Following passage of the VRA, nearly 1 million black voters registered to vote within just four years, including over fifty percent of the black voting age population in every southern state. We witnessed the number of black elected officials in the South more than double, from 72 to 159, following the 1966 elections. By the mid-1980s, there were more African Americans in public office across the South than throughout the rest of the nation combined.

More than fifty years later, we are once again faced with the same fight under a different, more sinister guise. The United States Supreme Court's decision in Shelby v. Holder has brought our nation back to our darkest times in history. Discrimination on the basis of race is a persistent reality throughout many localities in states once protected by Section 5 of the Voting Rights Act—including my home state of Texas. Absent these protections, many voters are at risk of losing their fundamental right to vote.

On May 11, 2017, President Trump issued an executive order that would create an ''election integrity'' commission. The stated purpose of this commission was to combat voter fraud, but we know the true meaning behind an executive order of this nature. It is to repeat the egregious mistakes of our past and once again prevent legitimate voters from exercising their constitutional rights to vote.

Mr. Speaker, the concerns of the Congressional Black Caucus and the concerns of countless Americans are worthy of our time in Congress. We must speak out against thinly-veiled commissions meant to suppress the vote. We must bolster the Voting Rights Act to its former power and encourage others to combat voter suppression and protect unfettered access to the ballot.

COMMUNITY PHARMACIES

The SPEAKER pro tempore. Under the Speaker's announced policy of January 3, 2017, the gentleman from Georgia (Mr. COLLINS) is recognized for 60 minutes as the designee of the majority leader.

GENERAL LEAVE

Mr. COLLINS of Georgia. Mr. Speaker, I rise and ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Georgia?

There was no objection.

Mr. COLLINS of Georgia. Mr. Speaker, tonight, as we come before the body, we have come back on a topic we have been here before on. It is really the hidden enemy, I guess if you would, of people and trying to get a drug pricing system, something where their community pharmacist, the independent pharmacist, it is that middle man called the PBM, the pharmacy benefit manager, who simply snuck in many years ago.

□ 2015

It originally started as a good idea so that you could collaborate, you could get better drug pricing, you could get it to the consumer through rebates and through concessions. And as in all things, I guess, good ideas and greed just get in the way sometimes.

We are at a point where this is an issue that I want to continue to highlight. We are going to do so in several ways. We are going to talk about some issues. I spoke with colleagues on the floor before about the really terrible actions of many in the PBM community, especially the largest ones that control over 80 percent of the market. There are only three of those that really control almost the entire marketplace of this and control plans that folks would understand very quickly. They control where you go, how much you pay, the formularies. It is down to that kind of a problem.

Last year, when the world began to wake up to these issues of pricing and all of this came to light, they began to question why these drugs were costing so much, such as the EpiPen. Well, what they began to find out was that these were problematic issues. But if you wanted to really look at the baseline, you had to look at the pharmacy benefit managers, and you had to understand what they were doing that was causing a great deal of problems.

We also have to go back to the basics. Community and independent pharmacists fill a critical niche in the healthcare system, serving the primary healthcare providers for over 62 million Americans. Community pharmacists are some of the most easily accessible health professionals, particularly in our rural areas.

Mr. Speaker, this is an area that I really have talked about before. We talk about the healthcare chain being a complete chain, and it is not just the doctors and the hospitals; it is the pharmacist who is typically the face of healthcare for those after they have gone to their doctors or come out from the hospital to get the medicine that will continue to keep them healthy.

You see, community pharmacists dispense roughly 40 percent of prescriptions nationwide, and a higher percentage in rural areas, such as mine. These community pharmacists regularly interact with their patients outside the pharmacy. They go to church with them. They go to shop with them at the local grocery store. The pharmacies are the sponsors of kids' Little League teams. They are the ones who have the closest personal relationships to the healthcare chain, and they are a trusted source of medical care and advice.

Pharmacists are also able to better treat patients' illnesses with their regular interactions, identifying potential risk factors early on. For example, independent community pharmacists play a key role in ensuring a patient properly uses their medication. In fact, 83 percent of community pharmacists perform the critical patient-care role of providing medication adherent services. Patients' failure to properly take their medication costs the healthcare system almost $3 billion and contributes to 125,000 deaths annually.

Face-to-face counseling by a trusted pharmacist has proven to be the most effective method for ensuring patients take their medications, saving thousands of lives and billions of dollars annually.

Mr. Speaker, independent and community pharmacists provide multiple and valuable services, and we can talk about these services and the importance of a community pharmacist. I would be remiss if I did not mention the recent and tragic passing of someone known well in the pharmacists' community for his contributions there.

While I did not know John Carson personally, his death had reverberations throughout the pharmacists' community. Mr. Carson was from San Antonio, Texas, and owned and ran his business there, Oakdell Pharmacy, for almost 50 years. He and his wife were tragically killed in a car accident on July 7, but the legacy Mr. Carson left behind as a father, a pharmacist, and former president of both the Texas Pharmacy Association and the National Community Pharmacists Association will live on. Tonight we mourn his passing but celebrate his achievements.

I could mention individual pharmacists and their work on behalf of their patients for the rest of the evening, and I could have probably every Member of this body do the same. Instead, I will provide some information that shows the great impact on services the individuals have had.

Sixty-five percent of community pharmacists offer home or work delivery; 68 percent of community pharmacists offer immunizations; 83 percent provide medication therapy and management services; and 67 percent of community pharmacists provide monetary support to five or more community organizations. These are the guys you see sponsoring the Little League teams, the chili cook-offs, and that are true participants in our neighborhoods and towns.

