

percent of working adults don't qualify for unpaid leave under the Family and Medical Leave Act—6 out of 10 workers.

Here is the bottom line: If you want to get America back to work, you need to back them up. The Family and Medical Leave Act is a promising foundation, but it just isn't enough. We need to modernize the American safety net for a new generation of workers.

Think about this: Over the next decade, adults over the age of 65 are projected to outnumber children in America for the first time in our history. That is going to make life even more challenging for the 53 million Americans who are today already serving as caregivers for a family member or partner. This is particularly challenging for young Americans. One in four family caregivers is a millennial who, on average, spends 21 hours a week caring for a loved one at home. That is more than half of a full workweek, and they don't see a dollar for it.

These Americans, many of whom are also balancing a full-time job with full-time responsibilities as a caregiver, really need our help. They deserve it—at least a living wage to start with. Our Federal minimum wage is a starvation wage. There is not a single part of the country where \$7.25 an hour is enough—not even close. Let's raise it.

While we are at it, let's also revive that enhanced child tax credit that reduced child poverty in America by one-third. Think about that. Kids living in poverty—the total was reduced by one-third just from the child tax credit. That is breathing room for a lot of parents to make ends meet.

If we really want to help Americans get back to work, we should start by building on the success of the Family and Medical Leave Act.

(The remarks of Mr. DURBIN pertaining to the introduction of S. 242 are printed in today's RECORD under "Statements on Introduced Bills and Joint Resolutions.")

Mr. DURBIN. I yield the floor.

I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. CORNYN. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

The Senator from Texas.

#### PRESCRIPTION DRUG COSTS

Mr. CORNYN. Mr. President, last weekend, the New York Times ran a story entitled "How a Drug Company Made \$114 Billion by Gaming the U.S. Patent System." This is an infuriating account of how a pharmaceutical company maintained a monopoly on a popular drug and the impact it has had on patients and taxpayers.

The company is AbbVie, and the drug is Humira, one of the most widely prescribed drugs in the world. It is an anti-inflammatory medication that is

commonly used to treat arthritis and other conditions.

Despite the fact that Humira has been available for two decades, its first competitor didn't hit the market until earlier this week. That wasn't due to a lack of interest by other companies or an inability to produce the biosimilar that could earn Food and Drug Administration approval. It was because AbbVie used a maze of overlapping patents and an aggressive litigation strategy to stave off any competition.

Unsurprisingly, this led to big earnings for the company—\$114 billion in revenue since 2016—and it has come at a high cost to patients who rely on this drug to maintain their health. The list price for Humira is more than \$80,000 per year, per patient. That is higher than the median household income in Texas.

So depending on the patient's insurance, that price could be lowered significantly for the consumer or the patient themselves. A woman in Kentucky said her employer's health insurance plan kept her payments at around \$60 a year. But, of course, we know that, if the insurance company is paying retail or some negotiated price, ultimately that price is going to be passed along in terms of higher insurance premiums for the consumer.

So there is a lot of bait and switch going on here. Once she retired and switched to Medicare, the cost skyrocketed to \$8,000 a year. So her private insurance kept her payments to \$60 a year, but when she changed to Medicare, it went to \$8,000 a year. This is, again, part of the shell game in healthcare and in pharmaceuticals.

I can't imagine anyone living on a fixed income who could afford such an expensive drug. The good news, at least for this specific drug, is that, at long last, Humira's monopoly has come to an end. Earlier this week, the first biosimilar came to market, and more are expected later this year.

Humira is one of the most egregious examples of patent abuse, but it is far from the only one. Other pharmaceutical companies are engaging in this practice every day, and there is nothing to prevent others from using this same playbook. I hope that will change soon.

Earlier this week, Senator BLUMENTHAL, the Senator from Connecticut, and I reintroduced a bill called the Affordable Prescriptions for Patients Act to put an end to this anti-competitive practice that keeps drug prices artificially high.

There are two practices in particular that this bill will address. One is called patent thicketing—patent thicketing—which involves building layers upon layers of patents to prevent competitors from ever hitting the market. That is what AbbVie did with Humira. The company has—or has had, until just now, with its monopoly ending—as many as 134 active patents for a single drug—134 patents.

