4/10/2019 House Energy and Commerce Oversight and Investigations Subcommittee Hearing on "Priced Out of a Lifesaving Drug: Getting Answers on the Rising Cost of Insulin"

The hearing began at 11:50 AM in Room 2322 of the Rayburn House Office Building.

Rep. Greg Walden (R-OR): All the witnesses from last week agree that insulin prices are a problem. Individuals rationing their insulin hurts their health. We must not forget that drug companies and PBMs play a role in making sure patients have access to affordable medicines. Investments from companies like Eli Lilly have helped a lot of people and improved insulin. And PBMs provide many important services and use tools to help lower costs. Last week Express Scripts announced a new program to ensure patients pay no more than $25 per month for a month's supply of insulin.

Rep Frank Pallone (D-NJ), chair of House Energy and Commerce Committee: insulin market has broken down. Little competition, perhaps incentives to keep raising prices, and patients need the drug in order to survive. Three companies currently manufacture insulin, and list prices have skyrocketed, harming consumers. We also have the PBMs, who are supposed to negotiate discounts, but there's not much transparency and discounts may not be passed on to consumers. PBMs and drug companies point fingers at each other. No one should suffer because of the high price of insulin. I hope we can learn why prices are rising, and make insulin more affordable.

Rep. Diand DeGette (D-CO): introduced the witnesses. They were:

Mike Mason, Senior VP, Eli Lilly and Company

Doug Langa, Executive VP, Novo Nordisk

Kathleen Tregoning, Executive VP, Sanofi

Thomas Moriarty, Executive VP and General Counsel, CVS Health

Amy Bricker, Senior VP, Express Scripts

Mike Mason: We are proud to have introduced the first commercial insulin product in 1923. We have invested in the discovery of new treatments. Lilly is actively developing better insulin devices. Four of my immediate family members live with diabetes, and I have seen the complications in their lives. Within the last two or three years we talk more about out of pocket costs. Too many people don't have affordable access to medications. Important to focus on that instead of list prices.

Some people don't benefit from low copays because their out of pocket costs are based on list prices. Those in Medicare Part D coverage gap and folks without insurance are most vulnerable. Our solution center connects people to a bunch of solutions. We have automatic discounts at the pharmacy counter, and announced the launch of a half price version of Humalog, we are trying to build a safety not. 95% of monthly Humalog subscriptions are less than $95 at the pharmacy.

Long term solutions: foster the widespread adoption of certain copays, like CVS said. The CREATES Act and eliminating pay for delay settlements would be great.

Doug Langa: Novo Nordisk cares about people. Patients rationing insulin is just unacceptable, and we need to do more. We are accountable for the list prices of our medicines. Why can't we lower list prices? In the current system, lowering list prices won't bring meaningful relief, and could jeopardize actions. Once we set list prices, we have to negotiate with PBMs to get access on their formularies. The demand for rebates are increasing. In 2018 rebates accounted for 68 cents of every dollar of our sales. So despite our list prices going down, overall prices aren't.

In the last few years we've seen more patients with benefit designs that require them to pay higher out of pocket costs and who don't receive the benefit of rebates.

Kathleen Tregoning: insulin is a clear example of the growing gap between list and net prices. Since 2012, out of pocket costs for one of our insulin products have risen, but list prices have gone down. We accept our share of responsibility. Approxiatemly 75% of our patients taking Sanofi insulin pass less than $50 per month. We are launching other programs and in June uninsured patients, regardless of income level, will be able to get Sanofi insulin for $99 per month at the pharmacy county. This action does not eliminate the need for broader reform.

Thomas Moriarty: CVS cares about patients. We are taking measures to reduce out of pocket costs, and have a number of tools to provide transparency at the doctor's office. We give doctors real time information about what is covered under their insurance and if there are lower cost alternatives, and we provide this information to patients online and on their phone. Transformed diabetes care-improves health and reduces overall costs. End pay for delay schemes, promote adoption of zero dollar copays. Reform Medicare to provide additional support services for patients with diabetes.