Unfortunately, the community pharmacists are in jeopardy across the country, in part, due to anticompetitive behavior and the lack of transparency surrounding practices of the pharmacy benefit managers. They have taken our community pharmacist, and they have abused their trust. Pharmacy benefit managers, especially in the system that we have today, are trying, I believe personally, to get rid of our community independent pharmacists because they have their own chain, their own distribution, and they own the supply chain. When they do, they want to take everything else out, and we have talked about that on many occasions here.

So as we continue tonight, we are going to talk about these issues, as we go from pharmacists and what they have done well, some new issues that have come to light, some lawsuits, also some audits that have come out that show the real problem that we are seeing with this community, and also that

they are having, but also just being run out of business.

Imagine, Mr. Speaker, if you were just trying to get up every day and run your own business, and you had a giant conglomerate tell you and tell your customers that they can't come see you anymore, not give you a reason. And if they are mistaken, they make you correct their mistake. I don't know how it operates in the rest of the world, but that isn't the way a business is supposed to operate.

At this point in the evening, I have several of my friends from Georgia who are here to talk about these issues. First off is my friend from south Georgia; another one, who has been with me on many of these occasions, a Member who has seen this up close and personal, to talk about the issues that we have tonight.

Mr. Speaker, I yield to the gentleman from Georgia (Mr. AUSTIN SCOTT), someone we have been working with on the Armed Services Committee on a lot of things that are going on.

Mr. AUSTIN SCOTT of Georgia. Mr. Speaker, I rise today in support of our Nation's community pharmacies which play a critical role in our healthcare system.

Many of these independent businesses operate in underserved or rural areas—like many of the counties in Georgia's Eighth Congressional District, which I represent—where access to carriers is already an issue and would be worse if community pharmacies did not exist.

In areas where a doctor can be many miles away, local pharmacists deliver flu shots, give advice on over-the-counter drugs, and help with those late-night drugstore runs for a sick child. Many people in our rural communities see their pharmacists much more often than their doctors. There is a very personal relationship between the pharmacist, the patient, and the physician.

As pillars in their community, they are also the businesses that contribute greatly to local economies. It is crucial that these pharmacies have an equitable playing field against large-scale competitors and middleman pharmacy benefit managers when trying to run a successful business in a challenging and complex environment.

I want to reiterate, Mr. Speaker, all they ask for is an equitable playing field. No advantages, just equality. Where I am from, local pharmacists are often a fixture in their communities. These pharmacists have known most of their customers all of their lives. They instill a level of trust that is unparalleled.

I frequently stop in at local community pharmacies when I am back home in the district and never fail to appreciate the unique value they add to their customers' lives. Unfortunately, on some of these visits, I am also troubled to learn how community pharmacies are finding it extremely difficult to serve the people who have depended on them for years and to compete with some of the larger entities in the healthcare marketplace.

Take, for example, the increased prevalence of preferred networks in Medicare part D plans. Currently, many Medicaid beneficiaries are told by pharmacy benefit managers, or PBMs, which pharmacy to use based on exclusionary arrangements between those PBMs and, for the most part, big-box pharmacies. What most people don't know is that, in fact, in several instances, these big-box pharmacies actually own the PBMs that are creating these preferred networks.

Patients must pay higher copays just because the pharmacy they want to use is excluded by the PBM, who again, as I said, in many cases, actually own the larger pharmacy that they force you to do business with. The majority of the time, the hometown pharmacy is never given the opportunity to participate in the network in the first place.

Another issue I often hear about from community pharmacies is the burdensome DIR fees. Most Americans probably assume that it is a pretty simple transaction when they purchase medication from their local pharmacy. They go in, they pay a copay, and that is the end of it.

But for the pharmacy, the transaction is anything but clear and simple. Pharmacy benefit managers use so-called DIR fees to claw back money from pharmacies on the individual claims long after the claim is thought to have been resolved. That means that a pharmacy often doesn't know the final reimbursement amount they will receive for a claim for weeks, or even months.

Anyone who runs a pharmacy, or any other small business for that matter, knows you can't operate when you don't know what your reimbursements are. When competition is stifled and these small businesses suffer, so do hardworking Americans when they have had their choice to use a community pharmacy instead of a big-box business taken away from them.

Another issue I frequently hear about is the lack of transparency in generic drug reimbursements to pharmacies. Generic prescription drugs account for approximately 80 percent of drugs dispensed. The reimbursement system for these medications is largely unregulated and a complete mystery to all of us. Now, if it is unregulated with transparency, that is fine. But it is unregulated without any transparency.

Pharmacists are often reimbursed for generics by what is referred to as the maximum allowable cost list created by the pharmacy benefit managers. But the methodologies used to create these lists are not disclosed, nor are the lists updated on a regular basis, which frequently results in pharmacists being reimbursed below the actual acquisition cost for various medications.

In recent years, these extra costs that affect prescription drug prices in community pharmacies have fallen on consumers. Take doxycycline, for example. Doxycycline is a drug that is used to treat a number of bacterial infections. As a generic antibiotic, it has been around for decades. I want to repeat: it is a generic that has been around for decades. In 2012, 30 capsules of doxycycline cost approximately $15. In 2017, the same dosage cost $115. That is a price increase of 667 percent.

I want to give you a real-world example of the impact this has on low-income patients in the world. I have a wonderful OB–GYN in my area, and he told me that prior to the price increase, he would simply keep doxycycline in his office, and when he had a patient that needed it, he could simply give the patient—if it was a low-income patient—the drugs instead of having them go to the pharmacy to pick them up. But with a 667 percent price increase, they could no longer afford to simply give the patients the medication that they need.

Nitroglycerin tablets are another example. Nitroglycerin has been used to treat chest pain and stop a heart attack and has seen similar price hikes in the past few years. Again, it is a generic drug that has been around for decades—no excuse in the price increases other than flat out greed.

