and that we address the mental health issues of each veterans population with careful consideration to their unique needs.

It is with a heavy heart that I recognize Suicide Prevention Month and urge every Member of Congress to honor our veterans with actions that reflect our nation's eternal gratitude for their service.

Mr. SMITH of New Jersey. Mr. Speaker, I rise today to mark Suicide Prevention Month and to join with my colleagues in helping to raise awareness of—and combat—the staggering rate of suicide among our veteran population.

The men and women of our military make tremendous, selfless sacrifices on behalf of each and every American. As a result, many veterans return from service with physical and/or invisible wounds and a disturbingly high number are taking their own lives.

In July, the VA released the most comprehensive study analyzing suicide among our veteran population to date, reviewing 55 million veterans' records since 1979. It showed that every day an estimated 20 veterans commit suicide. This number is tragic beyond words, unacceptable and numbing.

Mr. Speaker, we are in the midst of what can only be described as a staggering mental health crisis costing the lives of 20 of our nation's heroes every day. Too many veterans are being left behind and too many families are left with the pain and anguish of losing a loved one. Often times, family members witness the veteran struggling but the VA refuses to take their observations into account.

As the son of a WW2 combat veteran, I have witnessed the residual wounds of war, the struggle to cope with the post-traumatic stress that can continue for decades and the pain that a lack of access to services can cause for veterans and their families.

This Congress, we have passed legislation to give the VA additional tools and give veterans key support, including the Clay Hunt Suicide Prevention for American Veterans Act (P.L. 114–2), which targeted the gaps in the VA's mental health and suicide prevention efforts; and the Female Veteran Suicide Prevention Act (P.L. 114–188), which is intended to prod the VA to take into account the complex causes and factors that are driving the disproportionately high suicide rate among women veterans and use that information when designing suicide prevention programs.

The Comprehensive Addiction and Recovery Act (P.L. 114–198) included provisions to direct the VA to take several actions to expand opioid safety initiatives that help prevent veterans from becoming opioid abusers. As a recent Frontline investigation entitled ''Chasing Heroin'' summarized: ''Veterans face a double-edged threat: Untreated chronic pain can increase the risk of suicide, but poorly managed opioid regimens can also be fatal.''

The VA must do better: they cannot simply dole out drugs, as we saw in Tomah. It is a dereliction of duty for VA medical staff charged with the sacred task of caring for our nation's veterans and this law will help ensure proper management and controls are in place when the VA treats a veteran's chronic pain.

The VA does have a number of suicide prevention programs that can be a resource for veterans, servicemembers, their families and loved ones, including and especially the Veterans Crisis Hotline. Any veteran in danger of self-harm or suicide can call, 24 hours a day. It is anonymous and confidential. It is staffed by trained professionals who will ''work with you to reduce the immediate risk, help you get through the crisis, make sure you are safe, and help you to connect with the right services.''

We have an obligation to repay the debt we owe to those who have fought in defense of our nation and a sacred duty to ensure that we do everything in our power to get our vets the physical and psychological support they need.

This year's Suicide Prevention Month theme is 'Be There.' During the darkest hours in our history, the men and women who serve in uniform have always been there to answer the call. We can and must do better to be there for them.

COMMUNITY PHARMACISTS

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

GENERAL LEAVE

Mr. COLLINS of Georgia. Mr. Speaker, before I begin, I ask unanimous consent that all Members have 5 legislative days to revise and extend their remarks and to include any extraneous material on the topic of this Special Order.

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, well, we are back at it tonight. We are going to be going at a subject that I have been down here before on and will continue to come down here on until, frankly, I believe that we are moving forward with this issue that affects pretty much every hometown of every Congressman here. It is amazing, though, how much we don't know about it. It is amazing how much it goes unreported and how much it gets looked over.

In the sake of the shiny object of savings, our community pharmacists, our independent pharmacists, are being basically run out of business. Mr. Speaker, I don't tell you anything new.

For my friends who will join me here tonight, this is about hometown America. This is about the healthcare chain that we all talk about. And a forgotten element of that healthcare chain is something that we need to focus on.

Community pharmacists fill an important niche in our healthcare system, serving as the primary healthcare provider for over 62 million Americans. They dispense roughly 40 percent of the prescriptions nationwide and a higher percentage in rural areas, especially mine in northeast Georgia.

Community pharmacists play such an important role in our healthcare system by being that accessible voice at the other end of the phone or at the counter, just being there sometimes to answer those simple questions that are very important to somebody, or to answer the difficult questions that could, frankly, mean the life or death for that patient, knowing how to take their medication, knowing what to get and how to be there and be a part of the community, not just at the pharmacy, but at the ball fields and the community. Some of the best small business employees that we have in our communities are found in our community pharmacies.

When we look at the relationship that communities have with their pharmacies, and especially our community pharmacists, the face-to-face counseling and the work that goes into our community pharmacies, and pharmacists mainly in general, is something that we need to continue to focus on.

Patients' failure to properly take their medication regimen costs the healthcare system nearly $300 billion and contributes to 125,000 deaths each year. The face-to-face counseling that our community pharmacists give is the most important and the most effective way for ensuring that our patients take the right medicine, know what they are taking, and why they take it.

Yet, as I stated before and state here again on the floor tonight, there is a group that believes that our community pharmacists—really frankly if you just look at it—shouldn't exist. Because everything they are doing, the pharmacy benefit manager, the PBM, that middle person—I want to show you this. We are going to talk about this chart more here as we go—but the PBMs control the pharmacy system right now. In fact, if you just take the PPM here in the middle and you look at employers and you look at patients and you look at the pharmaceutical companies and you look at the pharmacies, they sort of circle around here.

We are going to talk about this ''savings issue'' and look at it and ask: Is it actually saving employers? Is it actually helping pharmaceutical companies get out products? More importantly, is it actually helping the patient?

I think tonight you are going to find out that there are a lot of questions to be had here. We will talk about that as we go forward.

As we look at this, we have a lot of things that my friends tonight are here to talk about. We are going to talk about MAC transparency. We are going to talk about generics. We are going to talk about the way this goes, but we are also going to talk about really what I believe is the unfair tactics used by PBMs that are constantly forcing our pharmacies and our community pharmacists out of business.

I think, at some point in time, many of the PBMs ought to change their mission in life into ''saving'' or being a part of the pharmaceutical system and say: our job is to run community pharmacists out of a job. They are the best I have ever seen at doing that.

