copped out on what is, in my view, a very, very good bill, a comprehensive bill that included rail transit—again, not included here. It was a bill that had $449 billion, not including the rail, over a 6-year period, compared to the $319 billion that we are spending today. That amounts to, what, $120 billion a year more—actually, $130 billion a year more.

That is good. That is what we need. I misquoted that. It is $130 billion over 6 years. That is the kind of money that we need to build the infrastructure.

Highways, $317 billion, over 6 years, compared to where we are today, $246 billion. Significant increase, enough to fix the potholes on I–5. Transit, $114.6 billion over 6 years, compared to today, $64 billion over 6 years. The entire sum, $449 billion, compared to $319 billion over 6 years.

That is the kind of progress that we can and must make if we want to move from 16th among the world's economies, developed economies, to get back up into the top five. That is what we need to do.

Now, once again, this does not include the rail transit. If you add the rail transit in, these numbers are a little bigger. That is the kind of effort.

The United States Senate, what did they decide to do in their bill called the Senate DRIVE Act? $276 billion compared to $246 billion over 6 years; $74.9 billion for transit, compared to $64 billion. That is good. That is $10 billion. Better, but not enough. We actually need over $114 billion or $115 billion.

The entire sum on the Senate side, not including rail, is $361 billion compared to $319 billion. Better, but not enough. Not sufficient to build the infrastructure that this economy and this society need to move out of 16th place back into the top tier of five.

Now, where is the House of Representatives?

This week, we are going to take up a bill that is less than the Senate bill and just a little, teeny, tiny bit better than what we are doing today. So if you are happy with what we are doing today, you will love the House bill. But if you don't want potholes, if you want to deal with congestion, if you want to deal with ports and freight, if you want to move from a D to a B or an A, you don't do it with the House bill.

I understand, this is a starting point. This is the beginning of negotiations. But why in the world would you begin negotiations at the bottom when you need to get to the top? It beats me. I don't get it.

We have got to build the American infrastructure. It is how we move our economy. It is how we move people back to work in good, middle-class jobs. It is how your tax money should be spent.

And how can we raise the revenue for this?

Well, we don't need to increase the gasoline or the diesel tax. Keep it the same, no increase. People can argue that it should or should not be increased, but you don't need to.

This proposal, the GROW AMERICA Act, the additional $100-plus billion dollars over 6 years to build our infrastructure, is fully paid for by keeping the gasoline and the diesel tax at the level it is today and going after the hidden profits of the United States corporations that have skipped out on their responsibility to this country.

They are hiding their profits overseas. We need to go after those profits and say: You owe it to America; bring that money back and pay your just taxes. That is how this is paid for, fully paid for.

How much? About $120 billion over 6 years, enough to get the job done.

American corporations won't be allowed to run away from their responsibility to their country. They will pay their fair share, here in America. No more tax dodges overseas, folks.

So, where are we? The question for the Congress of the United States is: Are we going to go with what we have today, just a little bit more, just keeping up with inflation? Is that good enough for America to be number one? No, it is not.

Can we do better without burdening the truckers, without burdening the commuters? We can, if we are willing to step up to the American corporations, the big and the powerful, and say: Pay your fair share.

Oh, by the way, their fair share is 14 percent, which is less than one-half of the corporate tax rate.

We will see what happens. The House of Representatives, the men and women that you have elected, are going to make some decisions. We will make a decision about Speaker eventually. That will get taken care of eventually. We will make some decisions about a few other things. But the infrastructure issue of this Nation is fundamental to economic growth.

I hope we make the right decision. I hope we make the decision to grow this economy, to make it in America, spend your tax dollars here at home, and give you the roads, the transit system, the ports, the freight movement, the airports that you need and America needs.

Mr. Speaker, I yield back the balance of my time.

HONORING AMERICA'S PHARMACISTS

The SPEAKER pro tempore. Under the Speaker's announced policy of January 6, 2015, the gentleman from Georgia (Mr. COLLINS) is recognized for 60 minutes as the designee of the majority leader.

Mr. COLLINS of Georgia. Mr. Speaker, I appreciate the opportunity to be here this evening. It is a good time to be back here on the floor tonight, especially after coming back from a week, I am always very pleased to go see home, be a part of folks who get outside this beltway, get outside where they get up in morning, they go to work, they do the things that families do and communities do, and they do so with a sense of purpose and work.

I think tonight we are going to bring to light, during our time together, we are going to talk about some of the great folks, our American pharmacists and the battle that they carry on every day. They are true champions on the front lines of health care.

Tonight we are going to be joined by several people. My good colleague from Georgia, BUDDY CARTER, is going to be here. DAVE LOEBSACK from Iowa is going to be here as well. We will have many people come in and out.

Over the next 60 minutes, I hope the words that we speak will encourage and inspire those who care for our constituents in their time of need.

Back in 1925, the first celebration of National Pharmaceutical Week was held October 11–17. In 2004, American Pharmacists Month was launched to bring greater awareness to the expanding role of pharmacists in the healthcare system and recognize their unwavering commitment to patient care.

On October 1, we celebrated Pharmacist Appreciation Day and participated in the third annual tweet-a-thon. This year, there were 7,214 tweets from 1,285 tweeters, and I wanted to share some of my favorite ones at this time.

They say:

Can you give me a flu shot through the drive-through?

We do more than count pills. We ensure medication safety for our patients in a variety of settings. We save lives.

We filled insulin for a patient after she was refused by the big box pharmacies.

What does Batman have in common with your pharmacist? They save lives.

I wanted to be a pharmacist because in my small town, doctors rotated in and out, but the pharmacist knew my community.

Every year, the American Pharmacists Association Academy of Student Pharmacists creates a national theme to encourage and advocate for the profession of pharmacy, and this year the theme is: Live your ''why.'' We are going to come back to that a lot tonight, Live your ''why.''

It is incredible to read the outpouring of stories from student pharmacists around the country.

Hannah Holbrook is a pharmacy student at ULM, one of the most active and committed student pharmacist chapters in the Nation. She told a local paper: ''Even as students, we can be leaders and have impact on patients.''

I believe the next generation of pharmacists is going to do truly remarkable things that could radically transform patient care, but it won't happen unless Congress acts. We must act to level the playing field so independent and community pharmacists can not only compete, all they are asking for is a chance, and we need to make sure that we step up and do that.

