So I am proud to announce that the Transportation Infrastructure Committee will authorize the VA to lease a new facility in Redding, California. This new lease will consolidate two buildings into one and will expand the regional VA square footage by over 50 percent in that consolidation, which will house an additional 17 mental health providers, a mammography division, and a second X-ray unit, significantly increasing the types of care available in Redding and in the north State.

Taxpayers will put up the money for the facility. Now it is time for the VA to ensure that this facility is properly staffed and these tax dollars are not wasted and instead respected, and, most importantly, that our veterans are respected with timely care.

THE UNSUSTAINABLE FUTURE OF STUDENT DEBT

(Mr. CARBAJAL asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. CARBAJAL. Mr. Speaker, I rise on behalf of millions of students and graduates in this country that are struggling to finance their higher education and pay off student loans.

Yesterday I invited Izeah Garcia to the President's address. Izeah is an advocate for increasing accessibility and lowering the cost of a higher education. Izeah and I share a similar story: sons of hardworking immigrant parents, and the first in our families to attend a university, both at UC Santa Barbara, located in my district.

Like many students today struggling to afford the rising cost of tuition, we relied on student loans to put us through college. In the President's speech last night, we didn't hear one mention of the over $1.3 trillion student loan debt crisis.

I urge this administration and Congress to commit to addressing the unsustainable future of student debt by allowing students to refinance their debt at a lower interest rate and expanding access to Pell grants. We can ensure that every student is afforded the opportunity to pursue a higher education and to better their lives, their communities, and our country.

HONORING ANGELA LARA FLORES

(Mr. VEASEY asked and was given permission to address the House for 1 minute.)

Mr. VEASEY. Mr. Speaker, I rise today to honor the life of Angela Lara Flores, a dedicated servant to her community and her family.

Angela was born in Palacios, Texas, on August 2, 1926, to her parents Cesario Lara and Lydia Teran.

She was a devoted, longtime member of Casa de Dios Presbyterian Church and served as the treasurer of the church for 32 years.

Not only did Angela give her time and energy to the church, but she was also known for her community service. She volunteered faithfully at a local senior citizens center in Dallas and even worked full time for the senior citizens center in Palacios.

Despite her busy schedule, Angela had time for her favorite pastime, and that was putting puzzles together with her family.

My heartfelt sympathy goes out to her four children—Jesse J. Flores, Lucinda Flores, Diana Flores, and Steve Flores—5 siblings, 19 grandchildren, 43 great-grandchildren, 8 great-great-grandchildren, and numerous nieces and nephews.

I ask my colleagues to join me in remembering Angela's 90 years of life.

OPIOID CRISIS AND PHARMACEUTICAL COMPANIES

(Ms. MICHELLE LUJAN GRISHAM of New Mexico asked and was given permission to address the House for 1 minute and to revise and extend her remarks.)

Ms. MICHELLE LUJAN GRISHAM of New Mexico. Mr. Speaker, we continue to see pharmaceutical companies put profits over people. Even though 33,000 people are dying every year due to the opioid crisis, Kaleo Pharma raised the price of a lifesaving opioid overdose medication from $690 in 2014 to $4,500 this year.

The pharmaceutical industry has not only misled consumers and their providers to create a system where there are more opioid prescriptions than adults in the United States, but they are now jacking up the price of lifesaving drugs and making money on this opioid crisis that they helped, in fact, create.

Meanwhile, the costs of the opioid epidemic fall on States, cities, communities, hospitals, counties, courts, and local communities who, quite frankly, do not have the resources to keep up.

This is why I introduced a bill which would impose a fee on the production of opioids and use the revenue for opioid prevention, treatment, and research programs across the country.

Pharmaceutical companies have to be part of solving the problem that they helped cause and to give back to the communities that opioids have ravaged.

THE IMPORTANCE OF COMMUNITY PHARMACIES

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

Mr. COLLINS of Georgia. Mr. Speaker, it is good to be back. It is good to be back on the floor, as we have been now, for the last few weeks doing the people's business, and we will continue to move forward.

I appreciate the last speaker discussing pharmaceutical prices. I think it is another issue, but we are going to go straight to really what I believe is the bigger cause of problems in our communities, and that is the pharmacy benefit managers and their monopolistic, terrorist kind of ways that they are dealing with our community pharmacies and independent pharmacies and actually causing problems in health care.

GENERAL LEAVE

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

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, as we get started now, we have a lot of speakers. This is something that has been on my heart for a while, and I know that it is something we have been getting more and more comments and questions about, especially when you are dealing with the pharmaceutical prices and the Pharma industry.

When they begin to look into it, they began to see that there was actually a bigger issue. It was not just big pharmacy and the problems that we do see in drug pricing. It was the end delivery that is going to the pharmacies and how the independent community pharmacists are being beaten down in a way that is really unseemly in our society. They are taking that healthcare line tonight.

I have a lot of speakers, and I have a lot of stuff that I am going to be talking about.

Just as an important reminder: A community pharmacist is an important niche in our healthcare system, serving as the primary healthcare provider for over 62 million people. Especially in our rural and suburban areas, this is a vital lifeline. Roughly 40 percent of the prescriptions nationwide and a higher percentage in rural Georgia—especially in northeast Georgia—are filled by our friends in the independent community pharmacy system.

Look, the problems that we have and we are going to be discussing even further tonight, we are going to delve into some issues that we want to see taken care of. We want to see this industry, especially in dealing with pharmacy benefit managers, put into proper perspective so that we can actually take care of our constituents.

A gentleman who has been a fighter and a leader with me on this from day one since I have been in Congress and dealing with this issue, especially with transparency, is the gentleman from Iowa (Mr. LOEBSACK). This is a fight that we are going to continue to keep fighting. I know he is as well, and we have a lot of friends tonight to help us out.

I yield to the gentleman from Iowa (Mr. LOEBSACK) as he continues to try

to tell the story that we have been trying to tell here for a long time.

Mr. LOEBSACK. Mr. Speaker, I really appreciate Representative COLLINS of Georgia's leadership on this issue. There is really no one in this body—maybe with the exception of Representative CARTER of Georgia—who can tell the story of community pharmacists the way Representative DOUG COLLINS does.

I thank Representative COLLINS of Georgia for putting this Special Order hour together. He has been such a strong leader on pharmacy issues. He has been a great partner on the legislation that we will be discussing this evening.

