



## JOINT STATEMENT

### Testimony in opposition to Connecticut Senate Bill No. 8 ("AN ACT CONCERNING DRUG AFFORDABILITY")



March 18, 2024

**Bill Name:** AN ACT CONCERNING DRUG AFFORDABILITY

**Bill Number:** CT SB 8

**Testimony:** ADAP Advocacy and the Community Access National Network (CANN) hereby submits the following testimony in opposition to Connecticut Senate Bill No. 8 ("AN ACT CONCERNING DRUG AFFORDABILITY") in the Senate Human Services Committee. We are opposed to this bill on two fronts:

#### **The Authorization of Drug Importation from Canada**

Our concerns around the importation of prescription medications from Canada are as follows:

- (1) Importing medications from Canada risks the introduction of unsafe or counterfeit products entering Connecticut's prescription drug market. The [Drug Quality and Security Act](#) (DQSA, 2013) requires the implementation of interoperable electronic tracing of pharmaceutical products at the package level to identify and trace certain drugs as they are manufactured, distributed, and dispensed in the United States. This system helps to ensure that the medications that reach American citizens are safe and authentic by limiting their exposure to drugs that may be counterfeited, stolen from wholesalers or manufacturers, contaminated, or otherwise harmful. This type of system does not currently exist within the Canadian government's infrastructure, which will make it virtually impossible for individuals, healthcare providers, pharmacists, law enforcement agencies, and other state agencies to definitively trace a batch of medications purchased from Canadian wholesalers back to the manufacturer of origin. This concern is not conjecture, but grounded in fact: in 2018, a [Canadian drug firm admitted to selling counterfeit and misbranded products in the United States](#). This firm included a number of companies, including Canada Drugs, Rockley Ventures, and River East Supplies. While these companies were sentenced to forfeit \$29 million in proceeds, to pay a fine of \$5 million, and to five years of probation from operating in the United States, this is emblematic of the concerns we have about the importation of medications from Canadian wholesalers.
- (2) The drugs most likely to be imported from Canadian wholesalers are those designed to treat the most medically vulnerable populations. Many of the [costliest drugs for state drug programs](#) are those for the treatment of diabetes, cancer, and other chronic illnesses. While SB 8 currently prevents the importation of infused and injectable drugs, other medications, such as Imbruvica (ibrutinib, Janssen), Jardiance (empagliflozin, Lilly), Januvia (sitagliptin, Merck), Trulicity (dulaglutide, Lilly), Xarelto (rivaroxaban, Janssen), Eliquis (apixaban, Bristol-Myers Squibb & Pfizer), and Revlimid (lenalidomide, Bristol-Myers Squibb), represent some of the costliest medications for state healthcare programs and are likely to be the candidates selected for importation in an attempt to mitigate those costs. These medications are vital for the continued health of the patients taking them, and the risk that the medications they depend upon for their survival might be counterfeit is an unnecessary risk that Connecticut's legislature should not be willing to accept.

- (3) The Canadian drug supply cannot support the importation of medications to the United States. Despite the optimism from advocates for wholesale drug importation from Canada, the reality is that the country simply does not have the supply of medications necessary to meet the needs of the American population and [they have enacted regulations](#) to discourage programs such as this. SB 8 does not stand alone in its attempts to authorize and implement the importation of medications from Canada—Colorado, Florida, Maine, New Hampshire, New Mexico, North Dakota, Texas, and Vermont have [all passed legislation](#) authorizing the establishment of importation programs. The population of Canada is approximately 38.25 million, while the population of those eight states combined is 65.34 million—more than 52% greater than Canada’s population. With Connecticut’s approximately 3.62 million citizens, Canadian wholesalers cannot feasibly supply medications to both its citizens and to those in the states who have or are considering authorizing drug importation, particularly when Canada is [already facing drug shortages of its own](#).
- (4) The importation of medications from Canada is unlikely to reduce the costs associated with purchasing and distributing medications to patients in Connecticut. In order to satisfy the stringent requirements set forth in §251–Section 804 of 85 FR 62126—the Importation Program—Connecticut will need to spend significant resources to establish a Foreign Seller and an Importer for the proposal to the United States Food and Drug Administration (FDA), determine which drugs it plans to import, ensure the security of the supply chain, and the literally dozens of other strictures necessary to successfully set up the state’s new drug importation infrastructure. Florida—the only state to successfully receive approval from the FDA for its program—has already [spent over \\$40 million](#) just securing approval without importing, purchasing, or dispensing a single drug to patients. Should Connecticut authorize importation, it will also have to compete with any other states who have enacted similar legislation, thus increasing the scarcity of medications and driving up their price.