Tonight, like I said, we are going to share from many as we go tonight, but I want to start off with Representative BLUM, who has come down to speak

with us. He has got to run off on some other events, but we wanted to get you here tonight. We are glad that you are here to speak on this important issue for your community and others.

I yield to the gentleman from Iowa (Mr. BLUM).

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Mr. BLUM. Mr. Speaker, I rise today in support of pharmacies across the country, especially the independent community pharmacies who operate in a tough business climate to serve rural areas and provide patients with convenient, affordable, and personal care.

In my home State of Iowa, 72 of our 99 counties are considered medically underserved; and of these, 27 are served by only one pharmacy. Many of these areas are rural, and a large number of citizens in these sparsely populated areas rely on their community pharmacy for access to lifesaving drugs and treatments.

Unfortunately, the implementation of Federal policy to address the rising costs of drugs has left independent community pharmacists at a disadvantage. Often unable to cover the costs of maintaining and managing a storefront, community pharmacies are closing their doors at an alarming rate. This leaves many Americans without access to the timely, efficient, and personal patient services they provide.

To that end, I am most happy to cosponsor H.R. 592, to ensure that pharmacists are recognized as providers under Medicare part B so that my constituents can have access to local healthcare services instead of traveling long distances to seek out care.

Additionally, I am also proud to work with the gentleman from Georgia (Mr. COLLINS) as well as my colleagues across the aisle, such as Congressman DAVE LOEBSACK from the Second District of Iowa, to lower the cost of drugs and promote fair competition and choice, which will ultimately benefit patients.

I will continue to work to pass legislation, such as H.R. 244, to increase the transparency of drug payment rates under Medicare part D and TRICARE, while ensuring a fair, competitive market for generic drugs.

Finally, I wish to highlight the work of Hartig Drug Stores, the second-oldest family-owned independent drugstore company in America, which has locations throughout my district, including my hometown of Dubuque, Iowa. Hartig's pharmacies operate in three States, employing 437 people.

I believe we should be enacting policies that allow these kinds of local pharmacies to thrive instead of shut down. My hope is that through the continued hard work of their dedicated employees and the implementation of better policies at the Federal level, these family businesses will continue to serve patients in and around my district for many years to come.

Mr. COLLINS of Georgia. Thank you, Mr. BLUM.

I think what you have recognized are the struggles that are going on right now. And what I have found—I was speaking with a Member tonight from one of our Midwestern districts. It was on the floor as we were voting earlier. I started explaining what was going on in our independent pharmacies. This Member did not know. They had not had a chance to interact. They didn't know what was going on and the changes that were going on. So you being here tonight helps highlight that.

I think as we educate Members, this is just an inequity that is in our healthcare system that needs to be fixed.

I appreciate the gentleman from Iowa (Mr. BLUM) being here.

There are many things that are talked about in our time up here. Many times, we talk about not being able to work together. This is an issue that draws us together.

Mr. LOEBSACK and I have worked through two Congresses now on this issue. We are going to work on more together. It is my honor to yield to the gentleman from Iowa (Mr. LOEBSACK) to expound on this because we have been working on this for a while, and it is good to have you here tonight.

Mr. LOEBSACK. Thank you, Mr. COLLINS. It is great to be here. I know that you folks have a lot of things going on on your side of the aisle, and it is a testament to your commitment to this issue that you have gotten a number of your colleagues here tonight to speak to this issue, to speak to the importance of independent and community pharmacists.

It is really, really important for America that we talk about this. And as Mr. COLLINS said—and Mr. CARTER, I appreciate your invitation as well—it is really important that we speak to how important these folks are for our communities, for health care, for their patients.

Mr. BLUM, thank you for being here tonight as well.

Mr. BLUM represents the district that borders me to the north, and he mentioned the Hartig pharmacy. They have a pharmacy in Iowa City, and I took a little bit of time out of my schedule a couple years ago to visit there and to hear the problems that they have when it comes to all kinds of issues.

This month, of course, is American Pharmacists Month. It is a month during which we recognize the important role that pharmacies play in our communities. Pharmacists are, in fact, frontline healthcare providers, and they are counselors for many patients who consistently depend on their training and expertise to stay informed, to stay healthy, and to stay out of the hospital. They also play an incredibly important role in strengthening the economies of the areas they serve, particularly in rural counties like so many of those that I represent of the 24 counties I have.

It is also crucial that these pharmacies have a level playing field, as was already mentioned by the gentleman from Iowa (Mr. BLUM), when trying to run a successful business in a challenging and complex environment. Like most small-business owners, community pharmacists face many challenges to compete and negotiate on a day-to-day basis with large entities on their business transactions.

I have personally visited, as I have said, many of these pharmacies in my district, the Second District. I have learned firsthand how they often struggle to compete.

One problem I have heard, for example, from many pharmacists is that the reimbursement system—and I am sure we are going to hear more from folks about that tonight—for generic drugs is largely unregulated; and it is, in fact, a mystery to many folks. Generic prescription drugs account for the vast majority of drugs dispensed, so it is critical for pharmacists' bottom line that their reimbursement is transparent.

However, pharmacists are reimbursed for generics via the maximum allowable cost, or MAC, lists created by pharmacy benefits managers, PBMs—the drug plan middleman, something we have heard so much about. But the methodology used to create these lists is not disclosed. It is a secret. It shouldn't be a secret. It should be open. We need to have transparency on this front. Also, the lists aren't updated on a regular basis, resulting in pharmacists often being reimbursed below what it costs them to actually acquire the drugs. That makes no sense whatsoever.

So to address the problem, I partnered with the gentleman from Georgia (Mr. COLLINS) to introduce H.R. 244, the MAC Transparency Act. We have a lot of folks onboard on this. It is a bipartisan bill at a time when, as Mr. COLLINS said, there is not a lot of bipartisanship in this body at the moment.

Basically, what this bill would do is it would ensure that Federal health plan reimbursements to pharmacies keep pace with generic drug prices, which can skyrocket overnight, as we know.

I am not going to go into great detail at the moment. We have got time to talk about this a little bit more. There are other things we can talk about tonight. But I just wanted to say a few things at the outset and to just thank you again, Mr. COLLINS and Mr. CARTER, for setting this particular time aside so we can really educate our colleagues, as much as anything, about the problems facing independent community pharmacists.

Mr. COLLINS of Georgia. I thank my colleague. I do appreciate that.