I am proud to say that this is a bipartisan issue, one of the few in this Congress at this point. It is one of the few in Washington, D.C., at this point. We have been able to find a consensus on this, at least with respect to one bill, and I think we are probably going to be able to do it with respect to others as well.

We know for a fact that pharmacists across the country serve as the first line of healthcare services for so many patients around this country.

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People count on pharmacists' training and expertise to stay healthy and to stay informed and, most importantly, to stay out of urgent care centers and out of hospitals. That is why I am proud to stand here today with my colleagues to recognize the quality and the affordable and the personal care that pharmacists provide every day.

Within that group of pharmacists, we have got a subset of pharmacists, and that is the community pharmacists and their pharmacies. They are also a great source not only of the expertise they provide, but economic growth in rural communities like those in my district and across the State of Iowa.

As Mr. COLLINS mentioned, rural areas are very important in this as well. I am a member of the Small Business Caucus. I recognize how challenging it can be for some of these small pharmacists to compete with the bigger companies. I appreciate their hard work to serve our communities.

Like most small-business owners, community pharmacists, they have to face challenges to compete and negotiate on a day-to-day basis with large entities as far as their business transactions are concerned. I frequently visit community pharmacists and I see the great job they are doing.

One pressing challenge facing many of our community pharmacists in particular that will be discussed tonight is the ambiguity and the uncertainty surrounding the reimbursement of generic drugs. Generic prescription drugs account for the majority of drugs dispensed by pharmacists, making transparency in reimbursement absolutely critical to the financial health of these small pharmacies.

But we know that pharmacists are reimbursed for generic drugs through what is called maximum allowable cost, or MAC. And this is a price list that outlines the upper limit or the maximum amount that an insurance plan will pay for a generic drug. These lists are created by pharmacy benefit managers, as Mr. COLLINS mentions, PBMs. This is the drug middleman.

There are lot of problems, but one of the problems is that the methodology used to create these lists are not disclosed. There is no transparency.

Further, they are not updated on a regular basis either, resulting often in pharmacists being reimbursed below what it costs them to acquire the drugs themselves. It 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 local pharmacies. And we know when they have a financial burden, that will affect their business, that will affect the economy in the area, and that is going to affect their patients as well. And we can't have that as we are moving forward, especially in this country, doing what we can to reform health care.

When we talk about reimbursement uncertainty for pharmacies, we are talking about uncertainty for those patients, as I just said.

So, look, when we deal with this issue, I think we have to be very transparent about it. We are going to be introducing later this week, on a bipartisan basis, this Prescription Drug Price Transparency Act. Specifically, what this act will do, it will increase transparency of generic drug payments in Medicare part D, in Medicare Advantage, the Federal Employees Health Benefits Program, and TRICARE pharmacy programs, by requiring that PBMs do three things; and Mr. COLLINS will flesh this out, and I think Mr. CARTER will as well.

First, provide pricing updates at least once every 7 days. Second, disclose the sources used to update maximum allowable cost—or MAC—prices. Third, notify pharmacies of any changes in individual drug prices before these prices can be used as a basis of reimbursement.

This is commonsense, bipartisan legislation. We are going to hear more about that in just a couple of minutes, but I am very thankful to be here to talk about these issues.

There is one more I want to talk about, if I might, Mr. COLLINS, and that is the importance of access to local pharmacies and Medicaid beneficiaries in particular. We know that Medicaid beneficiaries depend on their pharmacies as a provider of convenient, trusted care in their communities.

In addition to dispensing vital prescription drugs, pharmacies provide additional services to Medicaid enrollees, including immunizations, medication therapy management—a really big issue—and point-of-care testing like flu or strep tests. These are preventive and maintenance care services that help to fill in the gaps where provider shortages exist.

I know we are looking at reform and maybe replacing the Affordable Care Act, but we have to be very careful, too. We all recognize the importance of Medicaid, I think, going forward, and it is really important, certainly, for these pharmacies and these community pharmacists, and for their patients as well.

I thank the gentleman from Georgia. I really appreciate him including me in this process. This is bipartisan. It is important to so many communities, so many patients around America, and I am just happy to be here to say a few words.

Mr. COLLINS of Georgia. I appreciate the gentleman being here. I know there are others from across the aisle that are joining us in this fight, and we are looking forward to continuing.

Mr. Speaker, I am just going to highlight a few things as we go through, and we are going to move through some of our speakers.

Mr. Speaker, I want to highlight something that pharmacy benefit managers, PBMs, for those watching, may not know about, and they don't want you to know about it, and it is called spread pricing. Really, what happens there is PBMs have the maximum allowable cost, which is what Mr. LOEBSACK was just talking about, that determine the maximum amount a pharmacy will be reimbursed for certain generic drugs.

However, the PBMs' reimbursement price determinations are hidden. There is no transparency in the process. That is the bill that we are going to be putting out.

PBMs commonly manipulate the pricing by something called spread pricing. PBMs charge employers a higher price for drugs than necessary, and reimburse pharmacies at the MAC, or the maximum allowable cost, which is typically lower.

Spread pricing allows PBMs to skim money from the difference between the high rate they charge for a prescription and the low rate they reimburse pharmacies. Spread pricing is artificially raising the acquisition cost of pharmacy drugs by overcharging at the expense of retail pharmacies, consumers, and health plans. And that is probably one of the better things they do. This gets worse. We are going to continue to talk about it.

Tonight I look forward to hearing some more from my friend. I yield to the gentleman from Texas (Mr. BABIN). Welcome to the show.

Mr. BABIN. Mr. Speaker, I thank Congressman DOUG COLLINS for leading this very Special Order on a topic that is very near and dear to my heart, the invaluable role of community pharmacists in our society.

As a rural dentist who practiced for 35 years, I can relate to the plight of community pharmacists who must overcome all of the challenges involved in running a small business while serving their patients and serving their customers and doing their job as a medical professional.

Just like my small hometown of Woodville, Texas, where I practice, many of the areas in which community pharmacies are located are rural and have underserved, low-income and elderly populations. This can present unique challenges and, oftentimes, results in community pharmacists performing a lot of services, such as face-to-face counseling and planning services for patients' medication regimen at no charge, care that is uncompensated by Medicare and not typically reimbursed by private insurance companies as well.

What is even more challenging is the uphill battle that community pharmacists continually face in just getting adequate payment for the lifesaving medications that they dispense on a daily basis and still be able to earn a small profit.