Amy Bricker: Our diabetes care value program helps patients. Express Scripts offers remote monitoring so our team can intervene when patient blood sugars are dangerously low. We launched InsideRx, a cash discount program that provides the negotiated rebate at the point of sale, with an average of $150 in savings per drug. Employers use our discounts to keep benefit premiums affordable. And half of Express Scripts's clients receive 100% of the rebates negotiated on their behalf. Our 2018 report showed a 1.5% decline in unit cost for insulin. We are driving competition among manufacturers and leveraging discounts to provide savings.

Dr. Sumit Dutta: OptumRx's team includes 5,000 pharmacists who help patients take their medications and manage chronic conditions. We have lowered overprescribing and opioid additions. Our tools reduce drug costs by $1600 per person on average. Our formularies are evaluated based on scientific evidence, not costs, and they are open to the public. Millions of

consumers are now seeing savings of $130. We are expanding the point of sale solution to all new employer sponsored plans starting in 2020.

Still, the price of insulin is far too high. These price increases make consumers pay higher out of pocket costs. Best way to reduce prices is to promote more generics and biosimilars, which is why we support reforming the patent system.

Rep. DeGette: What strikes us is how the list prices are very high, but there are lots of workarounds that some people get to get lower insulin prices. Eli Lilly and Nova Nordisk increased list prices, and Sanofi increase insulin from $86 in 2006 to $207 last year. Since January 1st, the three main brands have increased prices by 4.4%. My daughter is a type 1 diabetic. She renewed her prescription, and the list price is $347.80 per bottle. She is on insurance, but she still paid quite a bit. Not everyone gets the workaround. Why is the list price so high? How do you justify these huge increases?

Mason: $210 of our list price goes to discounts and rebates. Langa: bad incentives, the higher the rebate, the higher the list prices. Tregoning: we have to look at the dynamics of the supply chain, including rebates. Moriarty: rebates are discounts, and over 98% go back to clients. I can't answer why list prices are so high, but it's not because of rebates. Brocker: I concur. Dutta: there is no correlation between rebates and higher list prices.

DeGette: every component of drug system is contributing to higher list prices and overall costs.

Rep. Brett Guthre (R-KT): on February 6th, you said that your list prices had gone up and your net prices gone down. What if you just said your list prices would be your net prices? Mason: a lot of people have access to insulin through their health plans, we don't want to disrupt that. Langa: the current formulary positions-the three PBMs here represent over 220 million covered lives, and we can't afford to lose their positions. We would lose our formulary positions if we lowered prices. We're spending $18 billion per year in rebates. Tregoning: PBMs are very effective negotiators, but rebates are being used for other parts of the system.

Guthre: you say rebates keep the price down? It seems like there's a price but inflation and another higher price.

Rep. Joe Kennedy (D-MA): two parents brought ashes of their children before Sanofi protesting these prices. The status quo can't continue, we heard testimony from patients last week who are rationing their insulin. You talked about the increase in list prices and saying it goes to PBMs, but the data I have says 50% of that baseline price is not PBMs. Mason: our net prices have gone down. Kennedy: have you ever lowered a price off your formulary? Mason: we have lowered our net prices over the last few years. Langa: we have never lowered a list price. Kennedy: why not? Langa: because we need to be on formularies. Kennedy: it takes us calling you in after people have to ration the lives of their children! You aren't giving us good answers. If you're in my position, what should we do to ensure that everyone has access to lifesaving medicine?

Langa: I suggest we all get together to form a solution. Kennedy: your programs are insufficient. How long does it take for people to access them? Tregoning: we expanded a program today.

Rep. Greg Walden (R-OR): Sanofi launched at a list price for Admelog about 15% lower than the list price for Humalog. Normally we would expect the price to be much lower. What obstacles prevent patients from getting this option? Tregoning: We were unable to get formulary access. And this has happened to us on other products. Waldern: has Eli Lilly told PBMs or plans that it will no longer provide rebates if they put Admelog on their formularies? Mason: no we have not. Walden: why isn't Admelog included on your formulary? Bricker: it was more expensive for us, Express Scripts. We have recognized one product as exclusive, and so it will receive less discounts if we include other products. Dutta: the lowest cost product gets preferential position on our formularies. Walden: we keep hearing that companies should lower list prices, but that doesn't mean that the prices will be lower.

Rep. DeGette: Why aren't you PBMs putting Admelog on your plans? Dutta: it would cost us more to do that.