We urge legislators to reject the Canadian importation provisions of SB 8 (Sections 1 to 9).

### **The Establishment of the Prescription Drug Affordability Board**

Our concerns around the establishment of a new Prescription Drug Affordability Board (PDAB) are as follows:

- (1) SB 8, Section 10, as written, does not require the PDAB to include patients in its Board. Section 10 instead requires appointed members to have “...an advanced degree and experience or expertise in health care economics, health services research, pharmacoeconomics, pharmacology, or clinical medicine. At least one such member shall have direct experience with consumer advocacy and health equity.” This requirement essentially precludes patient expertise, housing the focus of the PDAB on the “supply” side of the supply and demand equation. While Section 11 attempts to establish a purportedly balanced Prescription Drug Affordability Stakeholder Council, the composition of the Council—21 members who are either appointed by or are themselves elected officials—will be unacceptably influenced by political and business forces. This creates a circumstance in which for-profit entities could potentially sway elected officials to appoint specific members to the Council who could serve as advocates for positions that will increase their own financial gain to the exclusion of patient savings.



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- (2) SB 8, Section 10, as written, does not require that any recommendations or decisions made by the PDAB directly impact the costs patients pay for medications, instead focusing on the price that Connecticut agencies pay for to acquire medications. This means that any savings realized through acquisition costs of medications are not required to be passed down to consumers in the form of lower prices paid at the point-of-sale (i.e., pharmacies). Evidence indicates that, when patients are unable to afford the medications they need, they often behave in very specific ways: (1) Patients may be forced to choose between cost-of-living expenditures and purchasing medications. In many cases, patients choose to forego medications; (2) Patients may attempt to acquire medications from other sources. These sources may include (but are not limited to): online pharmacies based abroad, black market sources, or individuals. When patients attempt to access medications through these sources, they risk receiving products that are improperly compounded, counterfeit, placebos, or that contain components such as fentanyl or xylazine, thus placing them at risk of developing comorbid conditions if the drugs fail to treat their conditions or at risk of death from overdose.
- (3) As written, the PDAB may establish the rates of reimbursement that a pharmacy will receive for the dispensing of medications, but cannot set the actual acquisition costs that pharmacies must pay to acquire them. This could potentially result in pharmacies paying more for the medications they dispense than they will receive in reimbursement. In addition, the focus on Upper Payment Limits (UPLs) will have negative downstream consequences for pharmacies and healthcare providers who rely upon rebates received from participation in the 340B Drug Pricing Program by decreasing the rebate amounts received:

Under the program, qualified clinics and other covered entities buy treatments at a discount to help treat vulnerable patients and get to keep the difference between the reimbursement rate and the discounted price leveraging those dollars to provide needy patients with medications and care they might not otherwise be able to afford. Under a UPL, health facilities such as hospitals or clinics will receive lower reimbursements for prescribed treatments and therefore generate fewer dollars to support patients and the care we need to live and thrive. If the PDAB sets restrictive UPLs for drugs for chronic conditions like HIV, health facilities and the health professionals tasked with providing care will be faced with the decision to potentially stop prescribing these medicines and face having to cut support services that patients have come to rely on ([Laws, 2023](#)).

#### Closing

While ADAP Advocacy and the Community Access National Network absolutely supports efforts to increase the affordability of and access to prescription medications for patients, we believe that SB 8 will not result in net savings, either for the state of Connecticut or for patients living or purchasing medications in the state, and will in fact increase the risk that patients will encounter ineffective, counterfeit, or deadly medications in Connecticut's legitimate drug supply chain. We encourage the Senate Human Services Committee to reject SB 8.

Respectfully submitted by,

A handwritten signature in black ink, appearing to read "Brandon M. Macsata". The signature is fluid and cursive, with the first name being the most prominent.

Brandon M. Macsata  
CEO  
ADAP Advocacy

A handwritten signature in black ink, appearing to read "Jen Laws". The signature is cursive and elegant, with the first name being the most prominent.

Jen Laws  
President & CEO  
Community Access National Network