Community pharmacists rely on pharmacy benefit managers, or PBMs, who negotiate directly with payors, including private insurance companies, as well as Medicare part D and other government plans, for reimbursement levels for medications. The problem is that the payment levels that make it up to the community pharmacists after the PBMs have ''skimmed off the top'' are well below the pharmacists' acquisition costs and fail to be delivered in a timely manner in many circumstances, in many instances.

Simply put, there is a dire need for more transparency throughout this process and for more accountability for PBMs. I proudly cosponsored legislation that would do just this last year. It was called the MAC Transparency Act, and I now proudly support this bill again in this 115th Congress. Now is the time to act on this bill.

As a dentist, it was my goal to treat each patient to the highest standard of care, a goal that I share with all of the community pharmacists that I know. Sadly, if there is no change in the conditions that community pharmacists are facing, many of these providers will have to close their doors. Many already have, and our patients suffer.

For the sake of many rural communities that I serve, I hope to see the MAC Transparency Act and other similar pieces of legislation move forward, as well as a greater spotlight put on the actions of the PBMs so that community pharmacists can get the relief that they so desperately need to continue practicing.

I thank Congressman COLLINS for his leadership on this issue.

Mr. COLLINS of Georgia. I think the gentleman is hitting on something and, Mr. Speaker, I think this is really something we need to discuss. We are not discussing simply a business model that was designed in a vacuum, that was designed to help.

Early on I stated this, and I state it every time we have this. PBMs, in their first iteration, as they first came about, were a good mechanism to provide pricing and between the pharmacies and the wholesalers.

The problem was when they became vertically integrated, when they started owning distribution chains, when they started owning their actual end-result pharmacies. When they started doing this, it became then that they are negotiating for themselves. And this is where the end-user—at the end of the day, the person who pays is the Federal Government, but also the customer, our constituents. This is what happens here, and we are losing community and independent pharmacists every day. This is just not right.

When three companies control 80 percent of the market and they use tactics like gag orders and other things, where they don't want their pharmacists to talk about it, where they send out letters saying that the pharmacist is not on their plan anymore when clearly the pharmacist is, but then refuse to send a retraction letter, this is just—I have said this, and I have had people call me after we have talked about this, Mr. Speaker, where they basically said it is amazing this is happening. And all I say is it is true, and it has never really been refuted.

Mr. Speaker, I yield to the gentleman from Tennessee (Mr. DUNCAN) and welcome him here to the floor to talk more about this important issue for our communities.

Mr. DUNCAN of Tennessee. Mr. Speaker, I thank the gentleman from Georgia for yielding, and I want to say that, in a short time in the Congress, he has become one of our greatest Members, and I appreciate him leading this effort tonight.

It is sad, it is unfortunate that, with any big government program, a small number of individuals or companies find ways to manipulate the system and become wealthy. That is why 6 or 7 of the 10 wealthiest counties in the U.S. are suburban counties to Washington, D.C., and that is wrong.

I have read for years about the revolving door at the Pentagon, about the defense contractors hiring all the retired admirals and generals. The same thing has happened with the Food and Drug Administration, that the big drug giants have hired all the former top people at the FDA, and we have a drug price crisis in this country today. There are many parts of it, but we want to talk tonight about one that most don't know about and you almost have to be a pharmacist to really understand what is going on.

But I rise tonight, Mr. Speaker, to join my colleagues in exposing, as I say, an almost unknown culprit in our Nation's drug price crisis, pharmacy benefits managers, also known as PBMs.

PBMs are essentially middlemen between pharmacies and drug manufacturers, but the legal relationships among PBMs, pharmacies, and drug and insurance companies have become increasingly entangled and complex.

For instance, one of the largest pharmacy chains also operates its own PBM, and one of the largest medical insurance companies also operates its own PBM.

PBMs are supposed to be helping keep down the costs of drugs by negotiating discounts and helping pharmacies with managing drug plans, as they often claim to do. Despite these PBM promises, though, I have heard from several pharmacy owners in my district who say that many PBMs are, in reality, ripping them off by drastically raising drug costs.

PBMs have tricks of the trade that include retroactively charging pharmacies more for drugs that they have already sold and processed. I am also told that PBMs also take too long to update the market value of the drugs on their covered drug lists. But these tricks are just two. PBMs use many more.

According to one expert and pharmacy owner in my district, he has seen three primary causes for recent increases in prescription drugs: one, FDA involvement, including requiring ''modern clinical trials'' of old drugs that have worked for decades; two, drug manufacturers needlessly hiking the price of generic drugs; and three, PBMs charging ridiculous prices for drugs and pocketing the profits.

According to my constituents, PBMs are the main culprit of the three. This pharmacist recently met with me and shared an eye-opening example. One of his senior customers came in with a prescription for a fairly common drug. The prescription had a real or actual cost of $23.40, but the pharmacist found that the PBM was charging a copay of $250, over 10 times the actual cost of the drug. The pharmacist chose to just absorb the PBM's ridiculous copay, and only charged his customer the actual cost of the drug.

Another pharmacist in my district emailed me, describing how PBM practices are accelerating seniors into the Medicare part D coverage gap, or doughnut hole. He said: ''All of these PBMs have these types of unfair compensations . . . This is not fair, and it hurts our seniors.''

Even more pharmacists in my district have also reached out to me, saying that they only get pennies on the dollar for the drugs they sell. PBM actions are forcing pharmacies to deny patients access to critical medications, or to give drugs away for free.

The Daily Times in Blount County, in my district, recently ran a story on PBMs called ''Sworn to Secrecy.''

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The article cites a pharmacist in Pennsylvania, Eric Pusey, who says that his patients' copays for drugs are often higher than out-of-pocket costs. Why? Because of PBM clawbacks. Mr. Pusey says that if he explains clawbacks to his customers, some get fired up and don't even believe what we are telling them is accurate.

Another pharmacist in Houston says: We look at it as theft—another way for the PBMs to steal. Most people don't

understand. If their copay is high, then they care.

Susan Hayes, a pharmacist in Illinois, says that these PBM clawbacks are like crack cocaine, the PBMs just can't get enough.

Some PBMs are facing lawsuits with accusations such as defrauding patients, racketeering, breach of contract, and violating insurance laws. Since 1987, when the first of the three largest PBMs incorporated, drug prices have increased 1,100 percent, Mr. Speaker, and per capita expenditures have jumped by 756 percent.