And that is the issue here: education. People can look in on this. They can hear what we are talking about. They can see this education part of it.

This is found in every district. It is almost like veterans. There is no Member of Congress that doesn't have veterans' issues, because they come from

every area. Every one of our districts has independent pharmacists. And as one told me just the other day, he said, if the condition doesn't change, they will be gone in a year and a half.

I have had, even in my area, county governments who believe that they can cut their healthcare costs by going and taking the pharmacies and putting them with a PBM and centralizing it for county employees. They said that they would save X amount of dollars. And when I called my county commissioner and asked him about this, I said: You save this amount of money. But, I said: If you realize, if you take county employees out of the system, government operating this—and this is someone on my side of the aisle. I told him: You take government and put this in control, you are going to put pharmacies out of business. And I said: How much do you save when they have to lay off employees? They shutter their businesses, and you lose sales tax, property tax, and the peripheral income that comes with that.

We have got to address it, and that is why we are here tonight. This educational process is important.

When you come up through the legislative ranks—whether it is here in Congress or the State house, where I started, you meet folks who you learn to have a great deal of respect for, especially from the places that they have come and what they have done in the past.

BUDDY CARTER, the Congressman from the southeast coastline of Georgia, is one of those who actually is a pharmacist.

I think one of the things I want to emphasize tonight is—and some people might be saying: Why are you bashing pharmacists? We are not bashing pharmacists. Pharmacists are great. I love them. No matter where they work, it is the system that they are trapped in that is broken, that is hurting the individuals who need that care.

So tonight we are going to have a great perspective from one in the profession who understands this firsthand, from owning those pharmacies, but also dispensing and taking care of patients.

With that, I yield to the gentleman from Georgia (Mr. CARTER) for his comments.

Mr. CARTER of Georgia. Thank you, Representative COLLINS, and thank you for hosting this tonight. This is certainly a very important subject. It is very important to me, personally, yes, but it is more important to our healthcare system.

Mr. Speaker, for over 2,000 years, the practice of pharmacies has existed to help people with their ailments. Today, the most common pharmacy position is that of the community pharmacist. Community pharmacists are the front lines of medication, instructing and counseling on the proper use and adverse effects of medically prescribed drugs.

However, over the past decade, there have been several issues that have threatened the role of community pharmacists. Being a community pharmacist myself, I know these issues all too well. I believe that there are three main issues that we can address in Congress that will allow the community pharmacists to continue to fill the invaluable role of counseling Americans on the proper use and dangers of prescription medications.

First of all, MAC pricing transparency.

When I became a Member of the United States Congress and I got involved in government, I jokingly said that if I could learn 10 percent of all the acronyms in the Federal Government, I think I would have been a success. Then I got to thinking about it, and I feel a little silly now because there are a lot of acronyms in pharmacy as well. One of those is MAC, M-A-C, maximum allowable cost. Another is PBM, pharmacy benefits manager.

Now let's talk about MAC pricing transparency. This is a bill that is being offered, and this is a situation that needs to be taken care of. It needs to be addressed. It is perhaps one of the most pressing—if not the most pressing—issues facing community pharmacists right now.

MAC is a price list. The maximum allowable cost is a price list that lists the upper limit or the maximum amount that an insurance plan will pay for a generic drug. In other words, if you have a generic drug and it is on that MAC list, they are going to tell you what the maximum allowable cost is. That maximum allowable cost may be $10. Now, if you can buy it for $9, more power to you; but if you have to buy it for $11, you are only going to get paid $10. That is why they call it the maximum allowable cost.

Each insurance plan sets the maximum allowable cost for the plan. Some States require them to follow a certain policy, if you will, a certain procedure when they set those plans, those prices. Most States don't. In a lot of States that don't, the insurance companies can set it wherever they want to, whatever they want to set it at. They may choose a drug that is only available in a certain area for a certain price.

For instance, if I am in southeast Georgia, I may not be able to get that drug at that price that they set it at because they used the price that it is available in the northeast and is not available to us in the southeast. That is why we have got to have transparency. That is why we have got to have maximum allowable cost transparency.

PBMs are supposed to ensure that the cost of the drugs do not rise to unaffordable price levels, which is supposed to allow continued access to medications to Americans and maintain low costs for employers who provide coverage for those employees, and that is very important. They are supposed to set those prices so that their plan's recipients, the ones that are covered, are able to get those medications.

Therein lies a couple of problems. One is what I just explained, that it is not always available at the price that they set. A second is that sometimes the price goes up. We know that the price of generics have been going up significantly and rapidly. When that happens, sometimes the insurance companies, the PBMs, are slow to raise their MAC prices, which means that if I have got a MAC price of $10 and, overnight, the price of that drug went up to $20, until the insurance company raises the MAC price, I am still going to get paid $10 even though it is costing me $20. That cannot be sustainable for community pharmacists.

Community pharmacy is somewhat different from other healthcare providers in that we have a product. We actually have a product that we have to pay for. We have that product.

Now, granted, doctors' offices have injectables they have to pay for and so and so, and we understand that. But in community pharmacy, we actually have that product on our shelf, and we have got to pay for it, regardless of how much we get paid for it. The wholesaler doesn't say: Well, how much did you get paid for it? That is how much we are going to charge you.

We wish it worked that way, but it doesn't work that way.

The way it works is they have got a set price. If it is $20 and I am only getting paid $10 for it, I am losing that $10.

Now, some of you may think: Well, you can make up that $10, can't you, and charge the patient? No. You can't do that.

If they have got a copay, that copay is $5, that is what they pay. I can't charge them $15 to make up for that difference. That is not allowed. That is one of the things that is leading to the detriment of the community pharmacy.

But perhaps an even more important point there is what happens with the patient. Because, keep in mind, ultimately what we are talking about here, when we are talking about keeping community pharmacies open, when we are talking about making certain that this provider is available, we are talking about the patients.

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We are talking about the patient and patient care. If I am not able to pay for that medication because I am not getting reimbursed enough, that patient is not going to get the medication, and that is going to lead to even more medical costs. That is why this is so vitally important. In the end, what it comes to is patient care.

What is the problem? What is the problem with PBMs, with the pharmacy benefits managers? First of all, there is no transparency. There is no transparency in the contracts with the PBMs. For example, several years ago Meridian Health Systems, a nonprofit that owns and operates six hospitals in southern New Jersey, hired a PBM to help reduce their surging medication

costs for its 12,000 employees and their families.