Rep. Raul Ruiz (D-CA): Consider what works for patients. In my district 1 out of 4 people with diabetes are living below the poverty line. It's not just a problem for the uninsured. Some of my constituents had to go on special kinds of insulin, not covered by insurance. Need to lower out of pocket costs. Who is making a profit from these increases? Is Eli Lilly? Mason: our prices have gone down. Ruiz: what entity in the supply chain is prioritizing access for patients? Langa: we would like to think we are. Ruiz: your overall profits have gone up, as has your CEO pay! And we don't know if PBMs are helping patients. Do they? Bricker: Express Scripts supports point of sale rebates. Ruiz: how we know this if we don't have transparency? Bricker: we support transparency for our plan sponsors. Ruiz: we need to look into your statements. Are there barriers to passing discounts on at the point of sale? Moriarty: we have 10 million lives. Ruiz: what are you willing to give up to ensure everyone gets insulin? CEOs: (don't offer meaningful answers).

Rep. Morgan Griffith (R-VA): Numerous fees in the supply chain, that are based on list prices. Why? CEOs: it's the current system. Griffith: have any of you tried to negotiate flat fees with PBMs? CEOs: yes, but we have not been successful. Griffith: what's the justification for these fees, instead of a flat fee? And CVS did not answer our letter on this. CVS is using administrative fees based on a percentage of the list prices. Moriarty: over 98% of our fees go back to the plan sponsors. Griffith: that's not what your contract says. Wouldn't it make more sense for you to have a flat fee?

Rep. Frank Pallone (D-NJ): all I hear from my constituents is that they are totally disgusted with insulin. They don't believe in a market based system anymore. They say, set the price! List prices are set by drugmakers. Why are we talking about high drug prices when it is within your power to bring the list prices down? Mason: we are reducing the list prices, we are paying rebates to get on formularies. Pallone: what would be the problem if the government sets the price? You think competition is working? I don't hear that from my constituents.

Pallone: you're going to blame the PBMs. Let's get rid of the PBMs and have the government set the prices! No one thinks the market is competitive anymore. Langa: we spent $18 billion last year on rebates. Pallone: I think you're just passing blame along. Tregoning: simply lowering list

prices might not help patients and could cause some patients to lose access. Pallone: we have to interfere when the market is not working. Our constituents say they're all no good.

Rep. Susan Brooks (R-IN): we heard it's becoming increasingly common for insurers and PBMs to only offer one insulin on their formularies. The system seems really broken. Dutta: when you have more competition and products from different companies, you can negotiate prices down. Brooks: what if we removed exclusivity from formularies? Bricker: prices would go up. Drug companies would not offer the discounts. Langa: we believe in choice for patients and physicians. Brooks: what if we got rid of rebates and discounts? Tregoning: we would support a system of fixed fees. If we could make sure patient access was maintained, we could lower insulin prices.

Rep. Ann Kuster (D-NH): a lot of people in New Hampshire have diabetes. They are frustrated, not just because of out of pocket cost increases, but the incredible complexity, and that drug companies and PBMs have lost sight of who they are working for. No one comes here with clean hands. What measures would you recommend to improve price transparency? Mason: we want reform. Long term fix should be what can we do on high deductible plans. Kuster: so there is a discount for volume purchasing. How do we get to transparency for the patients? Bricker: we believe strongly in a real time benefit check. Transparency also for plan sponsors. Our program for $25 insulin is good.

Rep. David McKinley (R-WV): A vial of insulin in 1967 cost a dollar. Now Novalog costs $237. What innovation would cause such a drastic increase in insulin prices? Langa: what's most important is to keep the patient in mind. One injection today instead of four, and other improvements. McKinley: I don't need someone to filibuster on me. This worked prior to this, now prices are skyrocketing. If it worked before, why change it? Innovation is supposed to drive the price down. Langa: the higher the rebates, the higher the list prices. McKinley: should we get rid of rebates? Might be a good idea.

Rep Kathy Castor (D-FL): constituents are struggling with affording insulin. Why do we have laws that protect kids' safety, but not laws that allow them to get the medicines they need to stay alive? It's been reported that manufacturers game the system and use charitable contributions to deduct from their taxes. If PBM fees are standardized, what would happen? Bricker: over 50% of our clients get 100% of fees. When you delink the fee from the list price, there is nothing that prevents manufacturers from increasing list prices.