A drug that is even more common that has been affected by the lack of transparency in the drug market is insulin. As you may know, millions of Americans with diabetes rely on insulin. They have to have it, or they will simply die. According to the American Diabetes Association, the price of insulin in America has nearly tripled over the past 15 years, making the drug nearly unaffordable for many diabetic patients.

The dramatic price hikes of insulin is ironic since, in the early 1920s, Frederick Banting, one of the scientists who helped to first develop insulin, sold the patent for the drug for $3 because their goal was to make the drug affordable and easy to access for everybody in the world.

Now, nearly 100 years later, one vial of Humalog can cost nearly $400 in the United States, where it costs a fraction of that in other countries around the world. In Canada and Mexico, the same dosage of Humalog costs less than half, or sometimes even a quarter of what it costs in the United States.

I understand that there is a tremendous cost in developing lifesaving treatments, new drugs, and the next development that is going to save a cancer patient, but these are generic drugs that have been around for decades. These dramatic price increases, the international price disparities, they are occurring, again, on drugs that have been around for decades because of this pricing scam put in place by the pharmacy benefit managers.

In the coming months, I look forward to continuing to work with my colleagues to address the lack of transparency in the pharmaceutical industry, giving community pharmacies an equitable playing field to compete,

which gives hardworking Americans the choice of affordable prescription drugs and which pharmacy they choose to purchase those drugs from.

Mr. Speaker, I want to thank the gentleman, Mr. COLLINS, for hosting this Special Order today.

Mr. COLLINS of Georgia. Mr. Speaker, I thank my friend. We have been talking about this, and I think what is amazing is, the more we have these, and the more we talk about community pharmacists and the issues that we find, people are starting to understand the real problem that exists here.

Mr. Speaker, more than 250,000 individuals employed either on a full-time or part-time basis by community pharmacies, these people's livelihoods are facing consequential threats due to the often anticompetitive behavior of pharmacy benefit managers, or PBMs.

Many people may have never heard of a PBM. Well, let's give them a definition tonight. PBMs are middlemen who administer prescription drug plans. In fact, three primary middlemen control 78—almost 80 percent—of the market and control the pharmacy benefits of over 253 million Americans.

□ 2030

PBMs process prescriptions for groups that pay for drugs and control drug formulation to determine what drugs are covered by specific plans.

The three major PBMs—Express Scripts, CVS Caremark Health, and OptumRx—produce no tangible product. Let me repeat that. These three produce no tangible product. Yet they have a major impact on the way you and I access medication, on small business pharmacies, and even other small business PBMs.

If you don't believe me, just the other day, I was watching a business show, and there was a PBM—there was a transparent PBM who talked through this whole issue of fees, rebates, and everything else. They said: We show everything.

Well, I challenge the three big ones to do it. They don't want to because—if you started looking at actually what they did, they are what I have said many times—they are monopolistic terrorists. That is all they are in this market.

Mr. Speaker, as an example of the major market power that PBMs have, I would like to point you to Express Scripts' annual average revenue. That one company has average revenue of $101 billion. Now, Mr. Speaker, I am a conservative, free-market business person. I love to see a business actually make money. But you don't do it the way they are doing it. I am not decrying their profit. However, I am calling into question the business model of raking in massive profits on the backs of patients and small business pharmacists. You don't do it that way.

I brought this up on many occasions and only get excuses and obfuscations and everything from the PBMs going online and telling about how great they are but never addressing the real issue. The problem is relegated to the wayside far too long and is coming into sharp focus. In fact, Anthem, an insurer, is currently suing to end its contract with Express Scripts. It claims Express Scripts failed to renegotiate lower drug prices and withheld billions in savings. This lawsuit and stories surrounding it have called into sharper focus PBM tactics that community pharmacists have been grappling with for years. In just a few moments, we are going to hear firsthand about how that has actually been going on.

Through a variety of practices, PBMs make life difficult and undermine competition for our neighborhood pharmacists and the patients that they serve. For example, PBMs have maximum allowable costs—MAC lists—that determine the maximum amount a pharmacist will be reimbursed for certain generic drugs. However, PBMs' reimbursement price determinations are hidden, and there is no transparency in the process.

PBMs commonly manipulate drug prices using what is called spread pricing. I would encourage, Mr. Speaker, those who listen to this and would want to be a part to look this up. Everything we are talking about is actual fact. PBMs charge employers a higher price for a drug than necessary and reimburse pharmacies at the MAC level, which is typically lower. Spread pricing allows PBMs to skim money from the difference between the high rate they charge for a prescription and the low rate they reimburse pharmacies. Spread pricing is artificially raising the acquisition cost of pharmacy drugs by overcharging at the expense of retail pharmacists, consumers, and health plans.

You see, when we understand this, people say: Why is this a problem? Why are we talking about it?

This lack of transparency is also a problem when PBMs administer taxpayer-funded programs like Medicare part D, TRICARE, or the Federal Employees Health Benefits Program. Currently, we can't ensure that the savings generated by cost-saving rebates received by the PBMs are being passed along to government programs. PBMs can receive rebates to acquire prescription drugs at lower-than-advertised costs, and PBMs can then charge the government the full cost for the drug even if a PBM has a significant discount. This deceptive practice increases the cost of prescription drugs for beneficiaries of Federal Government prescription drug programs.

Let's break that down, Mr. Speaker. When we talk about Federal drug programs, these taxpayer-funded programs, we are talking about my taxes, your taxes, and everybody else's taxes. That is why this is important and needs to be addressed. This is what is the problem.