This PBM projected it would slice at least $763,000 from Meridian's $12 million in annual medication spending. Just 3 months into the contract Meridian was on pace to balloon by $1.3 million. This PBM insisted that it was actually saving Meridian money. It was not.

After some investigation by Meridian, Meridian discovered that this PBM was making huge gross profits ranging from $5 per prescription to multiple times that amount. In one example, Meridian was charged $92.53 on a generic bottle of antibiotics while the PBM only paid $26.91 to get the prescription filled. That is a profit spread of $65.62.

Therein lies the problem in what is referred to as the spread, the difference between what the PBM actually charged the company and the difference in what they actually paid for. That is the spread that the PBMs work on.

The amount that PBMs charge the small businesses, the customer, or the government under part D of Medicare can be significantly more than what it actually costs for them to fill the prescription. As I mentioned, PBMs don't always update their price list in a reasonable amount of time. This hurts pharmacies, and more than that, again, it hurts patients.

There has been evidence to suggest that some PBMs wait until 4 to 6 months to update that reimbursement rates after a drug price rises. There has been evidence of that.

I have experienced that while I was still working. Ten months ago, before I entered Congress, before I became a Member of Congress, when I was still running my drugstore, I experienced this. I experienced where a product would go up in cost, yet the PBM would not adjust their price, their cost, their MAC.

We would have months, literally months, where we were getting paid less than what we were having to pay for the drug. Obviously, that is not sustainable. That business model doesn't work for anyone regardless of who it is.

This leaves pharmacists getting reimbursed for drug prices that could be extremely out of date. Any small business in the country can't sustain operability when they don't know how much it costs to provide the customer with their service. You are basically asking a business owner to operate with no understanding of revenue. No one in the country can operate a business like this.

We need as much transparency as possible to make sure that PBMs are doing what they were created to do. My colleague from Georgia (Mr. COLLINS) has introduced H.R. 244, the MAC Transparency Act, which would provide much-needed transparency to the operations of PBMs and provide pharmacies, businesses, and Americans a better understanding of their insurance coverage and the true drug costs. This is a very important piece of legislation.

Another issue that is very important and extremely important to pharmacists is provider status. Now, Mr. Speaker, I graduated from pharmacy school in 1980. I have what is known as a bachelor of pharmacy degree. Back then it was a 5-year degree. The pharmacists that are graduating now are graduating with a doctor of pharmacy degree, a 4-year professional degree that usually comes after a bachelor's degree.

In most cases, they have at least 6 and, in most cases, 8 years of education. Their clinical expertise is so impressive right now. The practice of pharmacy has changed so much during the years that I have been practicing. I have seen it go from where we did nothing more than fill prescriptions to where now the pharmacist is a vital member of the healthcare team.

Mr. COLLINS mentioned a little while ago about someone asking if they could get a flu shot in a drive-through. We have actually seen that done sometimes. But the point that I want to make is pharmacists now are actually administering vaccines.

How does that help us? How does that help Americans? How does that help our healthcare system? Obviously, our vaccination rate improves. Keep in mind, in south Georgia, where I represent, rural health care is a concern. We quite often say that, in Georgia, there are two Georgias. There is north Georgia and the Atlanta metro area and then there is the rest of Georgia.

Access to health care is very important in south Georgia, particularly in the rural area of south Georgia, where you find that pharmacists are some of the most accessible healthcare professionals out there. If it were not for our pharmacists, many of these patients would not get those vaccinations, and that is very important. It is very important that we have provider status for pharmacists.

The U.S. healthcare system has come into an era of integrated care delivery systems that provide all-encompassing care to Americans. This new structure of care will provide Americans with the type of care that allows constant collaboration with all sectors of health care to provide the highest level of care.

As all of us know, the majority of Americans that rely on healthcare professionals are the elderly. However, under part B of Medicare, pharmacists are excluded from the list of providers under Medicare part B.

This is something that is going to have to change. Regardless of how you might feel about the Affordable Care Act, regardless of how you might feel about what is our state of health care here in America now, one thing is for certain. We are going to have to utilize all disciplines in health care to improve our system. We are going to have to utilize pharmacists. We are going to have to utilize nurses and physician's assistants. We are going to have to make use of all of those.

Now, to my physician friends, make no mistake about it. Doctors remain the quarterback. They remain the captains of the team. We have to have them. They are essential. But these services that have been provided in the old model where doctors did everything and the other healthcare professionals didn't participate has got to change in order for health care to sustain here in America.

We have got to utilize these. My wife is a physical therapist. The physical therapists who are graduating now, again, are so clinically oriented and they can do so much more. We find that in all different aspects in allied health care.

That is something that we have to do. That is why it is vitally important that we have provider status for pharmacists, physicians, physician's assistants, certified nurse practitioners, qualified psychologists, clinical social workers, certified nurse midwives, and certified registered nurse anesthetists.

All of those are reimbursable and covered under Medicare part B, but pharmacists are not. Pharmacists need to be included in that. These professionals make up a healthcare team that provides an integrated healthcare plan for the treatment of a patient. However, I have never experienced a patient that required this level of care without being prescribed medications. It is a vital part of it.

If we don't get the medications to them, the whole process fails. Why does the patient go to the doctor and spend all this time being diagnosed and this doctor use all of his expertise in diagnosing this patient if they are not going to get the medications? It is a vital part.

We refer to it as a three-legged stool where you have got the physician, you have got the pharmacist, and you have got the patient. All of them have to work together to make the system work.

If we really want to provide a fully integrated healthcare system, pharmacists' services should be included under Medicare. This is why my friend from Kentucky (Mr. GUTHRIE) has introduced H.R. 592, the Pharmacy in Medically Underserved Areas Enhancement Act. This legislation would include pharmacists under the list of providers under Medicare part B and provide a true integrated healthcare team for Medicare patients.

Finally, the third thing that we need to do and that Congress can do—some health plans, particularly Medicare prescription plans, have selected certain pharmacies to be the plan's preferred provider. We must have any willing provider, pharmacy legislation, rather than allow insurance plans to pick and choose a preferred pharmacy.

Now, this is something I have, unfortunately, a lot of experience with. I have been practicing for over 34 years

now. Let me tell you, I have had patients who have been with me that long. They are a part of my family.