The three largest PBMs make up about 80 percent of the drug market, which includes about 180 million patients. These PBMs often conduct business through mail order practices. They sometimes will automatically fill prescriptions month after month even if the patient no longer needs the medication, resulting in terrible waste. Patients include veterans and Medicare beneficiaries—endangering them, wasting their benefits and taxpayer dollars, and driving up the cost of drugs.

As we heard President Trump say in his address last night, we need to look into the artificially high drug prices right away. A good place to start is PBMs. Mr. Speaker, PBMs must be more transparent in their operations so that they can be held to their promises and to the law.

I will just close by saying that PBMs must no longer be able to get away with conducting their business with such unethical methods that they are using now. In short, PBMs must be held accountable for their roles in the Nation's drug price crisis. I join in supporting our community pharmacists.

Mr. COLLINS of Georgia. The gentleman couldn't have laid it out any better. That is exactly what we are talking about. If every Member of our body would go home and just go to their community pharmacy, they would hear this all over the country. This is not new.

I have been on this floor now for almost 2½ years talking about this, and I have not had PBMs come to me and say: Well, no, that's not really true.

Because they do it. So I thank the gentleman for being a part and lending your voice in your community.

We are also very blessed in this body to have someone who doesn't have to come to it like I did in having to deal with it from a family perspective or from my community. We have someone who has actually done this for a living. He is my friend from southeast Georgia. He is a pharmacist. He has made this his life.

I saw he was up at his alma mater the other day, and, President Cathy Cox, I would have to say he is a Young Harris man.

Mr. Speaker, I yield to the gentleman from Georgia (Mr. CARTER).

Mr. CARTER of Georgia. First of all, Mr. Speaker, I want to thank Representative COLLINS for holding this tonight, for organizing this, also for his advocacy, and for what he has done to bring about attention to this very important subject. This, of course, is something that is very dear to my heart. As the only pharmacist currently serving in Congress, I take this very seriously. I take that responsibility very seriously.

But it is more than that because, you see, in my professional life, for over 30 years, I had the honor of practicing pharmacy. I have built up relationships over that time, relationships with families and with patients. When I see what is happening in pharmacy now, it is an affront. It is an affront to me, and it should be an affront to all Americans. My heart is in this, truly in this.

In over 30 years of practice, I have built up relationships with patients and with families. I have served grandparents, I have served parents, I have served children, and total families. You can only imagine the hurt that it brings whenever I see these people suffering because of what has been mentioned here tonight.

Right now, in our country, prescription drug prices are something that is in the forefront, in the news. There is a problem, a real big problem, and that problem—yes, the pharmaceutical manufacturers have a concern here, and they have responsibility. But there is a bigger problem. It is what I refer to as the man behind the curtain. I wrote an op-ed about this and talked about the man behind the curtain. That is the PBMs, the pharmacy benefit managers. I am going to call them out tonight.

Before I do that, I want to just say something about community pharmacists because they play such an important and vital role in our communities. They directly interface and build relationships with neighbors and friends. I have been there, I have done that, and I understand how important it is. Representative COLLINS has spoken about it, and Representative LOEBSACK, a friend of pharmacy, has spoken so many times. He has spoken about it as well. Representative BABIN and Representative DUNCAN understand how important the community pharmacies are and how important they are to the healthcare system.

But beneficiaries are facing increased costs for prescription drugs without much of a basis or notification on why these costs are skyrocketing. So, very quickly, I want to talk about why these costs are skyrocketing. Yes, as I said earlier, some of the pharmaceutical manufacturers need to be held accountable. They do.

I say that, but I also say that I am a big fan of the pharmaceutical manufacturers. You see, in my over 30 years of practicing pharmacy, I have seen nothing short of miracles. I can remember when I started practicing in 1980. I can remember that people would come in to get an antibiotic and that we would have to dispense 40 capsules and have them take four a day for 10 days. Now I can give them one capsule, and they can take it and be done with it. People were going into the hospital back then to be treated for infections. Now we can treat then. The advances that we have seen are phenomenal.

We talk about the price of some of these drugs, for instance, the drug that is used for hepatitis C. Yes, it is too expensive, and that price has come down significantly. It is only as good as it is affordable. If it is not accessible, if it is not affordable, then it is no good. But stop for just one minute, and think about it. We cured a deadly disease through research and development. The pharmaceutical manufacturers put some of their profits back into research and development, which I applaud.

We cured a deadly disease, hepatitis C, that was killing people. Again, that price needs to come down so that it is more accessible to people. But, again, we cured it. So I am going to cut the pharmaceutical manufacturers a little bit of leeway there.

I think it is interesting that the President, in his first month in office, called the pharmaceutical manufacturers to the White House. He told them: You got to do something about these escalating drug prices.

He also talked about those people who are on the other side of R&D, who are on the other side of research and development. He put a notice out, and he said: You better beware because we're going to be watching you.

The next day, the stocks of two of the major pharmacy benefit managers went down. They went down significantly, almost 2 percent, because they knew what was coming, and they know what is coming now.

First of all, let's talk about the profits of the PBMs. A quick history, PBMs came about kind of in the mid 1960s, and all they were was a processor. Their goal and their charge was just to keep up and to process insurance claims as insurance came about and became more and more popular to pay for medications. That is all they did.

But over time, they have evolved into more than that. If you look at what has happened over the past decade, the profits of the three major PBMs—and Representative COLLINS alluded to this earlier—you have got three companies who control almost 80 percent of the market. That is not good. That is not competition, and that is what we have to have in health care in order to decrease healthcare costs. It is competition. When you have three companies that account for almost 80 percent of the market, that is never good.

But if you look at those three companies and you look at their profits over the last decade, you will see that they have increased some 600 percent—billions of dollars. Now, you can make the argument, well, the pharmaceutical manufacturers, their profits have increased, too. Yes, they have; and, yes, they should be accountable for that. However, at least they are bringing value to the system by investing into research and development.

PBMs bring no value to the healthcare system at all. They put no money into research and development. All they do is skim it off the top. As medications go up in price, they make more. Representative COLLINS alluded to spread pricing. That is exactly what he is talking about, and that is exactly how they are making their money. The more expensive a drug, the more money the PBM is going to make. That's all there is to it.