This lack of transparency is unacceptable and jeopardizes the quality of care for millions of patients across the United States. Northeast Georgia has a vibrant pharmacy community, but its pharmacies are being threatened by the unfair practices of the PBM. The fact is—and I have made mention of this before—several pharmacists tell me that if something doesn't change, we are going to see more and more of those pharmacies disappear within the next few years.

I introduced the Prescription Drug Price Transparency Act to help address this situation. My legislation preserves pharmacy access for patients by allowing pharmacists to know the sources PBMs are using to set reimbursement rates for community pharmacists.

PBMs' prices are often based on incentives for manufacturers not disclosed for long periods of time. Oversights of PBMs ensure taxpayers are not footing the bill for generic prescriptions by providing transparency into how drug acquisition costs are determined. The Prescription Drug Price Transparency Act also prevents PBMs from forcing their customers to fill or purchase prescriptions from pharmacies owned and controlled by the same PBM.

Let me go back over that real quickly. The PBMs, the pharmacy benefit managers, are allowed to force customers to fill or purchase prescriptions from pharmacies they own and control. There is no transparency here. They are simply controlling a system and running the market out. This means patients can keep the pharmacists they like rather than being improperly incentivized or coerced to use a PBM-owned pharmacy.

Finally, it would require PBMs to update their MAC pricing list every 7 days, codifying current CMS rules for Medicare part D and expanding it to TRICARE and FEHP. This legislation is vitally important to improving fairness and transparency in drug pricing and reimbursements to independent and community pharmacists.

I will tell you this: I've heard story after story, and we will continue these tonight. The community pharmacists may be muzzled by PBMs, those that are still. There may be fear of retaliations. But I won't let those concerns go unnoticed. We are going to continue to take this fight to the floor so there will be a voice for transparency and fairness for community pharmacists, for patients, and for taxpayers. Because if they think they can pull a fast one on the Federal Government at the cost of taxpayers, then they have got another thing coming. They may go in and intimidate and strong-arm our community and independent pharmacists. They may threaten them to keep quiet. They may tell them not to go to their elected officials or have a voice to say that we think that there is a better way, or just to be able to compete on a fairness level without anything else except just let us compete. The PBMs may try to strong-arm them and to silence them into submission, but they are not going to be able to silence me.

They can't audit me, and they can't do that to the American pharmacist who is simply trying to be a part of this system.

There is nobody that can understand that better than my friend from south Georgia. He is a pharmacist by training. He has left the pharmacies behind so that he can come up here and help us continue this fight for patient care and patient health all across this country. He is a champion in every sense of the word of this industry because, as the old saying is, he is one. He comes tonight to talk further and provide insight into this Congress.

Mr. Speaker, I yield to the gentleman from Georgia (Mr. CARTER). It is good to have him back in the fight tonight.

Mr. CARTER of Georgia. Mr. Speaker, I thank the gentleman for hosting this tonight and for his advocacy on the part of the community pharmacy, but, more importantly, on the part of the patients, because that is what this is about. This is about patients, about patient care, about escalating prescription costs. That is what we are talking about here, about unfair trade practices.

This is America. Like my colleague mentioned earlier, I am not opposed to anybody making money. That is great. More power to them. But where there is a problem with transparency, there is a problem with PBMs. There is a problem with escalating drug prices.

I want to mention that I have been a practicing pharmacist, as Representative COLLINS mentioned, for over 30 years. I have worked with my neighbors and my friends to really provide a helpful voice for their needs. Beneficiaries are facing increased costs in prescription drugs without much of a basis notification as to why these costs are skyrocketing.

My friend, Representative COLLINS; my friend, Representative SCOTT; others—even on the other side of the aisle—Representative PETER WELCH, Representative ELIJAH CUMMINGS, and Representative DAVE LOEBSACK, this is a nonpartisan issue. Everybody has to have prescription medications. Whether you are a Democrat, whether you are a Republican, whether you are an Independent, it doesn't matter. Everyone is the victim of escalating prescription drug costs. The problem is we have got to understand where that is coming from.

I thank Representative COLLINS for his legislation, the Prescription Drug Price Transparency Act, to bring about greater transparency in the role that pharmacy benefit managers, the PBMs, have in the drug pricing structure.

Many people don't understand the structure or where the additional fees are originating from, which is often a direct result of the lack of transparency between the manufacturer and the dispenser. Let me repeat that. Many people don't understand the structure. I will be quite honest with you. I have been working with this for over 30 years, and I still don't understand it. In fact, I have got numerous examples of where CEOs have said they don't understand it. It is intentionally—intentionally—complicated so that no one understands it.

I had the opportunity last year as a member of the Oversight and Government Reform Committee. We had the CEO of Mylan pharmaceuticals. Mylan, of course, is the manufacturer of EpiPen. It went up in price. The EpiPen costs $600 for a dual pack.

I said: Okay. When it leaves you, the manufacturer, you are the beginning. You are the manufacturer. How much have you got in costs?

She responded: I have got $100, maybe $150 in costs.

I said: Okay. You are the beginning. I am the end. I am the dispensing pharmacist. When it gets to me, it is $600—$150 at the beginning, $600 at the end. What happened in between? What happened in between?

Now, a lot of times it is lost on some of my colleagues here and on the average American because all they are concerned about what the copay is, if the copay is $15 or if the copay is zero. Okay.

But keep in mind that somebody somewhere is still paying that $600. In a lot of cases, it is the Federal Government through Medicare part D or State Medicaid plans. Somebody somewhere is paying it.

But when you have the CEO of a manufacturer, when I asked her a direct question, ''What happens in between that $150 and that $600?'' and she says, ''I don't know,'' and I am the pharmacist and I say, ''I don't know either,'' somebody somewhere has to know. I can tell you it is the middle man.