I have provided services to them. They have come to my store. I have provided generations of services to them, to their parents, to their grandparents, and now to them and to their children. Yet, they at the first of the year come to me, some of them in tears, and tell me, ''I have got to change pharmacies. I don't want to. But my insurance plan is telling me that this is the only pharmacy I can use.''

Sometimes the PBMs will mask it by saying, ''Well, that is not true. They can use you. They can go ahead and pay for the medications and submit us the receipts and we will see if we can reimburse them or they can go to our preferred pharmacy and pay the $5 copay.'' That is not a choice. That is not a choice at all.

Other plans will tell you, ''Okay. You can use this pharmacy outside of our preferred network if you want to. The copay is going to be $45. But if you use our preferred pharmacy, the copay is going be to $5.''

Well, let me tell you, if you have 10 prescriptions, as a lot of elderly patients do, are you going to pay $450 as opposed to $50? That is not a choice. That is not something that is going to lead patients to stay with their pharmacy.

They are going to have to change, and they don't want to do that. Mr. Speaker, having a choice makes a difference. These relationships that patients have with their healthcare providers are very, very important.

So my colleague from Virginia (Mr. GRIFFITH) has offered legislation to remedy this problem. The Ensuring Seniors Access to Local Pharmacies Act of 2015 would allow Medicare enrollees to keep their longtime pharmacist if that pharmacist agrees to the terms and conditions of the Medicare prescription drug plan.

In providing this reform, we will be able to provide a free market system for prescription drug plans that will lower cost while also providing comfort to Americans. This is win-win.

Now, before you say, ''Oh, Buddy, all you are saying is that you want to force people to have to do this,'' no, not at all. I am a free market guy. You will not meet more of a free market person than me. All we are asking to do is to have the ability to compete. That is all we are asking to do, to participate in the free market.

If the insurance company—if the PBM, sets the reimbursement, if I see, okay, this is the reimbursement they are going to pay me, if I am willing to accept that reimbursement, I should be able to participate. That is all we are saying.

Give us the opportunity, if we are a willing provider, to participate. Select Networks are hurting us. But, more importantly—more importantly—they are hurting the patients.

Why is that? Because now the patient, instead of going to my pharmacy where it is convenient, where they have been going for 34 years, where their parents went, where their grandparents went, are having to go and travel long distances, particularly in south Georgia, to get to the pharmacy that is a Select pharmacy, the Select provider. A lot of times they just do without. Then what happens? Then all of a sudden medical costs rise, and we don't see adherence. That is a problem.

So those three things, Mr. Speaker, are three things that are very important to community pharmacies.

I want to thank again my colleague from Georgia (Mr. COLLINS) for bringing this up and let you know that I have been honored to serve as a pharmacist. I think it is a noble profession.

But, most importantly, I want to make sure you understand this is about the patients. If community pharmacies don't survive, this is going to mean that health care in this country suffers.

Mr. COLLINS of Georgia. Mr. Speaker, I appreciate my friend from Georgia and his passionate defense of what we are doing here tonight.

Earlier this month many of my colleagues and I sent a letter to CMS in support of proposed guidance to ensure part D plan cosponsors consistently report pharmacy price concessions. That letter was led by fellow Georgian and a good champion of pharmacists, AUSTIN SCOTT, and it is my pleasure to yield some time to him now.

Mr. AUSTIN SCOTT of Georgia. Thank you, Mr. COLLINS and Mr. LOEBSACK. I appreciate your being here. This is certainly a bipartisan issue and gets to the heart of some of the challenges in health care in our country right now. I certainly rise today in support of our Nation's community pharmacists and our pharmacies which play a critical role in our healthcare system.

Many of these independent businesses operate in underserved areas like the ones that I represent in rural Georgia, 24 counties. In areas where a doctor may be many miles away, local pharmacists deliver flu shots, give advice on over-the-counter drugs, and help with late-night drugstore runs for sick kids.

Many people see their pharmacists much more often than their doctor, and there is a very personal relationship between these community pharmacists, patients, and the physician. They are community pillars, and they contribute greatly to the economies. It is crucial that these pharmacies have a level playing field when trying to run a successful business in a challenging and complex environment.

As you know, Mr. COLLINS, I was an insurance broker for many years. I thought I might tell a very personal story about one of my clients who, shortly after their contract was issued, the gentleman's child got sick and they needed a prescription filled. So they went to the local big box pharmacist or pharmacy, and they wouldn't fill it for them.

□ 2030

Even when I, as the agent, could provide evidence that the person was insured without the card, they simply would not fill the gentleman's prescription. The local community pharmacist was the one that filled the script.

Now, the irony of it and what we are talking about here and where the real problem comes in is that, when the person got their insurance card because of the PBMs, they could no longer use that community pharmacist that was the only one that would provide the service that they needed when they actually needed it.

So it is extremely important that, when we have these business models, we keep those local community pharmacists where they are able to run a successful business and stay in business.

During the August district work period, I stopped by another drugstore, a small drug store in Quitman that had been there many, many years. Generations of people have continued to rely on them for their services.

While I was there, I watched one of our senior citizens, a lovely lady, come in. The owner called her by name. They caught up on family and friends and what was going on in life, and she had some questions about the medications.

And let me tell you that pharmacist knew the answer to every single one. He knew her history with those medications and was able to answer those questions that she asked. She left there with a smile on her face knowing that she knew what she needed to take, when she needed to take it, and what she needed to take it with.

As I stopped at these local community pharmacies like the ones I visited in August, I continued to hear concerns from them about what is happening in the pricing structure and that, if the price on a drug goes up, the insurance company has the ability and takes several months to change the rate when the price goes up. But if the price comes down, as happens in free market sometimes, they immediately reduce the price that they reimburse to the pharmacist.

There should be no excuse for the difference in the timeframe in which the reimbursement occurs. If it can be done when the price is changing to the downside, it can certainly be done in the same time limit when the price is changing to the upside.

A lot of things we have seen lately in pharmacy. We saw where a venture capitalist purchased a drug and raised the price of that drug several thousandfold overnight. That has been happening, and local community pharmacists have expressed concerns with this issue for many years.

It has happened with nitroglycerine tablets, for example, that has been around for decades and decades. They

have gone from 8 cents apiece to $8 apiece. Digoxin for a heart condition, doxycycline, the same thing has happened with these drugs.