In one of my small towns just 20 minutes from my house, in the past year, three community pharmacies have

closed. Three. They are now in a smaller town being forced into choices they didn't want to have to make, into PBM-controlled pharmacies.

You see, PBMs, when they first started, had a good idea: How do we make sure that we get drugs and medications to pharmacies at a cheaper price so that the patients at the end save money and employers can save money?

Then PBMs decided that they wanted to be a part of all the system. They wanted to start owning pharmacies. They wanted to start owning the supply chain. They wanted to start being a part of it all. And when they did that then everybody else was competition.

I have said it before from here: The problems that we have—and Georgia pharmacists have talked about it, and we have talked about it as well—is when you have your competitors who are able to come in and audit you and they are able to fine you for clerical errors and keep you out of systems and out of payments and things that they give their own pharmacies, that is just wrong. It is wrong when they only come in and audit the name brands and leave the generics behind.

For some of you, if you are watching, if you are thinking about it and hearing my voice for the first time, you are maybe saying: Well, that is okay. They are making sure systems are safe.

PBMs are not auditing pharmacies to make sure they are safe. They are auditing pharmacies to make money because they are going to withhold the cost of the drug from the pharmacist. In other words, if they make a clerical error and the drug costs $100, let's just say, they don't take their profit. They don't take the margin. They take the entire $100 back. I wish I had a racket set up that good.

The sad part about that whole statement there is, at the end of the day, Joe or Suzy or Bob or Bill or whoever came and got their prescription knew nothing about this ''error.'' All they knew is the pharmacist filled the prescription that the doctor had ordered, and they went home and took their medicine and got better.

Yet, on this other end, PBMs are trying to destroy an industry and a group of people who mean so much to our communities. So tonight we are going to talk about it. We are going to talk about it some more, and we are going to keep bringing attention to this until the light is fully shined on this.

Tonight, as we get ready to talk about it, a gentleman who has been such a friend to us as we have been doing these, Representative LOEBSACK, is here tonight. It is good to share the stage again with him because this is something that needs to be discussed. It needs to be hammered home until every Member of the House and Senate understand this and we find a workable solution.

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

Mr. LOEBSACK. Mr. Speaker, I thank the gentleman from Georgia (Mr. COLLINS) for inviting me to join him in leading this Special Order. I have been in this job long enough to know there are people you don't want to follow when you speak, and DOUG COLLINS is one of those. The guy is absolutely inspired, but he is inspired for a lot of reasons.

He has been a strong leader on pharmacy issues. He has been a great partner on the bills that we will discuss this evening. I am proud to say this is a bipartisan issue. Although, at the moment, I am the only Democrat over here, I can assure you there are others who are with us on this issue.

Mr. COLLINS of Georgia. Well, bring them on.

I yield to the gentleman from Iowa.

Mr. LOEBSACK. Mr. Speaker, we have been able to find a consensus on this, too, among this bipartisan group of folks.

As my good friend said: Pharmacists across the country serve as the first line, really, of healthcare services for many patients, especially in small towns in Iowa and around the country. People count on pharmacists' training and expertise to stay healthy and informed and maybe, most importantly, to stay out of urgent care centers and hospitals, something we all want to see happen.

I am proud to stand here today with my colleagues to recognize the quality, affordable, and personal care that pharmacists provide every day.

Community pharmacists and their pharmacies are also a great source of economic growth in rural communities, like those in my district in Iowa. I have 24 counties. It is a big area. And when a pharmacy is under pressure economically, the community knows it and hears about it. And if they have to close, the community suffers as a result.

As a member of the Small Business Caucus, I recognize how challenging it can be for some small pharmacists to compete with bigger companies. I appreciate their hard work to serve our communities every day.

Like most small-business owners, community pharmacists face many challenges to compete and negotiate on a day-to-day basis with large entities in their business transactions. I frequently visit with community pharmacists in my district, and I have heard directly from them how hard they have to fight to compete on a level playing field that isn't always level for smaller pharmacies. So it is not really a level playing field.

One pressing challenge facing many community pharmacists, as was already mentioned, is the ambiguity and the uncertainty surrounding the reimbursement of generic drugs. Of all things, it is the reimbursement of generic drugs.

Generic prescription drugs account for the vast majority of drugs dispensed by pharmacists, making transparency in reimbursement absolutely critical to the financial health of small pharmacies. However, pharmacists are reimbursed for generic drugs through maximum allowable cost, or MAC, a price list that outlines the upper limit or the maximum amount that an insurance plan will pay for a generic drug. And these lists are created, as was mentioned, by none other than the pharmacy benefit managers, or PBMs, the drug middlemen, if you will.

The methodology used to create these lists is not disclosed. Further, these lists are not updated on a regular basis, resulting in pharmacists being reimbursed below what it costs them actually to acquire the drugs. This is a major problem because, when PBMs aren't keeping the cost of generic drugs consistent, those price differentials can be a serious financial burden for pharmacies.

Small pharmacy owners face even greater disadvantages than their larger counterparts because of the clear lack of leverage they have when negotiating the amount they will be reimbursed for filling prescriptions when dealing with the PBMs.

When we talk about pharmacies closing because they can't keep up with the financial challenge, we are talking about the creation of an access problem also that directly affects patients. It is not just the pharmacies themselves closing down and those folks losing their jobs. It is the patients they serve.

When we talk about reimbursement uncertainty for pharmacies, we are talking about uncertainty about patients' ability to get the medications they need at an affordable price.

When we talked about a community pharmacist being put out of work, we are talking about taking away a familiar face that local folks trust with their healthcare concerns.

To address this problem—and Representative COLLINS is going to talk about this, and others are—I partnered with him to introduce H.R. 244, the MAC Transparency Act. We have had actions along this line in the State of Iowa as well. We can do it at the Federal level if we can do it at the State level.

This bipartisan bill would ensure Federal health plan reimbursements to pharmacies to keep pace with generic drug prices, which can skyrocket overnight.

So specifically—and I know Mr. COLLINS is going to talk about this—it will do three things. It will provide pricing updates at least once every 7 days. It will force disclosure of the sources used to update the maximum allowable cost, or MAC, prices. Again, it is about transparency. It will require PBMs to notify pharmacies of any changes in individual drug prices before these prices can be used as the basis for reimbursement.