Rep. Markwayne Mullin (R-OK): Cost of insulin is already recouped since it was invented a century ago. When patients quality for your assistance programs, how long do they stay on those programs? CEOs: Maybe a couple of years? Not sure.

Rep. Paul Tonko (D-NY): System as it exists no is horrendously broken. Expenditures for insulin the U.S. reached some $15 billion. Where is the money going? Mason: our net prices are going down. Tonko: do those prices need to go down further?

Rep from New York (D-NY): Is there a point where net prices get settled, or do they go up again? Mason: they stay pretty flat. Rep: if you have a hundred year old product, it's the same

product. If we extract rebates from the system, what happens? Bricker: the rebates are discounts, so the results would be bad for patients.

Rep. John Sarbanes (D-MD): Is the rebate system transparent? CEOs: yes, our sponsors can look at them. Sarbanes: so we can track the prices and see the savings you pass along-it's transparent to the public? Bricker: no it is not transparent to the public. Sarbanes: should it be? It's a secret. What if we made it completely transparent? I think a system has been built that allows for gaming to go on, and you've all got your talking points. One of us has said the same thing ten times. The system is working for both of you at the expense of the patient. Most of my frustration is reserved for the PBMs at this moment, because I think the lack of transparency is allowing for a lot of manipulation. Rebate system is screwed up. I think the PBMs should be utilities or converted to nonprofits or something. I don't buy the argument that patients will be hurt by transparency. Maybe have the government get into the space and provide this function.

Rep. Jan Schakowsky (D-IL) (angrily): in the 2018 election the number one concern was the high cost of drugs. We have the names of people who have died because they couldn't afford their insulin. I don't know how you people sleep at night. Insulin went from $21 a vial to much higher! For Eli Lilly, it's now $275 a vial, for Sanofi it's $270, and for Nova Nordisk it's $280. Curiously close in price, and way too high! That will not stand in this Congress! The lobbyists out here need to understand that this is a commitment to get drug prices under control. And if you think you can outtalk us without any transparency or accountability, I want you to know your days are numbered.

When Azar became HHS Secretary, I reminded him that he came from Eli Lilly at the moment that prices went through the roof. We need to hold PBMs accountable, but don't excuse yourselves from this! You do get tax breaks when you donate to people.

Rep. Peters: it's a system that incentivizes people to charge higher list prices. What we have here is a market failure at best, and government will have to take action. And now we have companies owning PBMs and plans, there's a real risk of anticompetitive behavior.

Rep. Nanette Barragan (D-CA): Eli Lilly is making a lot of money. What is your revenue? Your CEO in 2014 made $14.5 million, and in 2018 your new CEO is making $17 million. I don't see any improvement. People of color are disproportionately impacted by diabetes, and are often uninsured. Do you all recognize that your pricing policies and system are causing people to die everyday? Yes or no? CEOs: we don't want anyone to do. Barragan: yes or no? CEOs (reluctantly): yes we recognize that.

Barragan: It's outrageous. And Medicare should have the power to negotiate lower drug prices. Do you support that? Some CEOs: yes. Other CEOs: no.

Rep. Buddy Carter (R-GA): I remember when PBMs first got involved. I have seen mothers in tears because they couldn't afford their medication, and I was a community pharmacist for many years. Has consolidation in the drug supply chain affected prices? Langa: yes. Mason: yes. Carter: PBMs and insurers are merging. Are you sending the money back to insurance companies? Moriarty: yes. Bricker: yes, we do. Carter: I want to congratulate you because you

have created bipartisanship. These abuses-PBMs, DIR fees, and others-will end. What CMS is proposing is going to happen and bring more transparency to the system.

Rep. DeGette: the people who are suffering are the people who need insulin or they will die. In 2001 Humalog cost $31 a vial and today it costs $275. The generic Humalog costs “only” $137 a bottle. Now Sanofi has a new generic alternative Admelog, which costs over $200 a bottle. So let’s not kid ourselves that the generic alternative is much cheaper for desperate people. There are people paying list price. Drug companies and PBMs are making massive profits. We are going to figure out how we can provide insulin to diabetics at costs they can afford. We are prepared to bring you back in a few months to talk about the progress we have made.