Now, I am a firm believer in the patent system. I believe we ought to pro-

tect investments made in cutting-edge and lifesaving drugs, and we ought to reward those who invent these lifesaving drugs with an exclusive right to sell it for a period of time. That is what the patent law does, and it incentivizes more and more people—more and more scientists and medical researchers—to come up with new lifesaving drugs.

But getting 134 patents on the same drug should outrage all of us. Like I said, this drug has been available for 20 years. AbbVie has spent years and exorbitant amounts of money, but, apparently, they still profited. They spent a lot of money fighting competition off in court, all to maintain control of the market on this drug.

Like I said, patents and exclusivity periods are not inherently bad. Discovering new cures is a time-, labor-, and money-intensive process, and we don't want to discourage that. Before a company spends years and hundreds of millions—or even billions—of dollars researching a new cure, conducting clinical trials, and undergoing the regulatory review, it needs to know that it can recoup its investment and maybe—just maybe—make a profit.

And many of the new drugs that are invented and tried do not succeed. So success is certainly not guaranteed. That is why the United States offers robust protections for intellectual property through the patent system.

The patent system gives innovators the confidence they need to invest their time and resources into research and development. Once that new innovative drug hits the market, the manufacturer can enjoy a limited time period as the sole supplier before generic versions become available or other competitors.

Patents are the key behind the incredible medical innovation that occurs here in the United States, and we need to find the right balance between stopping the bad actors who will game the system and, at the same time, encouraging the development of future cures.

I believe the bipartisan bill that Senator BLUMENTHAL and I are reintroducing strikes that balance. It places a reasonable limit on the number of patents that a manufacturer can contest. That will deter gamesmanship while preserving the incentives necessary for the patent system and for innovation.

The other anticompetitive behavior this bill will address is something called product hopping, which occurs when a company develops a reformulation of a product that is about to lose exclusivity and then pulls the original product off the market.

This is done not because the new formula is more effective but because it prevents generic competitors. One example is the drug Namenda, which is used by patients with Alzheimer's, a terrible disease. Near the end of the exclusivity period, the manufacturer switched from a twice-daily drug to a once-daily drug. It didn't change the

basic molecules. It just changed the prescribed dosage and taking, instead of twice a day, to once a day.

That move prevented pharmacists from being able to switch patients to a lower cost generic, even though it is just as effective, so the company could continue to profit. The Affordable Prescriptions for Patients Act puts an end to this practice by expressly prohibiting manufacturers from engaging in product hopping. It also facilitates market entry for generics and biosimilars, which lead to more options and lower prices for patients.

These reforms are, obviously, desperately needed. Patients in Texas and across the country are experiencing sticker shock at the pharmacy counter like never before. Many have tried to ration their critical medications, for example, in order to make them last longer. Some have been priced out of their medications entirely.

There is a clear need for Congress to step in and address the blatant abuse of the patent system, and I am optimistic that we will be able to do something important about it.

The Judiciary Committee will hold a markup next Thursday to consider this legislation and other bipartisan proposals to address sky-high drug prices. Last Congress, the Affordable Prescriptions for Patients Act passed the Judiciary Committee with unanimous bipartisan support, and I hope we will see the same level of support this go-round.

Over the last few years, we have held many hearings and advanced many drug pricing bills to the Senate floor, but, unfortunately, progress seems to often end there. We haven't had much success in getting those bills through the House and signed into law. I think I can speak on behalf of colleagues on both sides of the aisle and say I hope this year is different.

I have heard from many Texans who are frustrated by the lack of lower priced generic drugs. Given the impact of inflation on family budgets, that strain has only grown greater over the last few years. So there is a bipartisan desire to stop the anticompetitive behaviors that I have described here today that are costing patients and taxpayers a fortune, and I hope we can make progress this Congress and finally put a stop to some of the gamesmanship.

Senator BLUMENTHAL and I are committed to moving our bipartisan bill across the finish line, and we are eager to have others of our colleagues join us by cosponsoring this bill. But more important than that, it is important we actually get it across the finish line, get it through the House, and get it to the President's desk. So I hope this bill will continue to receive broad bipartisan support, and I am happy to work with anyone who has ideas to help us get there.

I yield the floor.

