and doctors that are developing these lifesaving technologies, that we are doing it in a way that says, you are going to get help regardless of how much money you make. You are not going to have to worry about getting that insulin to stay alive.

I am certainly hopeful we can get there, Mr. Chairman. I just wanted to come to just share a few of those stories that we heard from people back home as well. And again, understanding access to care.

Like I said, this mattered to me a lot before this last year, but there has been a bit of a revelation to me, that when you get sick, when you need help, when you need prescriptions, they should be there for you.

Otherwise, you might not get another day to fight for other people. And someone decided that I was going to get another day. So, I am going to be here. I am going to follow and—be nice. But I know how to fight too. And I am certainly hopeful that we can find a way to get this done together.

Thank you, Mr. Chairman.

The CHAIR. Thank you, Senator Luján.

Senator Markey.

Senator MARKEY. Thank you, Mr. Chairman, very much. Obviously representing Massachusetts. I am very proud of our biomedical research and development. But the challenge remains that much innovation is locked behind walls of research institutions, drug manufacturers, and mazes of pharmacy benefit managers and insurers.

Innovation without access is a hallucination for patients across the country. They need access to these lifesaving drugs. One in five Americans with diabetes is forced to ration their insulin, and when

patients don't get the insulin they need, they show up in emergency rooms in acute crisis.

Patients receiving care from community health centers shouldn't show up in emergency departments. And that is in Massachusetts. And we pride ourselves as the No. 1 state. You know, we are the brain state.

But even we have problems with this issue. In March, both Eli Lilly and Sanofi announced cuts in insulin prices. Some of these forms of insulin have been available since 1996 and prices have only been going up.

Now the price cuts that did occur followed intense public pressure and drug price reform in the Inflation Reduction Act. And if I am right, it seems that Congress acting was key to actually seeing a reduction in insulin prices that had not occurred in a generation.

Mr. Ricks, do you agree with that, that Congress has a role here to play?

Mr. RICKS. Senator Markey, thanks for the question. I agree everyone here has a role to play. In the case of Lilly, we started reducing—capping our prices in 2017 and implementing programs, including half price versions of our own best-selling products in 2019. So, it has been going on for a while. But I agree, everyone can play a role.

Senator MARKEY. Do you agree with that as well, Mr. Hudson?

Mr. HUDSON. I think that everybody does have a role to play. Of course, we introduced responsible pricing in 2017.

Lower cost versions of our most popular insulins in 2018. As recently as August last year, an unbranded Lantus made in the same manufacturing center, by the same highly qualified people, at a much lower price.

I think we are all trying to do our best. I would add importantly that we are yet to see whether it makes a difference for patients, whether their out of pockets go down, whether their access goes up, whether the lower list price actually has an impact on the choices and the—what they pay themselves.

Senator MARKEY. Right. And again, that is just another reason why Congress should act to put together some formula that ensures that the benefits flow down to those most in need. And I think that what we have seen in the last couple of years is that once Congress started to act, it got everyone's attention in the industry, and some of it was voluntary, some of it was coerced.

But from my perspective, it did demonstrate the need finally for the Congress to be playing a role, because the system is broken fundamentally, and we have to find ways of ensuring that all of these benefits ultimately flow down to those who are most vulnerable.

Mr. Jorgensen, do you agree that Congress acting has helped to control the drug prices out in the marketplace?

Mr. JORGENSEN. Senator, we, like the peer companies, we have faced declining prices since 2015. We have also tried to launch products with a lower list price. So, I agree with you that the com-

plexity of the system creates a floor system where patients are not getting the benefits. I think we should again really focus on the patient.

What happens at the counter for the patient? If you have insurance and a high deductible, and end up paying a list price that is a big issue. And that is the story I hear from many patients.

That, in the beginning of the year, they are in a very tough situation. And for those patients, we have already passed on the rebates, so they should pay manifold more than we as manufacturer——

Senator MARKEY. Just this week, Eli Lilly announced positive results from phase 3 trials on its own Alzheimer's treatment. And just as insulin for people with diabetes, these drugs could be a lifeline for people diagnosed with Alzheimer's. But comparable drugs on the market costs over $25,000 per year.

This is completely out of reach for most Americans. And if the medication is covered by insurance, it will weigh heavily ultimately on taxpayers. Eli Lilly has demonstrated that they can reduce their prices compared with their competitors. They have done it.

Obviously, this is a good example that we are talking about here today. Mr. Ricks, will you commit today to offering your Alzheimer's drug at prices lower than your competitors?

Mr. RICKS. Thanks for the question. We are really proud of those results, so I appreciate you highlighting that. We have been working in Alzheimer's for three decades and spent over $8 billion on research to get to that point.