I served on the Oversight and Government Reform Committee for the past session in the 114th Congress. We had a problem with Mylan Pharmaceuticals and a drug that they had, EpiPen. It went up to $600. Unbelievable. Here was a drug that is a lifesaving drug that people have to have for anaphylactic shock. We in Congress actually passed legislation that required that drug to be on hand in gyms and in schools in case there was a problem. Yet, they went up to $600.

It was really interesting because, during the time that we were asking questions of the CEO, she mentioned, well, when it leaves us, it is this price right here—I am just going to use round figures—it is $150. By the time it gets to the pharmacist and by the time it is dispensed to the patient, it is $600.

I asked her: What is that difference there? Where is that coming from?

I don't know.

I don't know either.

Now, there is the beginning and the end. The beginning is the pharmaceutical manufacturer. She doesn't know. The end is me, the dispensing pharmacist, and I don't know.

That is what I'm referring to when I talk about the man behind the curtain. That is where the PBMs come in.

Now, they will tell you: Well, we are taking that money, and we are giving it back to the companies, to the insurance.

Well, if they are, and they're not keeping any of it, then why are their profits going up so much? Why have their profits gone up over 600 percent? It's because they're keeping it. They're keeping it, and they're adding no value whatsoever to the system.

Now, they will argue the fact, they will say: Well, we are keeping drug prices down.

Oh, yeah? Well, how is that working out for you? It ain't working out very well at all because drug prices are going up.

I mentioned the competition, the fact that we have got three companies that control over 80 percent of the market. That decreases choices.

We are talking about community pharmacies, and I know that is what Representative COLLINS is really wanting to focus on here tonight, and it is so very important because we have to have community pharmacies. They are vital to the healthcare system. In many areas, the most accessible healthcare professional is the pharmacist, particularly in rural areas. As they go, and as they are eliminated, we are losing a vital part of the healthcare system.

But PBMs are shutting out a lot of these community pharmacies. I alluded earlier to the fact that I have served grandparents, parents, and grandchildren. I've built up those relationships. One of the toughest things that I have ever faced is for a family member to come in to me literally in tears and say: I have got to change pharmacies.

I say: Why?

Because my insurance company, because my PBM says that I have to get it from them through mail order.

Well, why would you have to get it through them through mail order?

Because they own the pharmacy.

Representative COLLINS alluded earlier about vertical integration, and that is what we see. The PBM owns the pharmacy that they are requiring the patient to go to. Well, guess what? That means they are padding their pocket even more. That is the kind of thing that we should be protected from.

I will give you a quick story, a true story. Back when I was still practicing pharmacy and owned my pharmacy, my wife had insurance through her employer. She had a different insurance plan than I had. She got her insurance, and she got a prescription filled at my pharmacy—at my pharmacy. Now, this is the pharmacy benefit manager who owns the pharmacy. That night when I got home, I got a phone call from the insurance company saying: Well, your wife got a prescription filled here at this pharmacy, but if she gets it filled at our pharmacy, we can give her a lower copay. We can give her a discount.

Now, supposedly there is a firewall in between the PBM and the pharmacy. Well, guess what? There wasn't that firewall there that night, not when I got that phone call.

□ 1915

Can you imagine? What is that doing? That is taking patients away from the community pharmacist. That is unfair business practices. So, that is what we talk about. Ultimately, who suffers?

I don't want to give the impression I am just here to try to make sure that community pharmacies stay profitable and make sure that they stay in business, although it is important. If they don't stay in business, who is going to suffer? It is going to be the patient. It is going to be the healthcare system.

Folks, the only thing that is going to bring down costs in our healthcare system is more competition and free market principles. That is what we are trying to do now in Congress, through the repeal and the replacement of the Affordable Care Act.

We understand that we have got to get free market principles back into the healthcare system. We have got to get competition in order to drive healthcare costs down. We understand that. This is a big problem, a big problem.

Very quickly, I want to talk about three bills that are being proposed. First of all, I want to talk about Representative COLLINS' MAC Transparency bill.

Transparency, that means give us an opportunity to see exactly what is going on. If you mention transparency to a PBM, they go berserk: My gosh, no, we can't have that. We can't have transparency.

But Representative COLLINS' bill, the MAC Transparency bill, which I am proud to be an original cosponsor of, brings about greater transparency in generic pricing—drug pricing, in general, but particularly generic.

Many of the recipients don't understand the cost structure. They don't understand how that works, where the original fees are originating from, which are often a direct result of the fees that are leveraged by the PBMs, the prescription drug plan sponsors.

Congressman COLLINS' bill addresses this issue, and it addresses more. Under his legislation, a process would be established to help mediate disputes in drug pricing. It would establish new criteria for PBMs to adhere to when managing the costs of prescription drug coverage.

This MAC Transparency bill is a step forward not only for the industry, but for the beneficiary, and that is what is so very, very important. It is no surprise that costs are going up. No surprise at all. With the lack of transparency, that is what is going to happen.

We have got to have greater transparency in the drug pricing system. And, yes, that includes pharmacy. Yes, that includes the pharmacy; yes, it includes the pharmaceutical manufacturer; but mostly, it has got to be with the PBMs.

If we have a CEO of a medication—a pharmaceutical company like Mylan which we had come up and testify before us here in Congress, and I ask her about that gap there and where that money is going, if she doesn't know and I don't know, there is a problem. That means we need more transparency. And that is exactly what happened.

Now I want to talk about another problem that is called DIR fees, direct and indirect remuneration. Let me tell you, this will be the death of community pharmacies.

DIR fees are what they refer to as clawback fees. What happens is, when you go into a pharmacy, you get a prescription filled, the pharmacy's computer calls the insurance company's computer, the PBM's computer, and it tells us how much to charge the patient in a copay and tells us how much we are going to get paid. However, with these DIR fees, months later, after we have already been promised how much we are going to be paid, pharmacists are getting bills from these PBMs that are saying: Well, we didn't make quite as much that quarter as we should have, so we are going to have to claw back this much.

I met with pharmacists from the New York State pharmacy association and they were telling me, literally, horror stories about getting bills for $85,000, $110,000 in clawback fees. Folks, that is not a sustainable business model. When you are trying to run a business, a community pharmacy, and you get a bill months later in the hundreds of thousands of dollars, that is not sustainable. You can't stay in business that way.

We have got to do something about DIR fees. Thankfully, Representative MORGAN GRIFFITH from Virginia has a bill addressing this. I am supporting him on that bill.