I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Ms. STABENOW. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

#### INSULIN

Ms. STABENOW. Mr. President, last month, I received a message that reminded me of just how important the work we do here is for people and families in Michigan and all across the country.

Diane of Bloomfield Hills wrote to me about the cost of her prescription medicine. Diane is diabetic and she takes two types of insulin or four injections per day. Diane is retired. She is on Medicare, with a supplemental policy for prescriptions.

Diane told me that usually, when she goes to the pharmacy, she owes a copay of \$650, and sometimes more, for a 3-month supply of just one of her prescriptions.

But the good news is, not anymore.

Thanks to a unified Democratic majority last year, people on Medicare now have the cost of their insulin capped at \$35 a month—\$35 a month for anyone who is on Medicare.

Last month, Diane went to the pharmacy like usual. The pharmacist told her that her 3-month supply would now be \$105 instead of \$650.

She says:

I paid and walked away with a big smile.

She added this:

I know that for many seniors, the cost of insulin has been difficult, or impossible, to afford if they have a limited income or live on the margins.

Thank you for your support of this important legislation helping seniors (and others) by reducing the cost of insulin.

Mr. President, this \$35 cap per month on insulin is helping millions of people on Medicare breathe a little easier, and I know because of your strong "yes" vote, as well as mine, this is the reason we get up every day, to be able to help people, to be able to reduce costs, to be able to make sure that they can enjoy their life and actually have a life—save their life. Insulin is a serious medication.

And so this was a really important accomplishment that we came together on.

It was disappointing we didn't have one Republican colleague join us in the House or the Senate, but we stood together and were able to get that done.

Unfortunately, people who need insulin and aren't on Medicare are still paying outrageous prices for a medication their lives literally depend on.

We tried to cap insulin costs per month for everyone, for children. We know for children with juvenile diabetes, this is incredibly serious. We have families who come here to DC every year. We have a wonderful group from Michigan who comes every year to share their stories; the children sharing their stories, showing us pictures, talking about what it is for them to

manage this every day; their families talking about the cost. And we tried to cap their costs at \$35 a month as well.

But, unfortunately, because of budget rules, the Republicans were able to force that to be a 60-vote margin, and they blocked it. Shockingly to me, they blocked it. So they blocked a \$35 insulin cap for children.

Why?

Unfortunately, to protect pharmaceutical profits. I am going to repeat that. Democrats tried to ensure that families wouldn't have to spend more than \$35 a month on insulin that keeps their children alive. Republicans blocked it.

It was just one more gift to an industry that has received quite a few gifts in recent years from Republicans.

First, let me start with the fact that from 2010 to 2019, American taxpayers contributed more than \$230 billion in research funding that helped drug companies develop new medications. I support that. I support public-private partnerships. I support public financing of research. We want that. We want new medications.

But then you turn around and you look at between 2016 and 2020, drug companies spent \$577 billion on stock buybacks, 10 times more than they spent on research—10 times more than they spent on research.

And they also significantly increased executive compensation. Now, drug companies CEOs can definitely afford insulin for their children. We want it for all the children of America.

After the Trump tax giveaway, some giant, profitable drug companies now have an effective tax rate of under 10 percent. Republicans lowered it for all corporations to 21, but some of the big drug companies got even a bigger gift—below 10 percent for an effective tax rate. That is less than the tax rate a typical postal worker or a typical preschool teacher pays.

And between 2000 and 2018, big pharmaceutical companies raked in \$8.6 trillion in gross profit—trillion with "t"—trillion dollars in profits.

Here is the CliffsNotes version: Pharmaceutical companies employed 1,587 lobbyists last year, almost 16 for every Senator—almost 16 drug company lobbyists for every 1 Senator.

Then, Republicans provide huge tax cuts for them and block legislation that would help families afford medication that keeps their children alive.

It is clear whose side they are on—the wrong side, in my opinion.

Diane is lucky. She is on Medicare and can afford a \$35-per-month copay for insulin. A lot of Michigan families aren't so lucky.

Consider the Lockwoods. Three children in the Lockwood family have type 1 diabetes and take insulin—three children.

A change to their insurance coverage meant that the family went from paying no copay to paying \$600 a month in a copay for insulin for each child—\$1,800 a month in a copay for their three children.