Today, unfortunately, there is a blockade on Medicare access for Alzheimer's drugs. The first step we need to talk about is how to remove that, because as you would imagine, most people rely on Medicare, rather, who have the condition.

I think when you have Medicare coverage, the out-of-pocket costs for patients will naturally be low, and I think the primary issue we want to talk about is how to lift that prohibition from Medicare.

Senator MARKEY. Right. No, I appreciate that. What you are saying on the one hand is, we would like to help patients, but we have to have the Federal taxpayer cover it. And that would ensure that obviously you would get paid.

But the question then comes back to you, what can you do to lower the price that then makes it more affordable, separate from a Medicare reimbursement? And I think that is the central issue that we are dealing with here today, is the excess of profit taking from a corporate perspective that just leads to catastrophic pricing, and then the off ramp is, well, we will just have to have the Federal Government pick up the tab.

I think that is something that this hearing is intended to finally put a spotlight on in terms of corporations reducing their pricing and maybe having a more reasonable discussion with the Federal Government with regard to then what is the cost to the Federal taxpayer.

Mr. RICKS. If I could, Senator. We will be reasonably lowering pricing in the sense that we will produce value to the health care system by delaying the effects of Alzheimer's.

But unique to Alzheimer's, Medicare beneficiaries paid into that program in their entire life, and they have access to every other type of pharmaceutical for every other condition, but not Alzheimer's right now. I am just pointing out that flaw in the current system. That needs to change.

Senator MARKEY. What I am saying is $25,000 a year is too high. And it is the ask that then goes to the system and then people are then afraid would have an excessively impossible burden for the system to be able to carry.

It then comes back, the ball comes back to you and your court in terms of what you can do to lower that price, as you are looking out at this vast number.

We have 15 million baby boomers who are going to have Alzheimer's, and that is just for our Country. It is a global issue, obviously, and so your market is going to be massive and $25,000 per year is just too extraordinarily high——

The CHAIR. Thank you so much. Senator Cassidy wanted to say a few words and——

Senator CASSIDY. It is two quick questions. I thought my first one, I must address spread pricing. But Mr. Joyner, Dr. Kautzner, both of y'all spoke of things that your organizations are doing to address some of the market distortions. I want to acknowledge that.

But for the rural pharmacies as well as for those people within their deductible, it is a question of how do we get wider spread adoption of some of the things that y'all are doing that would actually address the things that we are frustrated about. That I hear about in church. Like let me go, let me go, let me go.

I don't know if you have a real quick comment on that. I will call on you, Dr. Kautzner, because again, I appreciated our conversations. All the things that you have done. Is there a way we can get better, faster uptake in the market for that?

Dr. KAUTZNER. Thank you for the question, Senator. So absolutely, we are leading the way on patients having accessibility and affordability with our new co-pay assurance plan that we have developed. Cigna actually as an employer is going to implement it on September 1, and lead the way for that.

We are also asking employers to start—pharmaceutical manufacturers, to help us offset the cost to employers as we bring down the cost of getting to $5 generics, $5 specialty generics, and $25 brands. In terms of our initiative around helping independent pharmacies, we are absolutely working with them in partnership.

We have actually created a Committee with other independent pharmacies from across America, so owners of pharmacies that will help to inform us so that we can very quickly implement some of the things that I spoke of with Senator Budd.

We are excited to get to work on that and to make some real improvements, especially for rural Americans.

Senator CASSIDY. Thank you. Ms. Cianfrocco, I don't know this. I know what I am told, not what I know. I am told that the rebate aggregator is where a lot of money hangs up and is not included in that 98 percent pass through that you describe.

Your answer suggests that, no, that in the vertical integration of the company, 98 percent is passed along. I don't know the answer to that.

Is the money that hangs up—does money hang up in the rebate aggregator, or no, no matter where it is in the vertical integration of the company, 98 percent of a rebate in a fee goes back to the plan sponsor?

Ms. CIANFROCCO. Senator, 98 percent of total discounts go back to the plan sponsor. For our GPO, it does not cost the client anything. So, it is for the benefit of the client with no additional costs.

Senator CASSIDY. Thank you very much.

The CHAIR. Thank you, Senator Cassidy. Let me begin by thanking all of you for being here. I know you have to juggle your schedules. And thank Mr. Jorgensen, who is in Denmark, for being here as well. I think anybody who has listened to this hearing, has concluded that the system is broken.