In fact, in a recent survey, nearly 70 percent of community pharmacists indicated that they don't receive any information about when those fees will be collected or how large they will be. Again, ultimately, who ends up being penalized? Who ends up being penalized is the patient. The patient ends up being penalized.

Understand, this is not a partisan issue. These PBMs don't care whether you are Republican or Democrat. They care about one thing, and that is profit. That is all.

Now, let's talk about one other. Let's talk about a bill that Representative BRETT GUTHRIE from Kentucky has, H.R. 592, Pharmacies and Medically Underserved Areas Enhancement Act. Under this bill, many of the individuals who seek consultation, especially seniors, can continue to receive that quality input and expertise.

This bill is known as the pharmacy provider status. Simply, what this will do is make sure that the pharmacists who give consultations are being reimbursed for that. That is vitally important.

Pharmacies are the front line in health care. There are so many diseases. The pharmacists who are graduating today are so clinically superior to when I graduated. Their expertise is beyond anything that I ever imagined it would be. We need to make sure that we are utilizing that. That is going to be a key in helping us control healthcare costs: utilizing all these allied health fields and making sure we are using them to their fullest potential. This bill will help us do that.

So there are just three bills that are being introduced right now with community pharmacists that impact pharmacy but, more importantly, that impact health care and that are going to help us have a great healthcare system and to continue to have a great healthcare system.

There are a couple other things that I wanted to mention. I am going to hold off on those because, again, I want to make sure that everybody understands the point that I am trying to make, and that is just how important, how vital the community pharmacies are and just how bad the PBMs are and how they are ripping off the public. They are ripping off the public. Look at their balance sheets. Look at the profits. Again, they want to argue, and they want to say: We are holding down drug prices.

Again, how is that working for you? It is not working. It is not working because they are pocketing the profits. If they were truly doing what they said they set out to do, we wouldn't see escalating drug prices like we are seeing.

Yes, there are some bad actors out there, as there are in every profession. Yes, we had Turing Pharmaceuticals and Martin Shkreli, the ''pharma bro.'' This guy was a crook, no question about it. We had Valeant Pharmaceuticals and what they did with Isuprel and Nitropress.

Just recently, Marathon Pharmaceuticals bought a drug that was available over in Europe. They brought it over here and got it approved in America. It is a very important drug for muscular dystrophy. Now they want to increase the price to an enormous amount that won't be affordable for patients.

Those are bad actors. As my daddy used to say, you are going to have that, and we understand that. We have Valeant and Turing and Marathon. We are calling them out, too. They need to be called out.

But we also need to focus on what one of the biggest problems is in escalating prescription drug prices, and that is the PBMs. They bring no value whatsoever to the system. They put no profit back into research and development.

Communities' pharmacists play an important role in our healthcare system. I am proud to support our community pharmacists. I am proud to have been able to practice in a profession for over 30 years that I know brings a great deal of value to patients and to their families.

Again, I want to thank Representative COLLINS, and I want to commend him for his hard work.

Representative AUSTIN SCOTT is here, also. He has been a champion of this as well. They understand. They get it. I appreciate their efforts on that, and I appreciate everyone who has been here tonight. I thank Representative COLLINS for hosting us here tonight. I appreciate his support.

Mr. COLLINS of Georgia. Before the gentleman goes, you told the story about getting a call from your own pharmacist. You and I were here together, I think, sometime 6 months ago. We were doing this and talking about this issue of mail order. We were talking about this.

I had a Member who was watching us on the floor talk about the pharmacy and the PBM problem and got a call from the PBM because they had gotten a prescription for their child. Yes, the day before they are getting a call in their office from the PBM saying: If you just switch from your local pharmacist, we will do it better. That is why we are sitting here.

An interesting thing you brought up on DIR fees. What we have right here sort of describes what you were talking about. I am putting it here so people can see it.

There is an interesting part of this DIR fee issue. It forces Medicare part D beneficiaries to pay inflated prices at the point of sale that are higher in actual cost than the drugs. The cost of the drug will be recouped in DIR fees, which is retroactively assessed later.

Many beneficiaries are moving past their part D benefit faster and hitting the doughnut hole sooner, forcing them to pay out-of-pocket costs. This is particularly true with lifesaving or specialty drugs. These are things that we are seeing.

Patients forced to pay out of pocket might be forced to cut back or abandon treatment. According to the Community Oncology Alliance, pharmacists lose $58,000 per practice, on average, to DIR fees each year. This makes it difficult for independent community pharmacists to keep up.

When patients pass through the doughnut hole into catastrophic coverage, guess who picks it up? CMS takes on the cost-sharing burden. This is why this matter is in Congress. These costs have increased from $10 billion in 2010 to $33 billion in 2015. This is just dealing with this issue.

We have got to have greater transparency on this. This is why Morgan Griffith's bill is good and we are going to continue to fight about this.

Again, I have yet to have a PBM tell me I am wrong here. I know from your experience you are seeing it as well.

I yield to the gentleman from Georgia (Mr. AUSTIN SCOTT), our other friend from south Georgia who has been outspoken on this. He comes to the floor to talk about his experiences with this as well.

Mr. AUSTIN SCOTT of Georgia. Mr. COLLINS, I had several parents in my office today. I thought I would talk about a couple of the meetings that I had.

I had a father there talking about his son Gabe. He had a T-shirt on with ''H4G,'' which stands for ''Hope for Gabe.'' I listened to him talk about his son and the life-threatening disease that his son has and the threat that his son is under because of a U.S. pharmaceutical manufacturer named Marathon. I would like to read part of an email that I have from him:

> Hope you are well. I just wanted to let you know that my son Gabe takes a drug called Deflazacort. He has since he was 5 years old. He is now 11. We currently pay $116 for a 3-month supply of 15-milligram dose for Deflazacort. We were getting this drug from Europe, as it was not available here in the United States, and have had no problem with access to date.

Now, many of you heard about this story. The FDA approved the same drug for sale in the United States. What did the drug manufacturer do with the price of it? Well, Marathon took the price from $116 a quarter to approximately $87,000 a year.

Now, this is what is happening. For drugs that are available everywhere

else in the world, it is not that they are being developed with extensive research and expensive research in our country. People are simply buying the right to sell the drug in the United States. As soon as approved and available in the U.S. marketplace, it is no longer legal for people to import that drug from Europe. Marathon priced the drug at $89,000 per year.