This is a commonsense bill, folks. It is about access. It is about making sure folks have access to their pharmaceuticals, to their drugs, and generic drugs in particular.

Another issue I would like to highlight is the problem of direct and indirect remuneration, or DIR fees. The Centers for Medicare and Medicaid Services, CMS, originally coined DIR fees as a means of assessing the impact on Medicare part D medication costs of drug rebates and other price adjustments applied to prescription drug plans.

However, DIR fees have increased greatly over the last year on pharmacies, and, if the pharmacy agrees to enter into a contract with a PBM or part D plan sponsor, it does not seem fair that these mediators can reduce the reimbursement rate since the contract has already been agreed to.

□ 2030

This gets a little bit complicated. I know other Members are going to be talking about this later on as well. There is just basically no transparency regarding how the fees are calculated.

There is another bill that I have signed on to. I applaud my colleagues, Representative MORGAN GRIFFITH, a Republican, and PETER WELCH, a Democrat, for introducing the Improving Transparency and Accuracy in Medicare Part D Spending Act. It would prohibit PBMs and plan sponsors who own PBMs from retroactively reducing reimbursement on clean claims submitted by pharmacies after the contract has been submitted. This is a scam, and it shouldn't be happening. I urge everyone, leadership, to bring this to us and everyone to vote for this bill and for our other bill.

I want to thank, again, Mr. COLLINS and the other Members who have been here tonight. It is a great opportunity for me to participate and highlight some problems that our community pharmacists are facing and then, ultimately, their patients, the folks they serve as well. Those are the folks we are trying to look out for as best we can and trying to serve while we are here in this Congress. I thank Mr. COLLINS very much.

Mr. COLLINS of Georgia. Madam Speaker, Mr. LOEBSACK hit it. That last little part right there was dead-on. This is about the patient. This is about serving that patient who is used to that trust and faith, who understands it, and also really a part of that healthcare system that has been provided a long time that is now at risk of going away.

It is not too strong to say that if we do not look at this—and some say, well, this is a free market, let them go contract. Government is one of the biggest payers of this, and this is something we have got to get at.

In fact, something Mr. LOEBSACK brought up as I was listening to him talk, there was a study, TRICARE, in fact. In just a moment, I am going to introduce Mr. SCOTT here. He is from Georgia. He is on the Committee on Armed Services. He is a friend. But TRICARE did a study where it found that, if it eliminated PBMs from the TRICARE program, it would save roughly $1.3 billion per year. We are up here arguing about problems in our budget, and we could save this much money?

No, this is about profits. This is about consolidation. This is about vertical integration. This is about taking control of a market in which three to four companies control 83 percent of the market. We are not talking about a small little startup. Mr. LOEBSACK is right on, dead-on. I thank him so much for the work that he is doing, and I appreciate it.

In light of that, especially dealing with TRICARE, again, the bottom-line issue here is how we cost-effectively provide services to those members in our communities who need it the most. And this issue of savings, I know there is a Texas study that also showed if they went away, they would save money as well, in the millions of dollars. It is building, but we have just got to keep pointing it out.

I yield to the gentleman from Georgia (Mr. AUSTIN SCOTT), my friend, my longtime colleague not only in the House in Georgia, but the House up here, and fighting for the very values we find in Georgia and all across the country.

Mr. AUSTIN SCOTT of Georgia. Madam Speaker, I want to thank Mr. COLLINS and I want to thank my colleague from Iowa. This is a bipartisan issue.

Before I speak on behalf of the community pharmacists, I want to just take a second and speak on behalf of the taxpayers, the hardworking men and women in this country.

Free markets are transparent markets, and if we had transparency in the system, we probably wouldn't be here today because the American public wouldn't stand for what is going on. Unfortunately, we haven't seen any news reports or any reporting to inform the public of all of the things that have happened over the last couple of years, but we saw it on the EpiPen just a couple of weeks ago. You saw what happens when the press reports, the public finds out what is going on: pressure is put on, and then a response comes—maybe not the response that would have been what we would call equitable for the patients that need the treatment, but at least a response came.

It is not just EpiPens, though. It is not just multihundred-dollar drugs and multithousand-dollar drugs. When we talk about drugs as simple as nitroglycerin tablets, again, you, as the taxpayer, are the largest purchaser of this through the government. Nitroglycerin tablets have gone from 5 cents apiece to $5 apiece. Doxycycline tablets, an antibiotic that has been on the market for many, many years—again, another generic drug. It has gone from pennies apiece to dollars apiece.

I know my colleague, BUDDY CARTER, could probably name more drugs for you than I can where we have seen those same type of hundredfold increases in the price of drugs. I can tell you that the hardworking taxpayers of this country, in the end, pay that bill.

One of the best things that we can do for you is make sure that we are trying to shed light on and bring transparency to this system and to make sure that we are keeping that small-business owner in business so that we are able to get the information that we need to do a better job for you from them. That is where our Nation's community pharmacists come in.

I know for me, I walk into my local pharmacist, and they can tell me right offhand what the most egregious price increases were of the past week, and they are happening every single week, ladies and gentlemen. These independent businesses operate in underserved rural areas, like many of the counties that I represent in Georgia's Eighth District.

Access to care is already an issue in these areas, and it would certainly be much worse if our community pharmacies didn't exist. In these areas, doctors are many miles away. Local pharmacists deliver the flu shots. They give advice on everything from over-the-counter drugs to drug interdictions, and if you have got a sick child, most of them will meet you at the store after hours to help your child get the medication that they need. Try that with somebody who is not a small-business owner.

It is crucial that these pharmacies have a level playing field to stay in business against large-scale competitors and the middlemen, if you will, the pharmacy benefit managers, when trying to run a successful business in such a challenging and complex environment as the U.S. healthcare system.

Where I am from, these local pharmacists are fixtures in their communities. They have known their customers most of their lives, and it instills a level of trust in those patients that is rarely seen in today's day and time.

I have made some stops at these local community pharmacies: some to get my own prescriptions filled, some to see how things are going with the small-business owners, some to see how other things are going in the community. I never fail to appreciate the unique value that the men and women that work in these local pharmacies add to their customers' lives and to our communities.

Unfortunately, on these visits, I am also troubled because I continue to learn, as I have mentioned before, just how much more difficult it is becoming for those men and women to serve the people who have depended on them for years and to compete with some of the larger entities in the healthcare marketplace.