The most effective, the most immediate impact that we can have on prescription drug pricing is to pass this bill that Representative COLLINS has and to have transparency in drug pricing. Sunshine is the greatest disinfectant of all. If we have sunshine, we will have lower drug prices if we have transparency.

I want to give a couple of other examples. My colleague, Representative COLLINS, mentioned about three PBMs controlling 80 percent of the market. That is not competition when you have got three companies that control 80 percent of a market.

Did you know that Express Scripts, the number one PBM in the country, had gross revenues almost equal to McDonald's, Ford Motor Company, and Pfizer pharmaceuticals added together? Added together, this one PBM.

Now, again, I am not opposed to anyone making money. More power to them. But how are they making it? Nobody knows.

Why don't we have transparency?

Everybody wants lower drug prices, and we have all got to do a better job. Pharmaceutical manufacturers have got to do a better job. Pharmacists have got to do a better job. GPOs have got to do a better job. But until we have transparency, we are never going to be able to get it under control.

I want to give a couple other examples. The manufacturer of the hepatitis C drug has had so much criticism about the price, and it is too expensive. Gilead pharmaceuticals makes SOVALDI. SOVALDI accused Express Scripts of not warning them to go down on the price of SOVALDI. Gilead said: You never wanted us to go down on that price because you are getting a percentage rebate. The higher the cost of that medication, the higher rebate you are getting.

My colleague mentioned about the lawsuit that Anthem has against Express Scripts. Anthem is not going to renew their contract with Express Scripts because they are suing them for billions—that is billions with a ''B''—of dollars, saying: You owe us billions of dollars.

These are real-life examples of what I am talking about. That is why we need to pass the Prescription Drug Price Transparency Act that Representative COLLINS is pushing so hard, and has been, and we thank him for that.

I want to also talk about some other bills here continuing in the theme of transparency. We have an opportunity to address the issue of retroactive DIR fees and the impact they have on drug pricing. My colleague, Representative SCOTT, mentioned DIR fees and clawbacks. DIR fees are having a negative impact on the ability to provide accurate and comprehensive services to the beneficiary.

Those fees are a large unknown for pharmacists and don't provide clarity on drug costs to the patient or whether they will be able to accurately meet the needs of their patients. Ultimately, the patient ends up being penalized, and that is an issue that must be addressed. Ultimately, what this boils down to is the patient—the patient, Mr. Speaker, the patient. Let's stay focused on what we are supposed to be focused on, and that is the patient.

We talk about drug costs and we talk about healthcare. We want accessibility, we want affordability, and we want patient-centered healthcare.

□ 2045

That is what we want in prescription drugs, accessibility and affordability. Yes, they need to come down in prices. And again, the most effective, the immediate impact that we can have is to have transparency, transparency in the middleman in what they are doing.

That is the reason why Congressman MORGAN GRIFFITH's legislation is helpful in bringing about stability. Pharmacies would no longer be penalized for providing the same quality service they always have simply because PBMs have shifted cost under a lack of transparency. With this legislation, we can keep costs down for beneficiaries.

Now, I want to talk about another piece of legislation that another good friend, Representative BRETT GUTHRIE from Kentucky has introduced, H.R.

592, the Pharmacy and Medically Underserved Areas Enhancement Act, to address the role of pharmacists in rural communities. With this bill, many of the individuals who seek consultation, especially seniors, can contribute to receive quality input and expertise.

There are many underserved and rural areas of the country where patients don't have access to a primary care provider but have access to a pharmacist. Pharmacists are the most accessible healthcare professionals that we have. That is why provider status is so important. That is what we call this, the Pharmacy and Medically Underserved Areas Enhancement Act.

Under this legislation, pharmacists can continue to service those rural and underserved areas and fill a role that is vital to the healthcare of these residents in these areas.

I also want to compliment and commend Representative GRIFFITH again on his efforts to keep patients' access to compounded medications intact. In June, he introduced a Preserving Patient Access to Compounded Medications Act of 2017. This bill will provide further guidance for the FDA, medical providers, patients, and compounding pharmacies about what constitutes pharmacy compounding and what is regarded as drug manufacturing. This legislation will provide a crucial balance between public safety and patients' access to the medications they need.

Lastly, the leadership of the Energy and Commerce Committee has been critical in advancing legislation both in the 114th and 115th Congress that will lead to research and development of new drugs and treatments. I commend my colleagues on their hard work and thank my good friends for the opportunity to speak tonight on this issue that is very important to me.

Mr. Speaker, the President has identified escalating prescription drug cost as being one of his biggest priorities. He has said himself: If you are on the other side of research and development, you need to beware because we are coming after you. PBMs, you are on the other side of research and development, and we are coming after you.

This is too important. It is too important to the patients who are trying to get these medications, who need these medications. All we are asking for here is transparency. All we are asking for is to shine the light on what is going on.

I know they make it difficult to understand. It is a shell game. It is nothing more than a shell game. Again, I want to commend my colleague, my friend, Representative COLLINS, for his untiring advocacy on the part of community pharmacists and on the part of citizens who need and depend on their community pharmacists.

Mr. COLLINS of Georgia. Mr. Speaker, I want to thank my friend. He has brought out so many things. And you know, Representative CARTER, one of the things that is off the top, when we talk about Mack Transparency, when we talk about this list we talk about, one of things they come back at us, and they say: Well, it is going to increase cost. You know, if you do this, it increases cost.

And it is sort of interesting because in Texas, this actually happened in 2013, they did their top 200 drugs, and they were somewhere in the neighborhood of a little over $200. And then in just a matter of 3 years, those average prices of those 200 drugs dropped to below $100.

We are both from Georgia when we were talking about it. That is going down. It is not going up. It is because they are actually having to show what they are doing. That is why this—don't you agree that that is why we are having to do what we are doing here?