It is enormously complicated. There is virtually no transparency. I know that the price that Medicare will pay for drug is different than what Medicaid will pay. It is different than what VA pays. That hospitals pay a different price. Then doctors pay a different price. And all of that opaqueness, lack of transparency works for both the drug companies, and I think the PBMs as well.

The end result is, we have got to conclude, that there is an enormous amount of greed going on. Different Members have touched on this. Let's not be naive. The drug companies, major drug companies last year made $100 billion in profit. PBMs made $27 billion in profit. Drug companies tell us, well, we need that money. It goes into research and development.

Well, guess what, more money went into stock buybacks, significantly more, than went into research and development. So, Wall Street and your investors are making huge amounts of money while ordinary Americans are going bankrupt trying to afford the drugs that you sell. And I got a real concern that many of the new drugs that are coming out are outrageously expensive.

In fact, nearly half of all new drugs coming to the market are over $150,000. I don't know how somebody who has cancer pays $150,000 for a drug. And by the way, I talked to a leading oncologist who told me that in some cases, it costs a few bucks to manufacture those drugs. All right, let me just conclude by saying this Committee is going to stay on this issue.

We need profound change in the industry and in PBMs. Tomorrow, we are having a markup on a very modest set of bills. We are going to come back. And when you go to sleep tonight, I hope you ask yourselves, think about the people who died because they can't afford medicine.

Think about the millions of people, even not in the United States, who cannot afford the products that you make that cost you a few bucks. I, for the life of me, just don't understand how when you have something that saves a life, and it cost you a few bucks to manufacture it, and you are already making huge amounts of profits, why we can't make that product available to all at a price that they can afford. That is a moral issue.

We have got a lot of work to do, but we clearly need revolutionary changes in the way we do prescription drugs in this country. And that is tied into the fact that some of the Republican Senators have made, we are spending twice as much per capita in healthcare in this country.

Drug prices are an important part of that. People can't afford healthcare as well. So once again, we look forward to continue to work with you. I thank you all very much for being here. And this is the end of our hearing today. For any Senators who wish to ask additional questions, questions for the record will be due in ten business days on May 24th at 5.00 p.m..

Finally, I ask unanimous consent to enter into the record one statement from a stakeholder group outlining their views about insulin access to the prescription drug affordability crisis.

[The following information can be found on page 110 in Additional Material:]

The CHAIR. The Committee stands adjourned. Thank you all very much.

ADDITIONAL MATERIAL

CIVICA Inc.
May 8, 2023

Hon. BERNIE SANDERS, *Chair*,
Hon. BILL CASSIDY, *Ranking Member*,
U.S. Senate Committee on Health, Education, Labor, and Pensions,
Washington, DC.

Dear CHAIRMAN SANDERS and RANKING MEMBER CASSIDY,

Thank you for holding a hearing on the cost of insulin.

Civica Inc. (Civica) is a non-stock, non-profit pharmaceutical company that is developing quality, affordable insulin for the benefit of the 8 million Americans with diabetes who depend on this life-saving drug.

Civica was established by U.S. health systems and three philanthropies to reduce drug shortages and ensure a reliable supply of essential medicines to hospitals at fair prices. CivicaScript, a public benefit corporation, is the operating unit of Civica that was established in partnership with health plans to lower costs for consumers at the pharmacy counter.

Civica will produce biosimilar versions of the three insulins that account for most daily use in the United States—insulin glargine, lispro and aspart (corresponding to, and interchangeable with, Lantus, Humalog and Novolog respectively). Each will be available both in vials and prefilled pens.

As with any drug that Civica supplies, insulin will be available at a single transparent price, without rebates (except as required by law) or off-invoice discounts.

Civica plans to set a recommended price to the consumer of no more than $30 per vial and no more than $55 for a box of five pen cartridges, a significant discount to prices charged to uninsured individuals today. To maximize transparency and limit predatory supply chain markups, Civica will include a QR code on the drug packaging to make it clear that this is a maximum amount that consumers should pay (some pharmacies may charge less).

Our intent with this pricing strategy is both to pressure other insulin manufacturers to lower their prices (one of multiple factors likely leading to recent list price reductions) and, crucially, to eliminate the pattern of high list prices and non-transparent rebates that are common in the drug supply chain and which serve to harm consumers—especially the uninsured and anyone who has to pay full list price out of pocket at any point during the calendar year.

As you consider policies to protect consumers from high insulin prices, we urge you to ensure that payers and PBMs provide coverage of low-net-cost insulin prod-

ucts and do not continue to favor the rebated pricing long offered by brand insulin companies.

Sincerely,

ALLAN COUKELL,
Senior Vice President,
Public Policy.

[Whereupon at 4:02 p.m., the hearing was adjourned.]

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