Imagine a situation where your competitor's company gets to come in and audit your books. That is exactly what happens. That is exactly what happens when one of the big-box retailers who

owns a PBM goes in and audits the local community pharmacy.

Take, for example, one of the other problems that we have: the increased prevalence of preferred networks in Medicare part D plans. Currently, many Medicare beneficiaries are effectively told by pharmacy benefit managers, or PBMs, which pharmacy to use based on exclusionary agreements between those PBMs and, for the most part, big-box pharmacies.

Most people don't recognize that the big-box owns the PBM. Patients pay for this. They pay for this in lower customer service and higher copays. When their pharmacy of choice is excluded from the preferred network, it creates undue stress on the patients and forces them to do business where they may not want to do business. The majority of the time, your local pharmacy is never given the opportunity to participate in the network. That is an unfair business practice.

Another issue I often hear about from community pharmacies is the burdensome DIR fees. We as Americans, we pretty much assume that when you go in and you buy something and you leave with what you pay for that the transaction is over. But with medicine at your local pharmacy, it is a lot different. That transaction is anything but clear and simple for the pharmacist.

Pharmacy benefit managers use so-called DIR fees to claw back money from pharmacies on individual claims long after the claim has been resolved. It can be a typographical error and the pharmacy benefit manager will call back 100 percent of what was paid to the pharmacist. That means the pharmacy doesn't know the final reimbursement amount they will receive for a claim for weeks or even months; and even more so, they are not even reimbursed for the wholesale cost of the drugs that they dispense. In 2014, CMS issued proposed guidance that would provide some relief to our pharmacies struggling to deal with the increasing and opaque DIR fees imposed on them.

As I said, anyone who runs a business knows you can't operate when you don't know what your costs are or what your reimbursements are. That is why I have led over 30 of my colleagues in sending two separate letters to the Centers for Medicare and Medicaid Services urging them to move forward and finalize proposed guidance on this issue. Unfortunately, they have yet to move on that guidance.

I and, I know, many of my colleagues, in a bipartisan manner, are going to continue to advocate for CMS to use their authority to ensure a level playing field for all Medicare part D participants. When competition is stifled and our small businesses suffer, so do the customers of our local community pharmacies. I hope the committees of jurisdiction will consider these bipartisan bills.

Madam Speaker, I want to thank you for your time. I want to thank Mr. COLLINS for hosting this Special Order today.

Mr. COLLINS of Georgia. Madam Speaker, I thank Congressman SCOTT. He has highlighted a lot of things, and I think it is something that just matters. Sometimes we go through a lot of the big pictures up here, and we see a lot of issues, but this is one that matters to hometown. This is Main Street USA. This is something that goes on. Especially for districts like mine and for many others in rural communities, the pharmacy, especially the independent community pharmacies, are the lifeblood in these communities

I have said this before, and I have had this asked of me because we have been doing this a while. Let's make it very clear. Pharmacists, I love. I don't care who they work for. Pharmacists are great folks, whether they work in a big-box store or they work for a major chain or they are independent and own their own business. Pharmacists want to help people. That is why they went into it to start with.

I think what we are fighting here is a system. I have talked to many pharmacy students who are now saying they are not sure they want to go into this or they are very concerned about their futures because they are looking at the abusive policies of PBMs, and they are saying: I don't want to follow in my mom or dad's footsteps; I don't want to follow and open up a storefront and hire people because I can't make it this way. And they end up being forced in.

I want to talk a little bit—we have been vague about this, but I am not going to be vague here for the next little bit. I am going to talk about PBMs and this regular auditing of community pharmacists to recruit large reimbursements. Let me go back over this.

There is nothing wrong with audits performed with the intention of uncovering abuse; however, PBMs' auditing has another motivation. Pharmacists have told me that the most expensive prescriptions are always the target during the audit—always.

PBMs used to audit only the most expensive medications looking for clerical errors like typos, misspelled names or addresses, or, better yet, as I just heard recently from one of my pharmacists, in which they dinged one of my pharmacists because the doctor wrote a specific amount for an eye medication—the doctor. Let's make this very clear now. I know Representative CARTER is probably going to get into this a little bit more, but the doctor himself wrote the prescription. The prescription goes to the pharmacist. The pharmacist filled the prescription as the doctor said. But when the PBM auditor got there, they said: No, you are not supposed to use that amount. Use this amount.

I want to know what medical school this auditor went to. I want to know when they decided to start practicing medicine without a license where they can come in and say amounts. I can understand swerving to a generic over a name brand or a name brand over a generic. That is within sort of what we have become used to. But when they can actually go in and ding one of our pharmacists for amounts that the doctor said, we have got a system that is a little bit abusive. Well, let me rephrase that. It is downright corrupt.

They go in and they do these audits. They find these clerical errors. And when they do this, they take back, they recoup, all the funding paid for that prescription. Like I said earlier, they don't take back just the profit. They don't take back the cost. They take back everything.

These audits are not intended to end Medicare fraud. The PBMs use them to take taxpayer funds and claim them as profits. If a pharmacist checked the box that said send by fax instead of send by email, the PBM is able to reclaim the entire cost of the drug. They don't just take back the copay or the pharmacist's profit.

Again, I just want you to understand how crazy this is. But, you see, instead of looking and having their time and effort of audits that could be better spent helping local pharmacists do what they do best, they are having to look over this all the time, focusing on improved quality for their patients.

□ 2045

The PBMs, frankly, have shown over the last little bit that they are not interested in the well-being of the patient. They are interested in that other P word, profit, not patient.

It is really concerning, and this is what has happened. In the interest of that profit, the PBMs have engaged in anticompetitive business practices. Certain PBMs own or have ownership stakes in the very pharmacies they are negotiating to lower drug prices with. When a PBM is owned by the entity it is supposed to be bargaining with, there is an inherent conflict of interest. This can lead to fraud, deception, anticompetitive conduct, and higher prices.

Here is a great one. I love this. Many large PBMs own their own mail order pharmacy and financially penalize patients that use their community pharmacist instead of the PBM-owned one. PBMs try to drive customers from community pharmacies into the mail order firms, arguing it saves consumers and drug plans money.

However, a study by the Taxpayers Protection Alliance highlighted waste, fraud, and abuse within the mail order system run by the PBMs. The TPA study noted that 90 percent of patients were moved to mail order due to encouragement or mandate from a PBM.