How is this happening? And who is going to help us fix this if not for the ability to get the information from their local community pharmacist?

They are the ones that care the most, and they are the ones that are willing to help resolve the challenges with the higher drug costs in this country.

So one would ask: How is it that, in many cases, our local pharmacists are kept from being able to participate in the networks? Well, in many cases, the networks that are blocking out the local community pharmacists are actually owned by the big box pharmacies.

If you want to talk about a conflict of interest, that is about as conflicted as it gets when your big box pharmacists own the network that actually can determine who you can get your drugs from and they box out their own competition.

Quite honestly, I think it would be a wonderful issue for the Federal Trade Commission to get involved in and to bring competition back into that area.

One of the things that I think would help is H.R. 793, the Ensuring Seniors Access to Local Pharmacies Act of 2015. I want to thank my colleagues that are here that are also cosponsors for it.

This bill allows community pharmacies that are located in medically underserved areas or areas that have health professional shortages the ability to participate in Medicare part D in the preferred pharmacy networks so long as they are willing to accept the contract terms and conditions that other in-network providers operate under.

This is reasonable. This is patient choice. This keeps the small business owner out there. Let me ask you to make no mistake about it. This is big business versus small business.

One of the other things that I want to talk about is MAC, the maximum allowable cost. Pharmacists are often reimbursed for generics by this MAC list. You have heard BUDDY CARTER talk about this earlier. He certainly knows more about it than I do. This list is created by the PBMs, but nobody knows how they create this list.

As patients, we have a right to determine how the costs are derived for the drugs that we are going to take. And understand this. It is not a manufacturer's cost. It is not a manufacturer's cost. It is a maximum allowable cost. When the lists are updated, certainly it should be done in a timely manner.

I am happy to have cosponsored H.R. 244, and I certainly hope to see that bipartisan bill pass.

With that, Mr. COLLINS, thank you for taking the lead on this issue.

Our local community pharmacists are extremely important to our healthcare system. There is a way to create a scenario under which the patients have more choice and that requires keeping that local community pharmacist in business.

Mr. COLLINS of Georgia. Well, Mr. SCOTT, I don't disagree with you. I thank you for being here. You have been a great champion to this cause as well.

I think the interesting thing here—I want to repeat—basically, what we are going back to is some simple fixes. We are not asking for one to be preferred over another one.

I think exactly what the PBMs actually want is they want to prefer and they want to run you into their network and control you.

And, by the way, most people don't realize that a lot of our community pharmacists have to buy from PBM, who operate other big box stores, who, in turn, then audit them and can fine them if they don't follow the plan exactly.

These are the kind of crazy things that just obviously——

Mr. AUSTIN SCOTT of Georgia. Can I repeat one thing you just said right there?

Mr. COLLINS of Georgia. Go right ahead.

Mr. AUSTIN SCOTT of Georgia. They get to audit their competitors. Now, in what other scenario in the world could you say it is a free market when your competitor, who is the big box multi-billion-dollar operation, gets to audit their small business competitor?

Mr. COLLINS of Georgia. It is baffling. That is why H.R. 244 simply says you have 7 days to update the list, number one. Number two, it says that patients will not be forced by PBMs to use a PBM-owned pharmacy, an obvious conflict of interest.

And according to Medicare data, PBM on mail order pharmacies may charge plans more, as much as 83 percent more, to fill prescriptions than community pharmacies.

Mr. LOEBSACK, you have been with us on this from day one. Tell me some more about what you are hearing out there.

Mr. LOEBSACK. Oh, my gosh. First of all, I want to thank Mr. CARTER. It is testimonials like his that I have been hearing for the last 10 years, since I have been in Congress, since I first went to an independent community pharmacist, and you spoke with such great passion.

You are not alone, as you know. Every single person like you in my district can tell me the same things that you have told me. That is why I am on these bills. That is why I am talking tonight about these issues.

I don't have the firsthand experience that you have as a pharmacist. The closest I ever got to a pharmacy, other than picking up my prescription drugs, before I got into Congress was when I was 16 and 17 years old. I was a delivery boy for Greenville Pharmacy in Sioux City, Iowa, which, by the way, still exists, since 1969. Actually, longer ago than that it was established. But I would deliver prescription drugs to folks, especially to the elderly who couldn't get out of their home, who couldn't get to the pharmacy.

That is what this is about, as you said. It is about making sure ultimately. And as a Member of Congress, my job is to make sure that folks have access to affordable quality health care.

And that is where pharmacists play such an important role, whether it is with medication therapy management or just simply consulting on an informal basis with someone who comes in and has a lot of different prescriptions and is confused by what to take and when to take them.

You folks really do such a wonderful job. And if we lost that service, as you said, because of unfair business practices, because of being squeezed by the big guys—and it doesn't make any sense at all for that to happen—then patients would suffer in the end.

That is why I support both of these pieces of legislation, two of these that have been mentioned already. 244, which Mr. COLLINS just mentioned again, to make sure that everyone understands what it is about, it is a measure that will increase transparency of generic drug payment rates in Medicare part D and the Federal Employees Health Benefits program, which serves a lot of folks, as we know, millions of folks, and in the TRICARE pharmacy program by requiring those PBMs, one, to provide pricing updates at least once every 7 days. That doesn't seem like a lot to ask, to me, and I am sure it doesn't seem like a lot to ask for you; number two, disclose the sources used to update that MAC list and to notify pharmacies of any changes in individual drug prices before these prices can be used as a basis of reimbursement. This is complete common sense. That is why there are Republicans and Democrats alike on this bill, and I hope we can move this bill forward.

In Iowa, the State legislature did pass something not quite this comprehensive, but something similar to this, because in Iowa folks understand what these PBMs are doing and what those independent community pharmacists are up against.

And the second piece of legislation, H.R. 592 that was already referenced, again, a bipartisan piece of legislation, has got 218 cosponsors. If memory serves me, that is exactly the number we need, if everybody votes, to pass a piece of legislation in this body. We could get it done. If we brought it to the floor, we could get it done.

Maybe we ought to do a discharge petition. Sorry. I don't mean to create too many anxieties there with you folks. But, nonetheless, we have got to get this thing done. It is about making sure that our pharmacists are able to continue to deliver the kind of quality health care.

Look, whatever we decide at the Federal level when it comes to utilizing pharmacists to their full potential, this legislation does stipulate that nothing

will override State scope of practice laws as well.