Reading again from his email, in bold letters:

It is the same drug we are getting today from Europe for $450 per year, the exact same drug. We need your help here. The Duchenne community needs your help, and specifically Gabe needs your help.

□ 1930

As I sit here and look at the American flag, you know, there is no other country in the world that allows their citizens to be treated like this. None. I am embarrassed that this Congress hasn't done anything about this abuse to the American citizens from the pharmaceutical and the PBM industry.

I know our President, and I am glad that we have a President with the courage and the boldness that our President has, had the executives to the White House. I would suggest that a good meeting also would be to have the parents—have the father of Gabe, have the mother of Gabe come to the White House. Sit down in the same room with the TVs on with the executives from those companies that are cheating these people. Let's let the executives explain on TV in front of the parents, in front of the child who needs that lifesaving drug why it costs $450 in another country but should cost $87,000 in America.

Another group of parents that was in my office today was there representing juvenile diabetes. I had a heart-wrenching discussion with a mother in my office in Warner Robins about her daughter, insulin-dependent. She has got to have it or she dies. This mother had a job, actually, in another country and talked about what she paid in another country to receive that same drug, insulin, for her child. It cost a fraction of what it cost in America.

I think it would be great for our President to have that mother and that daughter or the mother who was in my office today talking about her daughter come and sit down at the White House, and maybe the president of Eli Lilly could come and sit down. Maybe we could put the TV on, the cameras on so everybody in America could see the CEO explain why insulin, which has been around for decades, costs as much in this country as it does when it doesn't cost anywhere near that in any other country.

Something has got to give. Something has got to give. The American families have given enough. I am hopeful that we will move sooner rather than later. American families can't take it anymore. A drug that costs $450, that can be imported from Europe, shouldn't cost $87,000 in America.

On top of the issues with what is happening with the manufacturers, we have got the issue with the PBMs.

Why shouldn't you know what the PBMs are getting in a kickback?

Everywhere else you go, you get a price sticker. You know what the rebates are when you go to your local car dealer. They are readily advertised.

Why shouldn't you know as the American citizen?

My friend Mr. COLLINS and I have been working on it for years. We worked on it back in the State legislature. In fact, we passed a bill back in, I think, 1987, the first transparency act that we passed in the State legislature in Georgia. I hope that governors and members of the State legislatures will go back and address this issue as well. The transparency issues can be done at the State level. That bill came to the Georgia House floor, and it passed 150–0. Not a single Democrat, not a single Republican voted against that bill. Every single member who was there that day voted for the bill.

Mr. Speaker, we know something has got to be done. I just hope that we take action sooner rather than later.

I would just like to make one last request. Mr. President, I hope you will invite these parents and their children to the White House. I hope you will invite the CEOs of these companies to come and sit down at the same table, and I hope you will even invite the press to come and publicize the meeting.

I thank Mr. COLLINS so much for standing up for the American citizens. I am honored to be a friend of his, and I thank him for allowing me to be in the fight.

Mr. COLLINS of Georgia. Representative SCOTT brings out this issue with passion. That is exactly what we need as we go forward in this discussion.

This is exactly what the PBMs don't want to have. They don't want to have transparency. They don't want to talk about it. We have been talking about it now for years on this floor. It just continues to get worse.

In fact, the Prescription Drug Price Transparency Act that we are getting ready to introduce—and Mr. SCOTT and others are part of it—just the other day they were trying to undercut this bill.

I recently saw an interview with Mark Merritt. He is the CEO of PCMA, the trade group for PBMs. The article misrepresented PBMs' role in the marketplace. Now, that is a shocker, really. Distorting the facts to protect PBMs' ability to continue profiting at the expense of beneficiaries and taxpayers.

So tonight let's have a little fact check. Let's look at the claims by Mr. Merritt versus the truth.

First, Mr. Merritt claimed that PBMs play an important role in negotiating price discounts in order to pass those savings along to customers. In fact, what he said was:

We have an interest in lower price or bigger discounts . . . and we're going to negotiate the most aggressive discounts we can.

Well, it is true that PBMs do effectively negotiate huge discounts. However, the patients never see this discount or rebates reflected in their prices or out-of-pocket costs. These rebates and discounts merely pad PBMs' profit margins. They do not increase patients' well-being. This lack of transparency allows PBMs to receive massive rebates and refuse to pass those savings along to consumers or customers.

In fact, what is interesting, there is proof that transparency in MAC pricing saves more money than the PBMs are willing to admit.

You want an example?

Let's look to Texas. Texas has one of the oldest MAC-style laws. Texas passed MAC transparency legislation similar to the Prescription Drug Price Transparency Act in June of 2013.

Now, here we go, Mark, explain this one.

Since Texas passed their law, their Medicaid fee-for-service prescription drug expenditures for the top 100 drugs fell from $219.54 per prescription to $91.32. Yep, you are doing a good job negotiating for your bottom line.

What else does he say?

Number two, Merritt tries to distort the purposes of the Prescription Drug Transparency Act by drawing concern to transparency in the drug marketplace. Let's see what he says. He says:

The kind of transparency to be concerned about is where competing drug companies and competing drugstores can see the detailed arrangements that we have with all of their competitors.

Well, seeing as how they own part of the competitors, not really a lot of things going on there.

Our legislation simply would not allow competing drug companies to see detailed arrangements that PBMs have with competitors.

Mark, quit lying.

This statement is a misrepresentation of what the Prescription Drug Transparency Act does. Competing pharmacies would not be able to see the arrangements their opponents have with PBMs because they would not be publicly disclosed. Transparency measures and contractual agreements include confidentiality clauses preventing public disclosure.

May I remind Mark that he has gag orders in some States where the pharmacists can't even talk about these issues.

By the way, they send letters to pharmacists saying: Oh, don't go talk to your elected officials, because if you do, we will cut your contract off.

Wow, that is concern, Mark.

Furthermore, the disclosure of sources of drug pricing determinations remains confidential and is only disclosed to pharmacies and their contracting entities. PBMs distort transparency to mean only public transparency in an attempt to protect the profitability that comes with keeping their corrupt business practices in the dark. I wish he would have stopped there. He didn't.

Let's go on to the third. Mark Merritt says:

We want to make sure that wholesalers who sell to the drugstore aren't trying to sell the most expensive thing and pass the cost onto consumers.