According to Medicare data, PBM-owned pharmacies may charge as much as 83 percent more to fill prescriptions than community pharmacists. PBM's practices limit consumer choice, increase drug prices by engaging in vertical integration in their ownership of mail order pharmacies, killing competition.

And here was one that was classic. I walked into one of my smaller towns. It had a pharmacist. And the pharmacist said: I got in trouble. I got a letter.

They showed me the letter. They delivered some medicine to some of their customers. They get a letter from the PBM saying, You are not in the mail order business. And they actually were going to have their contract threatened if they sent these people their drugs.

Representative CARTER is going to talk in a minute. I just want to break for a second. But that is unbelievable that they actually will get on the pharmacies and say: You can't reach out, you can't contact your customer to tell them that they can be a part of the plan.

One of my pharmacists actually was left off of a plan that they were actually on. The PBM sent a letter to all his customers saying that they are not a part of the plan, when, in actuality, he was. And then, when confronted, they refused to send a letter out to the customers saying: We are wrong.

Just briefly, am I highlighting something that is uncommon? Or is that a common practice?

Mr. CARTER of Georgia. No. It is. As the gentleman states, it is a very common practice. And you know, it is downright unAmerican.

Small businesses are the backbone of our economy here in America. When you do not allow a small business to participate, even if they are willing to take the reimbursement that an insurance company is offering, but that insurance company, nevertheless, will not let them participate, that, in my opinion, is unAmerican.

Mr. COLLINS of Georgia. You have hit something. You have led into a great example. This is highlight. And if there are problems, let's fix them. You hit on that issue.

We have heard of DIR fees tonight. We have heard about reimbursements. Let me leave you an example from a little company called Humana.

I had a pharmacist call me about proposed amendments to their Pharmacy Provider Agreement. Humana decided to withhold $5 per prescription from initial reimbursements to the pharmacy. Now, you understand what is happening. They are withholding $5 of what they should be sending to the pharmacy. The return of the reimbursements was conditional on the pharmacy meeting certain patient adherence metrics. This is essentially a fee conditional on meeting certain performance standards, and Humana would withhold reimbursements from poorly performing pharmacies.

That sounds good, doesn't it?

It has got a great twang to it. Somebody in the marketing office there thought, This is going to be pretty cool. It sounds so good, but let's talk about it.

Humana's criteria, however, had little to do with patient care and more with driving community pharmacists out of the market. Many of the metrics used, including patient adherence, are beyond the control of the pharmacist.

Humana's amendment unduly burdens small pharmacists and protects large chain pharmacies, many of which they own. Humana enlisted their actuaries to ensure this formula guarantees they will retain 60 percent of the withheld reimbursement moneys, most of it coming from community pharmacists.

Pharmacists in the 80th percentile and up in each category would receive $2 per category. If a pharmacy meets expectations in all three categories, they will earn $6—a $1 profit per prescription. Now, remember, this is what was already withheld from them. Pharmacists below the 80th percentile would receive .67, or 67 cents; and below the 50 percent percentile would receive none of the reimbursement that they withheld. This is a reimbursement that is supposed to go back to the pharmacy. They are not getting any of it. Many of the community pharmacists often can't afford to lose this additional 33 cents to $5 for every prescription they fill. Only big box pharmacies really have that ability.

Humana also favors big box pharmacies by allowing the number of patients to serve as a function of a tiebreaker. This amazed me. For example, a community pharmacist and a big box pharmacist might both have 100 percent adherence to certain performance measures. However, if the big box pharmacy served more patients than the community pharmacist, it will achieve a higher percentile score than the community pharmacy.

Humana disproportionately favors large chain pharmacies at the small pharmacies' expense. Certain pharmacies have enough patients to minimize the effects of patient nonadherence to their ratings. At independent community pharmacies, one patient's nonadherence could cost pharmacies thousands of dollars by moving a pharmacy from the top bracket to one below.

If somebody were listening to us, Representative CARTER, they would say we were making this up. We are not. I have been doing this now for well over a year—almost 2 years now. I have never been challenged on these facts. They don't like it. And they are listening probably right now, saying: What can we do to go settle this down?

But it is just not right when they look at these things and they see savings in the State governments. It is like they are saying: Look at the shiny object over here. Don't face reality.

This one is just amazing to me. When you are taking money that should go back to the pharmacist and putting them on this metric scale that they can't compete on; or you are taking their customers, but won't allow the pharmacist to reach out, these are the kinds of things that just really, really are amazing to me.

I wrote a letter with the gentleman urging CMS Acting Administrator Slavitt to review Humana's proposed amendments for their part D Pharmacy Provider Agreement. This is just something that has got to change as we go forward.

There is nobody that knows that any better than Representative CARTER, knowing the situation. I have said this all along. I do this because I have been helped so much by community pharmacists and believe when wrong is wrong, you call it. When you can, try and make it right.

You have lived this. And you continue, by your service on the Georgia legislature and up here, to help us continue to be on the front lines, continuing this fight. You are there working it out as well.

Tonight, I think we just need to continue the practice of saying, Here are the facts, and encouraging our committees of jurisdiction to take action on this and just evaluate it.

We have the MAC transparency, the clawback bill. These bills have a chance just to be heard, because I found that every time I share this with Members, they can't believe it. They want to know more. And when we show them the facts, they say: This needs to be discussed.

We have some time tonight. I want to share what you are seeing as we continue this fight for what is right.

Mr. CARTER of Georgia. Well, I want to thank the gentleman for organizing this and for bringing this to light.

This is something that I know you are obviously very passionate about and that you have worked on for a long time; many years.

You know, it is not just you. You are obviously a leader here. But also, Representative SCOTT, who spoke earlier. Representative LOEBSACK. I may be the only pharmacist in Congress, but we have many friends of pharmacy in Congress, and we appreciate this very much.

But even more so—if I may, even more so, what you are concerned about, what Representative SCOTT, what Representative LOEBSACK, what everyone up here is concerned about is patient care. That is what we are talking about.

Mr. COLLINS of Georgia. Exactly. What you are saying, every time we do this, we gain Members who begin to look at the issue. They just don't believe what the PBMs bring to them.

All I am asking for me and I know for you is for every Member here to go talk to a community pharmacist. All they have to do is go talk to them. We are not sharing anything that is not real.