Because I know that a lot of folks in other professions have concerns about that, that pharmacists are going to go too far. Well, they are not going to. If States have laws in place about scope of practice, this legislation will not override that.

But it is about making sure, as Mr. CARTER said and as Mr. COLLINS would agree and others who have been so active on these issues would agree—it is about making sure that folks get the quality care that they need.

If we close down these pharmacies in these rural areas—95 percent of the folks in Iowa are within 5 miles of an independent community pharmacist—if they close down those pharmacies, those folks in my district who depend upon those pharmacies and those pharmacists are going to suffer. That is unacceptable to me.

Thanks again for giving me the time to speak on this.

Mr. COLLINS of Georgia. Mr. LOEBSACK, you hit it right. There are so many times we get to talking policy and big picture up here. The bottom line is what we do up here—and when I was in the State legislature, you could see it because you were a little bit closer—States are starting to pick up this mantle, as you just said, in Iowa and other States. But it goes back to that feeling of what I call security.

Now, as I said just a few minutes ago, the pharmacist is not the issue. The pharmacist is someone who helps in the curing process. They are part of that.

I don't want to ever have anyone who happened to watch this to say, ''Why are you bashing pharmacists?'' We are not bashing pharmacists. What we are taking shots at and what we are trying to find solutions for is an abusive practice that has been set up in the name of saving money at the expense of the patient. That is unacceptable.

It is time we have a hearing up here on those kind of abuses. I call for that. I call for the bills to be brought to the floor. Let's do those kind of things. We have got 26 cosponsors and growing daily on H.R. 244. They are understanding the issue.

As we go into this thing, one of the things that I talked about earlier and I said I was going to come back to was: Live your ''why.'' You know, think about this. I want everybody to have a choice. If you like going to the big box and getting your bananas, your shotgun shells, and your aspirin at the same place, go for it. That is great. I love it.

But if you want to go to there and then go by and see your pharmacist who opened up, hung a shingle, so to speak, had that American Dream, he sells other things—and in my pharmacy I can get a scoop of ice cream and I sit there and talk and I see people and see life. That is what it is about. It is not about forcing us in.

That is one of the problems that on our side we have had about health care in general. The government, that is not the place. This is an area where we have got our thumb sort of on the scale, and we have got to stop that. I think this is what does that, and your help has been tremendous in that regard.

Congressman CARTER, one of the things we see in Georgia and I know we have seen it in Iowa—in short, you have a story—I have got stories I am going to probably share a little bit later—just where this is has affected a patient.

Several of my pharmacists talk about how they have had customers that have been coming to them for years and then get a disease that they can't keep the medicine because it is too expensive. Do you have some examples like that where this kind of legislation would help?

Mr. CARTER of Georgia. Well, there is no question about it. As I said earlier, I am a free market guy. All I want to do is compete, and I want to compete on a level playing field. Let me compete.

You know, when I first entered pharmacy before PBMs became so vogue and became such a big part of this, it was pretty easy in the sense of being in business in pharmacy because all you had to do was be nice to the people.

□ 2045

I mean, it was about customer service. It was about taking care of the patient, and that is what we are talking about—taking care of the patient.

I told you earlier I have had generations of families who trade with me—grandparents, parents.

Mr. COLLINS of Georgia. I want to jump in right here on this, and if you have a story, we will talk about it.

My own family member had an issue, and we were discussing medication. I knew the doctor—I could call—but my first call was to my pharmacist because I said I knew I could get him; I knew he would answer; and at the time—and what was amazing was—my parents didn't buy their drugs from him, but, yet, he picked up the phone, and he heard my complaint.

Is that sort of what you see and what you have seen as well?

Mr. CARTER of Georgia. Oh, there is no question about it. In fact, I have experienced it.

Look, I have been a community pharmacist, as I said earlier, for 34 years. I have been in business for myself for almost 28 years now. I live near where my pharmacy is. I live less than 5 miles away from it. I am a member of that community. I was the mayor of that community for 9 years. For 9 years, I was mayor. I served in the State legislature. I represent them now in Congress, and I have gotten calls in the middle of the night.

What is interesting and what has been very rewarding for me professionally is when I ran for office and when I would be knocking on doors, and I would introduce myself. ''I know you. I know you. You helped my mother when she was under hospice care. You got up and went to the store and met me there one night and got her medication.'' Now, let me tell you that that makes you feel good.

Mr. COLLINS of Georgia. It does. Again, when you get into this, it is about people.

Mr. CARTER of Georgia. It is.

Mr. COLLINS of Georgia. Politics and drug stores and people. This is about politics. This is about people. It is those people. It is people. It is policy.

What kinds of things have you heard, Mr. LOEBSACK?

Mr. LOEBSACK. I just want to say one thing.

Pharmacists are among the most respected folks in all of America, and there is a reason for that.

Now, Mr. CARTER, I realize you went from being a pharmacist to being a Congressman.

Mr. COLLINS of Georgia. We do question that.

Mr. LOEBSACK. We might question your judgment about that kind of a transition, and you are finding out about that; but, nonetheless, every single time I go to a pharmacist, it is the same thing—they care. They care about their patients.

Again, I have so many stories, but it would take forever for me to recount all the stories of all of the pharmacies I have gone to in my congressional district over the last 9 years. I have 24 counties. I have a lot of local pharmacies, as you might imagine, and those pharmacists are among the most respected folks in the community. They are right up there with the clergymen; so that tells you something about them and about their profession and about how folks look up to them and about how folks depend upon them.

As you just said, they are the folks who get called when they are worried about their prescriptions. They are the folks who can be reached the most easily. Other professionals can be reached, but pharmacists are right there at the ready, and that is very important.

Mr. COLLINS of Georgia. It is.

If you are following and tracking, we can talk bills, and we can talk regulations, and those are great things; but the bottom line is what is best in the health care arena from the whole perspective.

You did a great job, Representative CARTER, about talking about the doctor and all the different agencies coming in together.

I will never forget, when growing up, the story, for me, of, when you got to the pharmacist, you were getting better. One, I had gotten through the doctor's office—I had gotten my shot, or I had gotten whatever—but I had gotten to the pharmacist's. Just give me some medicine. Let me go home. Back then, there was some tasting bad stuff—I don't know where that came from—but I remember going in, and they would take time, and they would care.