All right. Here we go again. This is getting familiar. It has little to do with wholesalers. PBMs design the formularies—yes, we understand this, Mark—that dictate what drugs are covered by insurers. Because there is no transparency, PBMs are able to receive drugs at discounted prices but refuse to tell employers. PBMs are then able to still charge employers the full amount for the drug, even though they are receiving it cheaper. PBMs often receive large rebates to incentivize them to include expensive brand name drugs in their formularies, even though cheaper generics are available.

Mr. Speaker, listen. They receive large rebates to incentivize them to include the expensive brand name drugs on their formularies. I had an issue just like that with my own mother just recently. She needed medication. She had been on it for 8 months. They had to reauthorize it after the first of the year.

I asked: Well, is there another issue she could have?

They said: Well, this is the only one on the formulary.

PBMs don't control pricing; PBMs don't control what drugs come to market. Another falsehood. PBMs substitute expensive drugs and overcharge Medicare part D, TRICARE, and FEHB programs. This means they are lining their pockets with money from the taxpayers.

Fourth thing:

If drugstores like those terms, they can sign a contract; and if they don't, they can join with some other plan or PBM.

Oh, I love this. This is classic, Mr. Speaker. PBMs hold a disproportionate share of the marketplace. We have already talked about three of the largest PBMs own 80 percent of the market—80 percent. Because PBMs have a stranglehold on the market, community pharmacists cannot stay in business without being forced to contract with them. It forces community pharmacists to sign take-it-or-leave-it contracts with anticompetitive and unfair provisions, and from transmitting it without written consent. These are just crazy.

I had—one of my pharmacists who was on their plan actually had a letter sent to their customers who said: You are no longer on the plan.

He called the PBM. The PBM said: No, you are still on the plan.

He said: Then why did you send a letter out?

PBM said: Oops, must have been a mistake.

He said: Well, why don't you send a letter out telling them that they are wrong?

PBM said: Oh, we don't do that. That is on you.

Yeah, because all you want to do is keep the money, follow the money. Mark, it is easy. I understand running a trade association is tough, but at least be honest about it.

The last thing. Community pharmacists typically get paid more by plans because there is not as much competition. Well, five for five. Community pharmacists in northeast Georgia and across the United States are under constant threat of going out of business because of PBMs. PBMs exploit the market, prey upon community pharmacists, using spread pricing and retroactive DIR fees. PBMs also use a disproportionate share of the market to steer patients to pharmacies they own themselves.

The Prescription Drug Price Transparency Act is vitally important to improving fairness and transparency in the healthcare system. Community pharmacists must be kept in business and patients should have the choice to receive care from their local pharmacists. Community pharmacists might be afraid to stand up to PBMs. Community pharmacists many times are basically scared into submission.

I have stood on the floor of this House many times. My pharmacists can't speak, but I can, and I will remind the PBMs one more time: You can't audit me. You can go audit for profit, which you do every day. You can go hit them, but you can't hit me.

I will continue to be a voice for community pharmacists. These Members are being a voice for community pharmacists. Our numbers are rising every day. The President himself has actually begun to look at those middlemen and those pricing.

Tonight ends another night of telling the truth when the truth needs to be told. Mr. Speaker, we end another time of standing up for the American people and the community pharmacists.

I yield back the balance of my time.

CONGRESSIONAL PROGRESSIVE CAUCUS: REACTIONS TO THE PRESIDENT'S ADDRESS TO CONGRESS

The SPEAKER pro tempore. Under the Speaker's announced policy of January 3, 2017, the gentlewoman from Washington (Ms. JAYAPAL) is recognized for 60 minutes as the designee of the minority leader.

GENERAL LEAVE

Ms. JAYAPAL. Mr. Speaker, I ask unanimous consent that all Members have 5 legislative days to revise and extend their remarks and include extraneous material on the subject of my Special Order.

The SPEAKER pro tempore. Is there objection to the request of the gentlewoman from Washington?

There was no objection.

Ms. JAYAPAL. Mr. Speaker, today I stand here for this Special Order on behalf of our Congressional Progressive Caucus, and we have decided that we would like to use this Special Order hour to address our reactions to the President's address to the Union last night.

Before I offer my part of those remarks, Mr. Speaker, I yield to the gentleman from Maryland (Mr. RASKIN), my friend and colleague.

Mr. RASKIN. Mr. Speaker, I thank Congresswoman JAYAPAL. She has been a sensational leader within the Democratic Caucus and within the Congressional Progressive Caucus, especially on the issues of immigration and the rights of refugees. It is such an honor to be able to serve with her. I appreciate being able to spend some moments just reflecting on what took place in our Chamber last night with the President's speech.

We should start by giving credit where credit is due. This speech was not ''American Carnage II.'' It was a vast improvement, I would say, over all of the violent and apocalyptic imagery and rhetoric that we saw in the inaugural address. So hats off to the President's new speech writer, whoever that may be.

However, having said that, I think it is simply old wine in a new bottle. The same basic extremist Steve Bannon infrastructure governed that address despite the fact that the manners had improved considerably.

□ 1945

When I thought about President Trump's speech in this Chamber last night, I thought about George Orwell. Not because of 1984, although I admit that my well-thumbed copy of this great dystopian novel is sitting on my desk right now and the words ''war is peace'' and ''ignorance is strength'' have been running through my mind over the last several weeks. No, I thought of Orwell not because of 1984, but because of a great essay he once wrote called ''Notes on Nationalism.''

In this essay, George Orwell contrasted patriotism and nationalism—two concepts that often get conflated. But at least, in his view, they represented two very different things. Patriotism, he argued, was a positive emotion, a passionate belief in one's own community—its people, its institutions, its values, its history, its culture.

An American patriot today, I would argue, believes in our magnificent constitutional democracy—our Constitution; our Bill of Rights; our judiciary and our judges; our States and our communities; our poets like Emily Dickinson and Walt Whitman and Langston Hughes and Merrill Leffler; our philosophers like John Dewey and Ralph Waldo Emerson; our extraordinary dynamic culture which invites and absorbs new waves of people from all over the world, our artists, our musicians like Bruce Springsteen, the Neville Brothers, and Dar Williams. All of these people and things are what we love about America, and they evoke the positive emotion of patriotism.

Patriotism is all about uplifting people; drawing on what is best in our history; finding what is best in our culture; invoking our Founders, Madison,