Mr. CARTER of Georgia. That is the whole key. The whole key is that what we are talking about is patient care. We are not talking about community pharmacies trying to pad their pockets. But what we are trying to point out and what you have done so efficiently, particularly with your chart, is to point out what is happening here.

Everyone is concerned about high drug prices right now. It is one of the

biggest subjects that we hear about in the newscasts and everywhere. Granted, this is not the only part of that, but it is a big part of it.

What is happening is we are taking competition out of health care. If we talk about ObamaCare, if we talk about the Affordable Care Act, ObamaCare, whatever you want to call it, my number one concern with is that it has taken competition, it has taken the free market out of health care.

I mean, think about it. Am I talking just about independent retail pharmacies?

No. I am talking about independent health care.

How many independent doctors do you know anymore?

Most of them are members of healthcare systems, most of them are members of hospital systems, which are fine systems, but, again, we are taking away competition. And that is what is happening here.

I thank Representative COLLINS. I want to thank him for, again, organizing and bringing this to light.

As you have mentioned, I have been a community pharmacist for over 30 years. I graduated from the University of Georgia in 1980. Go Dogs. I am just as proud as I can be of my alma mater.

You know, pharmacy has changed tremendously since I graduated. I serve on the advisory board at the University of Georgia at the College of Pharmacy, and I can tell you the quality of students that are graduating now from pharmacy school is just tremendous. The clinical expertise that they are graduating with makes us all in health care very, very proud. I still maintain that pharmacists are some of the most overtrained and underutilized professionals out there.

But, again, I want to get back in full disclosure here. I am a free market person. I am someone who believes in the free market. I believe in competition. And that is all community pharmacists are saying: Let us compete.

But as Representative COLLINS has pointed out so succinctly here, we don't even have the opportunity to compete.

When you have the insurance company owning the pharmacy and making decisions that impact patients and where they can go and tell patients, No, you cannot buy your prescription over here, you have to buy it over here, that takes the free market out of the system. That takes competition out of the system.

Who cannot see that?

There are chains there who will tell you that their operation is a three-legged stool. They have the PBMs, they have the pharmacy, and now they have their health clinics.

Well, what does that do?

It is a great business model, sure, but once they get you, they got you. If you go to a pharmacy and they write that prescription, and then that prescription is filled right there, well, obviously, that is a conflict of interest. But that is what is happening now. If the insurance company owns the pharmacy and tells you that you have to go to this pharmacy, that is a problem.

True story. I owned three community pharmacies before I became a Member of Congress. My wife owns them now. While I still owned those pharmacies, I filled a prescription for my wife at the pharmacy that I own. This was about 3 or 4 years ago. Later on that night, she got a call from the insurance company encouraging her to get that prescription filled at another pharmacy. I am telling you, this is true. Honest. That is just crazy.

Mr. COLLINS of Georgia. Yet, if you had done that, they would have cut your contract off.

Mr. CARTER of Georgia. Well, exactly.

Mr. COLLINS of Georgia. You can't engage in that kind of practice. It is just amazing.

Mr. CARTER of Georgia. Well, it begs the question: How did they know about it?

Here is how they know about it. What happens when you bring a prescription into a pharmacy is we fill that prescription and we adjudicate the claim. What that means is that the community pharmacy's computer calls the insurance company's computer and it tells you automatically whether they are going to pay it and how much they are going to pay.

Well, guess what?

That pharmacy that owns that insurance company that I just called, they have that information. Yes, there are laws against it. There is supposed to be a wall there in between them, but you tell me how that pharmacy knew that my wife had a prescription filled that day at the community pharmacy that I owned at that time.

□ 2100

Obviously, that is what is happening. Representative COLLINS, you have introduced your bill, a great bill. It has to do with MAC transparency, MAC, maximum allowable costs. Let me tell you very quickly what maximum allowable cost is.

We talk about acronyms. Well, nobody uses as many acronyms as the Federal Government uses. I tell people all the time that one of my goals in Congress is to learn at least 10 percent of all the acronyms that we use up here.

But the acronym, MAC, M-A-C, maximum allowable cost, what that is is that insurance companies come up with a list and they say this is what we are going to pay you. This is the maximum we are going to pay you. If you can't buy it any cheaper than that then, I am sorry; you are just going to lose money.

Well, that is okay to a certain extent. We understand that. We can work within that. But what happens is they don't update it, so all of a sudden—and you have seen it. We have all experienced what has happened with the spikes in drug costs here recently, particularly in generic drugs. What happens is that drug goes up. Well, the insurance company drags their feet and they don't increase that maximum allowable cost and, all of a sudden, the pharmacy is dispensing something at a loss.

Well, that is obviously a business model that is not going to sustain. You are not going to be able to stay in business if you are dispensing something and losing money on it.

Then, how do they come up with this MAC list?

What we are talking about here, and what Representative COLLINS' bill addresses is what is called MAC transparency. All we are asking here is to shine light on this, is to have some transparency, so we can see exactly what is going on. And that is what his bill does, and we appreciate his work on that very much.

His bill is a step forward, not only for the industry, but again, for the beneficiary, for the patient. That is ultimately who is going to save money, and that is ultimately what we are trying to do here.

It is no surprise that the costs are going up because of a lack of transparency in the system, no surprise at all. We have got to have more transparency, particularly in the pricing of generics if we are going to be able to create a stable and an affordable healthcare system.

Now, you heard mentioned here earlier, DIR fees. DIR, direct and indirect remuneration, and you heard mentioned clawbacks. Now, let me try to articulate this the best I can and what happens here with these DIR fees, which is something that has come up in the past probably year, maybe year and half or 2 years.

But what this is is, I mentioned earlier that, when the community pharmacy fills the preparation, we adjudicate the claim, that our computer calls their computer, the insurance computer, and it tells us how much they are going to pay. Okay. We are okay with that. We understand what we are going to get paid.

But yet, with DIR fees, months later, the insurance company comes back and says, oh, we told you we were going to pay you $2.50. No, we have got to take back that $2.50. We are not going to be able to pay you that.

Folks, obviously, that is not a sustainable business model. Nobody can stay in business that way. Yet that is the way DIR fees are being imposed now.

Thank goodness, just last week, Congressman MORGAN GRIFFITH from Virginia, our colleague, introduced a bill that addresses Medicare part D prescription drug transparency and DIR fees. I thank Congressman GRIFFITH for that.