Mr. CARTER of Georgia. There is no question about it. Let me, if I may.

Mr. COLLINS of Georgia. Continue.

Mr. CARTER of Georgia. Mr. Speaker, if I might just give two examples. First of all, there is an example of Caterpillar. Caterpillar has done away with PBMs. They have done away with the third parties. They are doing it themselves. And you know what it has resulted in? Stable drug prices for the past few years.

As opposed to the increases that most companies have seen, Caterpillar, when they cut out the middleman, they have had stable drug prices. They said: We can do this better. And they have done it better.

Keep in mind—the second thing that I want to point out is, keep in mind, why were PBMs created? First of all, they were created to process claims, insurance claims. But what is their purpose? They will tell you our purpose is to keep drug prices down. Our purpose is to keep drug prices down.

Mr. Speaker, how is that working out for you? They are not keeping drug prices down. They are keeping drug prices up. They are one of the reasons why drug prices are going up, one of the primary reasons.

I can remember when I started practicing pharmacy in 1980. And I am proud to say that I am that old. I started practicing pharmacy in 1980. We used to buy directly from the drug companies. I would buy directly from Upjohn, from Merck Sharp & Dohme, from Squibb, from whoever. There was no middleman there. Now I can't even do that. I have to go through the PBM. I have to go through all these different layers and layers in order to get the medication.

PBMs, if their purpose is to control drug prices, then what is going on? Because drug prices are escalating. What a tangled web we weave.

Mr. COLLINS of Georgia. Mr. Speaker, it is that, and I think the interesting thing is the middleman who produces nothing on their own. That is the thing. They don't produce anything in this. They are simply—you know, I think I will just sort of describe it like I see it in northeast Georgia. It is like a tick on the back of a dog. They just simply suck profit off and do not do what you exactly just said. They don't do what they just said.

I mean, Caterpillar. You brought up Caterpillar. I will bring you some numbers with Caterpillar. Caterpillar started moving away from PBMs. They suspected that they could save as much as, in a quarter, $150 million in drug prices being spent inefficiently.

They went back and did their own formularies. They worked this out so that they are on this straight, and just—the company saved 5- to $10 million per year in just cholesterol-lowering statins alone, one of the most widely prescribed medications, just in that right there.

When you see how PBMs claim to save money, you look at the Caterpillar model. There are other models out there that are finally looking at this and saying: We can do this in a better way.

And I appreciate your input tonight. I think that has been—you are just highlighting this that there are ways to do this. This is not the only way. And to go into State legislators, and to go into county offices, and to go into county governments, and the Federal Government, and to pull the wool saying ''we are saving money,'' while all along we are seeing this tangled web of DIR fees and clawback and no transparency.

You know, it isn't amazing to me that they are spending so much money on advertising right now. It is not amazing to me that they are trying to spend so much money claiming what we are saying is not true. But they never address the point. They never say this is not true. They simply say we are saving all this.

I encourage the Energy and Commerce Committee to take these bills up, hold hearings on these things. They are not going to deny it, and they are going to find out that unfortunately what is supposed to be a help has been really falling backwards, and actually, you know—and really, even from the Federal Government, those community and independent pharmacists are not wanting.

Mr. CARTER of Georgia. Mr. Speaker, if I could just mention one thing, and I would be remiss if I did not mention this, because the gentleman has just brought up an outstanding point, and that is: What value are they bringing to the system? What value are PBMs, are middlemen, bringing to the system? That is what I would ask.

Now, look, pharmaceutical manufacturers need to do a better job. They need to bring their prices down. But I will cut them some slack. At least they are using their profits to go back into research and development. At least they are doing that. PBMs don't put one red cent into research and development, not one red cent.

I repeat what I said earlier. I am not against anybody making money, but, Mr. Speaker, this is causing escalating

drug prices. The lack of transparency is causing the problems that we are experiencing right now.

The most immediate, the most effective impact that we can have on prescription drug prices is transparency. Sunshine is the greatest disinfectant out there, and we need sunshine.

Thank you for what you are doing for the patients. Thank you for what you are doing for the people who are struggling to pay for their prescriptions. That is what this is about.

Mr. COLLINS of Georgia. Mr. Speaker, it has always been about that. I have come to this well and come to this floor on many occasions to talk about it. And when you look at the impacts they are having on DIR fees and these clawback fees that are coming back after the fact and not at the time of when there is no really need or cause for it, according to the Community Oncology Alliance, pharmacists lose $58,000 per practice, on average, to DIR fees each year. You know, this makes it completely—I mean, think about that.

Mr. Speaker, if you had a business in which you had $58,000 just sucked away for no apparent reason, I mean, this is—we wonder why this is happening, and we wonder why people can't get their drugs. We wonder why people wonder why can't I get this drug? Why do I have to wait to get approval here? It is this area right here—DIR fees.

And I do applaud my friend, Mr. GRIFFITH from Virginia, who has introduced this bill, and I am a proud cosponsor with him on this.

You know, it is amazing today to see when patients—when this happens in Medicare part D, the beneficiaries are going through this process, and really what happens, it increases the problem called the doughnut hole, and they are hitting that doughnut hole sooner, forcing them to pay out of pocket for their drugs. And when patients pass through the doughnut hole into catastrophic coverage, CMS takes on most of the cost of burden-sharing.

Now, here is where it gets important, Mr. Speaker. When CMS picks it up, the cost increased from 10 billion in 2010 to 33 billion in 2015. You cannot tell me DIR fees are not part of that problem right there. You cannot tell me that what they are doing is now taking—they are simply reaching into your pocket, Mr. Speaker. Maybe you can feel it right now. You can feel that hand going into your wallet. You can feel that tax money being taken out and being taken away, sucked away by PBM through these fees and DIR fees, and they are getting into it through Medicare part D. And 10 billion to 33 billion increase is simply from 2010 to 2015.