Still, in my district and in many of your districts, you can go in and look at the community pharmacist who was on the square. A lot of them had lunch counters. A lot of them had other things. They sold cards and trinkets. What is amazing to me today is I do not want to see through consolidation and corporate work a system that has a fingerprint on the scale, where government has basically allowed this to happen—to start taking away the centerpieces of American squares. When you start taking away the centerpieces of squares and of lots and of communities, both big and small—when you start doing that—then we are part of the problem. It is time we started educating everybody we can.

Do you see that?

Mr. CARTER of Georgia. I do see that.

I want to mention just two things.

First of all, as an American taxpayer, you can imagine my being in business and having what we call ''taxation without participation.'' Here we have Medicare part D plans that are paid for and supplemented through the government, which I pay taxes to, but my business is not allowed to participate. I am being taxed. I am paying my taxes and am doing what I am supposed to do. It is being used for a plan that excludes my business. How fair is that? I am not asking for anything special. All I am asking for is an even playing field.

Another thing that I want to mention is that I have intentionally not mentioned the names of PBMs. There are some good PBMs, and it is not the company that I have the problem with as much as it is the process and the model. I mean, that is very important to understand—we are talking about the model here—but I will tell you this. There have been numerous instances where companies think they are going to be saving money, and the PBMs have misled them into thinking they are going to save money. Let me tell you that these are some of the most profitable businesses around.

Mr. COLLINS of Georgia. May I jump in right here?

Mr. CARTER of Georgia. Sure.

Mr. COLLINS of Georgia. You may have heard this.

I agree with you in that there are some great PBMs out there that do work. We are not just saying PBMs in general.

The other thing that bothers me is—and I have heard this from my pharmacist, and you, I know, have experienced this, and we have talked about it, and Mr. LOEBSACK has as well—my pharmacists, my community pharmacists, are scared to say something. They are scared to talk about what is actually going on because they are scared their contracts will get canceled. They are scared that they will get another audit.

I am sorry. I am not a pharmacist. You can't audit me, and I am going to stand here and talk about it for the pharmacists because they can't. That is wrong. Anybody who wants to say that that is right, I do not understand that; but when you have got pharmacists who are just honest, hard-working people who are trying to run independent businesses and when they are scared to talk about their vendors to work a workable plan, what are we doing here? This should be easy.

Mr. LOEBSACK. It doesn't serve any of us. It certainly doesn't serve any of us in the end, because those folks are the ones who are serving us, and if they are suppressed—if their voices cannot be heard—that stifles competition. It goes back to the market. It stifles competition, and that is not good for any of us in the end.

Mr. COLLINS of Georgia. When things change and when they say that we can't give input because we are scared, that is just a problem.

We are coming up on our time of closing.

Any last comments, Mr. LOEBSACK?

Mr. LOEBSACK. Yes.

Thank you, Mr. COLLINS. Thanks again for inviting me and Mr. CARTER. I really do appreciate this.

As always, Mr. CARTER, I have learned something tonight from a pharmacist—I always do—and I really appreciate your comments.

I just want to touch upon sort of the issue of the city square. That is so important for so many of our rural districts, as you folks know all too well. It is kind of hard to explain that to our more urban colleagues, but we have to do the best that we can. A pharmacy is so absolutely critical for the economy of a small community. Yes, it is absolutely critical and necessary to serve the population in the area, but it is important for the economy as well.

We have a pharmacy—Mahaska Drug in Oskaloosa, Iowa. It is off the square a little bit, but it is such an important institution in its own right. Every Christmas, they have wonderful decorations, and they have things to sell for Christmas. I mean, people come to depend upon them to do the kinds of things they have done in providing not just the pharmacy services but other things as well. If they were to go under as a pharmacy, I am not at all sure that they would survive, and that community would suffer as a result. Folks' choices would be lessened. Their tradition would be hurt. It would be a disaster in many ways for so many of our local communities if those pharmacies were to close down.

I, for one, am with you. I am not willing to accept that. I am going to fight as hard as I possibly can with you, and we are going to do it together, holding hands across the aisle, which, as you know, doesn't get done a lot around here; but when we can come together, I think it is important for us to do that. So thanks again for organizing this tonight. I appreciate it.

Mr. COLLINS of Georgia. Mr. CARTER, would you like to add just a couple of things?

Mr. CARTER of Georgia. I will very quickly.

First of all, again, I want to thank you, Representative COLLINS and my colleagues—all of you—for participating in this. This has been a great exercise.

Among my proudest possessions are the plaques that the baseball teams give you every year whenever you sponsor a team, and I have got a wall that is just filled with them. Patients come in all the time. ''There I am. I played ball. That was the team I was on,'' and they point toward it. It was the Carter's Pharmacy team.

I want to ask you: How many PBMs have you seen sponsoring Little League Baseball teams? I mean, seriously.

Folks, we are talking about something that is essential to our communities, and this is a dire situation. I am telling you. If this is not fixed soon, you are going to see a whole profession of community pharmacies going by the wayside. This is a matter of survival here.

Again, we are not asking for a government handout. All we are asking for is to be able to compete. It is to be able to compete in a fair market, in a free market, on a level playing field. Ultimately, the loser here is going to be the patient. If we allow this to happen and community pharmacies go away, the ones who are going to suffer are going to be the patients.

Thank you again for this. I can't tell you how proud I am of my profession, a profession that I chose years ago when I was in high school and when I was a delivery driver. After I realized I was not going to be the athlete that I wanted to be, I decided it was time to get serious and decide on a profession. I did, and I could not be any prouder than the profession I chose of professional pharmacy. Thank you.

Mr. COLLINS of Georgia. I thank all of my colleagues for coming here tonight.

I am going to go back to where we started: Live your ''why.'' Live your ''why.'' That is all we are asking. Our independent pharmacists and our community pharmacists are just simply saying: Let us have an even playing field. We will play with the big boys. We don't care. Just let us have our ''why.'' When we do that, our benefits come to our communities.

Mr. Speaker, I yield back the balance of my time.

LEAVE OF ABSENCE

By unanimous consent, leave of absence was granted to:

Mr. HUDSON (at the request of Mr. MCCARTHY) for today on account of family reasons.

Mr. PAYNE (at the request of Ms. PELOSI) for today through October 23 on account of medical procedure.

ENROLLED BILL SIGNED

Karen L. Haas, Clerk of the House, reported and found truly enrolled a bill of the House of the following title,