Again, keep in mind, folks, we are not talking about, oh, we have got to make community pharmacies profitable. All community pharmacies want

to do is to compete. We just want to have the opportunity to compete on a fair, level playing field. That is all we are asking. We are not asking for any favoritism at all. Yet, when you have got an insurance company that owns the pharmacy, that is obviously a conflict of interest. Who cannot see that?

Again, Congressman GRIFFITH has introduced this bill, and it is a great bill. These DIR fees, a big unknown for pharmacists, as I mentioned. They can sometimes total up to thousands of dollars per month, and they can significantly complicate what your net reimbursement is going to be to cover your cost.

In fact, in a recent survey, nearly 67 percent, almost two-thirds of community pharmacists, have indicated they don't receive any information about when those fees will be collected or how large they will be—two-thirds, two-thirds of the pharmacies here.

And folks, I was so happy to see Representative LOEBSACK. He pointed out that he was the only Democrat here tonight, but I can assure you that there are other Democrats, because this is a bipartisan issue.

Listen, when you go to get a prescription filled in a community pharmacy, they don't ask you if you are a Republican or a Democrat. They could care less. All they know is you are a patient, and we need to take care of that patient, and that is what we are trying to do.

There is another bill that I want to touch on here. It is a very important bill. It is one that has been introduced by another good friend of pharmacy, Representative BRETT GUTHRIE from Kentucky. It is called the Pharmacy and Medically Underserved Areas Enhancement Act, and this is really the pharmacy provider act.

As I mentioned earlier, the pharmacists who are graduating today are so clinically superior to when I graduated. And Congressman SCOTT, I believe, mentioned earlier about the things that pharmacists are doing now: flu shots, immunizations, all of those things that pharmacists are able to do.

Pharmacists are the most accessible healthcare professionals out there. We in America, if we are ever going to get our healthcare costs under control, we have to take advantage of that. We have to take advantage of having that expertise right there before us and having it so accessible.

Representative GUTHRIE's bill, the pharmacy provider status bill, will give us the opportunity to reimburse pharmacists for those clinical services that they are capable of and that they are currently providing. This is something that needs to be done under Medicare part D.

I mentioned Congressman GRIFFITH and what he has done, and it really has been a blessing, then Congressman BRETT GUTHRIE and what he has done, and Congressman COLLINS and what he has done. All of these things are very, very important.

I want to mention one other thing, and that is something that has come out of the Energy and Commerce Committee this year, and that is the 21st Century Cures. 21st Century Cures is a great piece of legislation. That and the opioid bill that we passed earlier this year, I think, are two of the bills that I am most proud of since I have been a Member of this body; and part of that has to do with the fact that they are healthcare bills and I am a healthcare professional.

But 21st Century Cures is a great piece of legislation. It has been passed under the leadership of, as I say, Chairman FRED UPTON and the Energy and Commerce Committee. It has been critical in advancing research. It addresses so many different things.

It increases funding for the National Institutes of Health. It streamlines the process of the FDA and how they approve medications. It offers incentives to companies to come up with new innovations with new medications.

Right now we know of over 10,000 diseases that affect humankind, yet only 500 of them can be treated. 21st Century Cures addresses this. It is a great piece of legislation, and I would be remiss if I did not mention that.

Again, I want to thank Congressman COLLINS, and I want to thank all my colleagues who have spoken here tonight on a very, very important subject.

Again, folks, all we are saying is let us compete. I have had so many patients who have been, their parents, their grandparents, treated at our pharmacy; yet, because their insurance plan changed, they literally left our pharmacy in tears and had to go down the street and have a prescription filled somewhere else. That is not American. It is not right.

Again, I want to thank Congressman COLLINS for giving me this opportunity to speak on this, obviously something that I have dealt with all my life, my professional life. I am very proud of our profession. I am very proud of community pharmacy. I am very proud of the patient care that the community pharmacist and all pharmacists provide to the patients.

So I thank the gentleman for doing this and thank him for giving me the opportunity.

Mr. COLLINS of Georgia. I want to thank the gentleman for being a part and providing an insight that is—as I have said, for those of us who see this and call unfair unfair, and we are learning about it every day, you have lived it, and I think providing those insights is valuable.

The more we continue down this path, it just—and again, I spoke about it. I am on the Rules Committee as well. I talked about it in the Rules Committee, and it was amazing when I heard the other members. Some were on Energy and Commerce, some were on others, and they finally said, that deserves a hearing. MAC transparency deserves a hearing. Griffith's bill deserves a hearing. Guthrie's bill deserves a hearing.

These are things that actually save money, except for the coercive, twist-arm tactics of PBMs who just think that 83 percent of the market is not enough, 83 percent, roughly, of the market is not enough, that they get on people about mail order. They want you to turn—and your insight on how they actually know. That wall, that is the flimsiest wall I have ever seen. Maybe they will start building it better. I don't know. In north Georgia, we built them a little harder than that. But I appreciate that.

I want to go into something tonight, and it is something that we have talked about. It just explains how this works, because maybe some aren't as familiar; they haven't studied this and had a great staff. I have actually had a great staff that have put together—you know, Bob's here tonight. I have got a staff member who is still with me in spirit, but she is not with us. Jennifer has been working on this for a long time.

But I also had Daniel Ashworth. Daniel is an intern, a pharmacist intern who helped us out a lot and helped prepare this. I want to show you this. I showed you this at the beginning, and it is sort of—the PBMs are at the middle of the world here, if you will.

So let's just talk about this. Let's just start off with where it should start, and that is with the patient. The patient makes medication decisions, or he gets it from the doctor. And they are typically okay if you go this way, their employer. A lot of times the employee, their health benefit plan, that is where they get that.

So as we start here with the employers, the employers turn to PBMs or the insurance companies for plan decisions. So they turn to them and say here is how the plan is going to work. Here is how the plan operates. They expect the PBM to look after their best interest and to help save them money. That was the whole setup in the beginning, until they began to vertically integrate, to take on and become the main player in the market.

So what happens here is they make a plan decision to entrust the PBM to do that, and the PBMs, in turn, are supposed to give back the savings in this. We have already seen tonight how TRICARE has already saved $1.3 billion. This was their own internal study. We have also seen others where the fraud and abuse are not finding these savings.

So again, let's just continue on.