Pharmacists are at distinct disadvantage when DIR is taken and collected from pharmacies after point of sale. There is a lack of transparency in the detail provided to pharmacists, and the retroactive nature of these fees creates operational and cash flow challenges for pharmacists.

Think about having something that you think you have one price on, and they come back and say: No, you messed it up.

We talked about so many different things. We talked about how PBMs can come in and audit basically their competitors. We talked about how they can send out letters to a pharmacy's clients and say: This pharmacy is no longer taking this prescription plan. And then when the pharmacist points it out, they say: Yeah, you are right; you still have the plan.

And the pharmacists have the audacity to ask: Would you please send a letter to these people who you just sent a letter to and tell them you were mistaken? And the PBM said: No, we can't do that; you will have to do that on your own.

Is this America, Mr. Speaker? Where do we operate like that? And we wonder why our healthcare system and these community pharmacists are bearing the brunt of it.

At the end of the day, it is about people. It is about moms and dads. It is about kids. It is about those folks who simply want a healthcare system that works. And one of the most visible parts of the healthcare system is the community pharmacist, the one who dispenses the drug and asks them: How are you doing? How are the kids? Are you taking your medicine?

And they will ask those questions that maybe some of us just don't want to ask our doctor. You know, you might just ask that pharmacist that question and say: Really, what does this do to me?

That is what we need. And as long as they are being frontally assaulted, retroactively assaulted with DIR fees, and generally pummelled out of business, the PBM will continue to just drown our community and independent pharmacists.

And as long as that happens, there will be myself and others in the well speaking the truth and pushing our committees to do something about this, because at the end of the day, businesses ought to operate properly. But when you are affecting the taxpayer dollars, when you are going after taxpayers, and you are doing so in a way that takes pharmacists out of the loop, you have threatened them, you have done everything else you can to them, well, the day is over, this Congress will continue to fight. And there are many Members who are learning what is going on, and it is now time I challenge this body and the committees of relevant jurisdiction to take this issue up because we are not going to stop.

And we will be back soon, Mr. Speaker, with some more details on this issue and how much it can be effective. And with that, I yield back the balance of my time.

Mr. DUNCAN of Tennessee. Mr. Speaker, thank you for this opportunity to speak, and thank you, Congressman COLLINS, for your leadership and persistence on this critical issue.

Community pharmacies are so important to our Districts. There is nothing like walking into your local pharmacy, and the pharmacist knows you by name. He knows your medical history. He knows what you need. He knows you.

As one community pharmacist described, "People call me all hours of the day and night. They know where I live, and they come to my house if they need me."

These local pharmacies are in danger of disappearing across the Nation. Why? Because PBMs are running them out of business.

Pharmacy Benefits Managers, or PBMs, claim to act as middlemen and help pharmacies and manufacturers find the best deals for their patients. It's a great idea.

Despite these PBMs' promises, I have heard from more and more pharmacy owners in my District who say that many PBMs are in reality ripping them off with various unethical tricks of their trade.

PBMs are often dictating the prices charged by manufacturers and pharmacists or insurance plans. PBMs are a key problem behind drug price inflation.

One critical aspect of their strategy is gag orders that they impose on pharmacists and manufacturers in contracts, thereby silencing dissenters under threat of being excluded from networks or formularies . . . in other words, under threat of being blocked from buying and selling in the drug market altogether.

Often, PBMs use what they call clawbacks. The outright cost of a drug might only be $40, but the patient might have to pay double or more than that price through their insurance.

Too many times, pharmacists have to decide between two choices: either violate their consciences by watching often low-income patients pay exorbitant prices—or tell the patients to buy the drug outright, saving them money.

But the second choice comes with a threat . . . because if a pharmacist informs her patients about how to save money, she is violating her contractual gag order imposed by PBMs.

A pharmacy consultant recently interviewed by the LA Times accurately described PBMs like this—"The PBMs are sitting at the center of a big black box. They're the only ones who have knowledge of all the moving pieces."

But awareness of PBMs' deceitful practices is increasing. More and more pharmacists and manufacturers are speaking up and exposing PBMs.

One endocrinologist and professor of medicine at the University of Washington recently said, "It's becoming very, very common to see patients intentionally withholding their insulin." Doing so can be deadly, but patients are often facing $300 per vial and need two vials a week.

There are three PBMs that control the market: ExpressScripts, OptumRx, and CVS Caremark. These three PBMs rake in over $200 billion a year and are responsible for 290 million Americans through their contracts with both private insurers and government programs like Medicare.

CMS, the Centers for Medicare and Medicaid Services, is "wising up" to PBMs. In June, CMS proposed a new guideline for Medicare Part D PBMs. If finalized, this guidance will address PBMs' common practice of imposing retroactive fees.

One of the pharmacists in my District told me these retroactive fees, known as DIR fees, can cost him tens of thousands of dollars months after the claims have been processed with no clarification, no explanation, no reasoning from the PBM.

No business or even individual can plan a budget, if months later they may be forced to pay thousands of dollars more for something they thought they had already paid for.

According to one expert and pharmacy owner in my District, he has seen three causes for recent increases in prescription drugs:

(1) FDA involvement, including requiring "modern clinical trials" of old drugs that have worked for decades;

(2) drug manufacturers' needlessly hiking the price of generic drugs;

(3) PBMs charging ridiculous prices for drugs and pocketing the profits.

According to my constituent, PBMs are the main culprit of the three.