Pharmaceutical companies have an interesting relationship as well because, through rebates that they give to the PBMs or to incentivize, if you will, the use of drugs, their brand names, their ones under patent—which is very valuable. You are not going to find a stronger proponent of patent and copyright content in this Congress than me. What they are doing here is they are saying, okay, we are going to

give rebates back so you can purchase, and we are going to have brand preference so that you will encourage this brand over this generic or, frankly, this generic over this brand. And that is okay. We understand that.

This rebate is supposed to actually go into the savings part, but there is no transparency here. We don't know where it is going. And you are not getting the savings back over here where the rebates could.

And then we get to, really, the one that is interesting, and the pharmaceutical companies, through the pharmacy, and then back to patient care. This is where it gets interesting with the PBMs and their interesting relationships with the independent community pharmacies.

Predatory pricing, such as we are addressing in the MAC transparency list, where the numbers change, they are not sure. We get into the DIR fees. We get into all this stuff that has now become, instead of, for the PBM, the P in patient, the P actually should be—and I am not going to write on this beautiful chart, but I might as well just put ''profit'' because, as I have already discussed earlier tonight, the audits aren't about patient safety.

As Representative CARTER said, this is not about giving independent pharmacies or community pharmacies a leg up.

□ 2115

They don't want to be guaranteed a profit. They just want to be guaranteed to be able to open their doors and not be intimidated, coerced, or backed down by threats from PBMs that are much larger than them that basically say: we will put you out of business.

Madam Speaker, that is what they do.

They are supposed to have random audits. One of my pharmacists started laughing when we talked about random audits. They had the same audit about a year earlier. In other words, they are on a cycle. They just come back around the same time. These aren't random. They are not there for safety. They are there for profit.

It is frustrating. I have never seen anything else like this. It is the most amazing thing I have ever seen in which a business model that we have actually condoned—especially with the taxpayer money side—says that you can extort from pharmacies whatever you want. We will take back fees. We will put you on a metrics like Humana did. We will put you on a metrics that will give you the possibility of making more, but then inherently rig it against the small pharmacies. That is a problem.

They can't answer the question. If they had, they would have said it a long time ago. They just hope I go away and quit talking about this. But there are Members every time we talk, some couldn't come tonight, and every time we come down here and we shine light on this very dark subject, more Members come along and say: that doesn't sound right.

I know you have had those conversations, Representative CARTER. I have had those conversations. There are Members all over this Chamber that have experienced this in their own lives.

So I come to you tonight just saying, look, we put this here, and we look at the interaction. I am going to say, this is the most important part right here. It is about the patient. It is about the patient. We want to fix this. Let's look at how our money is spent. We want to fix this. Let's look at being able to come back weeks, months later. Let's talk about what the problems are here, but never forget the patient. It shouldn't be hard for them. Pharmacy benefit manager, the first letter is P. Let's just change it from profit to patient. Let's change it from being a facilitator to help pharmacies and help employers to market drugs to help the patient. Studies after studies show that it doesn't work.

Madam Speaker, we could talk for hours, but this is something we are going to continue to fight on. I appreciate the time we have had tonight, and this is not the end of this fight.

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

ZIKA FUNDING

The SPEAKER pro tempore (Mrs. MIMI WALTERS of California). Under the Speaker's announced policy of January 6, 2015, the Chair recognizes the gentleman from California (Mr. GARAMENDI) for 30 minutes.

Mr. GARAMENDI. Madam Speaker, I thank the gentlewoman from California for the opportunity to speak this evening. We have just been listening to a very lengthy discussion on the part of the healthcare issues in the United States, and, undoubtedly, the family or the small community pharmacist is a piece of the solution to the problems. But I want to spend the next 10 minutes or so, maybe a little longer, talking about a problem that currently affects some 19,000 Americans and a problem that is growing every day.

This is the new four-letter word that we fear. We are accustomed to a lot of four-letter words, but this one begins with a Z. This is the Zika crisis. This is a very, very real problem for some 1,600 pregnant women in the United States. This is a problem that men and women that intend to have a family, women that intend to bear children, get pregnant in the days and months ahead have a gut feeling of fear—a deep, deep fear—and husbands, spouses, and lovers similarly.

This is the Zika crisis. We have heard a lot about it during the Olympics. It hasn't passed off the radar screen except here in Congress. I know it is on the minds of Californians, over 500 in California, and nearly 15,500 Americans in Puerto Rico. They have that fear. They have Zika.

So all across this Nation, this new four-letter word is not used as a cuss word. It is a word of fear, and it is a word of trouble. Apparently, in the Halls of your Capitol, in the Halls of the United States Congress, it is ignored. Several months ago, we did pass a piece of legislation that was supposed to deal with this. But understand this: The Centers for Disease Control is about to run out of money at the end of this month and will have to stop research on Zika, on the virus, on vaccines, and on how it is spread.

We know that the mosquito is a piece of this, and we know it is prime mosquito time across much of the United States. Let me show you a map—a lot of blue on that map. That doesn't mean Democrat. That means Zika. Where you see the bright blue, that is where the Zika mosquito—the aedes—is found, and this is where we presently have cases.

South Florida, the only time in American history that there has been a travel alert for health reasons within the Continental United States is now found in south Florida. Why? Because now we have mosquitos that are spreading the virus.

In other parts of the Nation, we know that this mosquito is present, and we know it is going to happen, if not this year then next year. This is not something that is going to go away in the next few months as winter approaches. It will come back next year, and it will come back with a greater vengeance, just as the West Nile virus that spread across the United States is now found in most every State. But that is not an illness that leads to the tragedy of children being born with severe injuries that will affect them the rest of their lives, which may be a very short life.

This is a problem. This is a problem that your United States Congress is ignoring. There is a bill bouncing around, and it is loaded with a bunch of riders that are: What are you talking about? Riders that prevent women's health clinics from providing assistance to women. It is the women, after all, that bear the great burden of this. They are the ones that are going to be pregnant. They are the ones that will be carrying the children. But those women's health clinics cannot allow access to the money. What in the world is that all about? What foolishness. What meanness.

By the way, none of the money can be used for contraception. Give me a break. What do you mean? That is the legislation that is being proposed here in the United States Congress. Even the Pope has suggested that because of this crisis in Brazil that the steadfast opposition of the Vatican to contraception may need to be pushed aside. But not here in the House of Representatives. Come on. Let's get real. Let's understand the nature of this crisis.

The Zika virus is not transmitted only by mosquitos. We are discovering that the transmission can come in