A number of lawsuits are being filed against PBMs, including one class action lawsuit. More and more people are realizing what one lawyer said recently: "We describe this as basically a massive fraud."

We need to address artificially high drug prices right away. A good place to start is PBMs and their "massive fraud."

As one small town pharmacist said, ". . . The pharmacy benefit managers . . . set rates I cannot control. I can complain, but it does no good whatsoever. And in a town of 3,000, I cannot make it up on volume."

PBMs must be more transparent in their operations, so they can be held to their promises and to the laws.

PBMs must not be able to get away any longer with conducting business with their unethical, at best, methods.

In short, PBMs must be held accountable for their roles in the Nation's drug price crisis.

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KEEPING AMERICA'S SKIES SAFE

The SPEAKER pro tempore (Mr. BACON). Under the Speaker's announced policy of January 3, 2017, the Chair recognizes the gentleman from Louisiana (Mr. ABRAHAM) for 30 minutes.

Mr. ABRAHAM. Mr. Speaker, I am here to talk for a few minutes about the FAA reauthorization act, better known as the AIRR Act.

Now, this particular bill has two components: modernization and privatization. President Trump, being a great businessman, the very astute businessman that he is, has told us that we need to modernize our airspace, our air traffic control facilities, everything that allows us to continue to have the safest and busiest airspace, literally, in the world, and I agree wholeheartedly with our great President that we do need to modernize. The issue that I have is with the privatization part.

As mentioned, our airspace is the busiest it has ever been. On a daily basis, somewhere between 87,000 and 88,000 flights take place in the airspace of the United States of America.

We have been asked to compare our air traffic control system with that of our great neighbor to the north, Canada, but the issue with that, Mr. Speaker, is that Canada only has a small, small fraction of the air traffic that we have here in the great United States.

The U.S. airspace is unique because it is a public resource that is accessible to all users, and it is protected by the fact that the air traffic organization, under the FAA, is directly accountable to Congress, but more importantly, to the American people.

Handing over that control of air traffic services to a private corporation, as this AIRR Act wants to do, will put the interests that right now are under the tutelage of air traffic control to a board of directors that may not have the interests of the American taxpayer and the consumer as its foremost priority.

Under the plan that is in the AIRR Act, this corporation will not be answerable to Congress. The only thing they will have to do is to provide reports on its operations every now and then. Under this plan, Congress has ceded its oversight over a major component of interstate commerce and, might I add—very important—national defense.

There is also very little oversight from our executive branch, the President. Decisions by the corporation to change safety standards or to reduce air traffic services will be subject to minimal scrutiny from the Department of Transportation. Also, as stated, the President will have limited authority to take command of the airspace unless there is a declaration of war.

On the cost and the funding uncertainties, I have an issue with this AIRR Act. The CBO predicts that this plan will cost the Federal Government—which, by the way, is us, taxpayers—$21 billion over the 10-year budget window, but this doesn't take into account any other factors that will probably exceed that cost by many, many billions, and that is with a B. The administration's fiscal 2018 budget paints a fuller picture of the costs, and it estimates a $46 billion cost over the same 10-year period.

Mr. Speaker, we have got enough budget problems without adding more gasoline to the fire.

The problem is that this revenue is critical for filling the Airport and Airway Trust Fund, which pays for popular programs like the Airport Improvement Program that communities all across the country rely on for their airport improvements, to pay for infrastructure upgrades, runway overlays, lighting, taxiways, those types of things that are essential for an airport to work.

The FAA bill before us authorizes more funding for the Airport Improvement Fund program, which is great, but it is still uncertain where these funds will come from. What makes up for the shortfall? I don't see it in this bill.

Mr. Speaker, I represent a great swath of the great State of Louisiana, good, good people, a lot of them in a rural community that are far away from any major metropolitan areas. My concern with this AIRR Act is that a private corporation concerned with raising money from user fees will be heavily incentivized to go to where the users are: the East Coast and the West Coast.

My question and my very much concern is: What happens to all of us in between that East Coast and West Coast? I worry that we will be left out of the mix and be left out of the equation because we will not be as able to contribute to user fees because of the population.

Decisions to change air traffic services can too easily be justified by this corporation, this private corporation that is talked about in this AIRR Act, and will face minimal scrutiny from the Department of Transportation.

A reduction in air traffic control services means a reduction in enplanements and a reduction in revenue at small, regional airports, just as I alluded to, and this makes it even harder to access the funding from the Airport Improvement Program.

All of these factors taken together will exacerbate the problem with access to air travel for 95-plus percent of the people in America, and this is hard for rural areas. They have a hard enough time making ends meet. They don't need the extra costs and the extra burden of traveling to a large city, maybe spending the night at a hotel to catch an early flight, the cost of transportation just so they can catch a flight to some other part of the United States.

The taxpayer seems to be on the hook here, too, under this AIRR Act. Under the plan, the Federal Government would simply hand over all the air traffic control assets to the private corporation free of charge, and this will negate decades and hundreds of billions—again, that is with a B—of dollars in taxpayer investments that the corporation will be able to dispose of and sell as it sees fit.

The plan will also create a potential multibillion-dollar unfunded liability for the Department of Defense to upgrade its systems to be interoperable with the new ATC corporation. What if the private corporation has one set of systems, our Department of Defense doesn't have that, but they have got to be talking to each other? This is a national security issue.

And again, who pays for that? Well, again, the taxpayers would certainly be on the hook to bring the Department of Defense up to speed. Again, this is something that we need to look very, very closely at in this bill.

The board of the corporation is not restricted in how much debt it can take on, and this sets up a very dangerous potential for a taxpayer bailout that, although this bill says it won't happen, I again question because these are the same types of promises that we got with Fannie Mae and Freddie Mac,