JOINT STATEMENT

Testimony in opposition to Connecticut Senate Bill No. 8
(AN ACT ADDRESSING PATIENTS' PRESCRIPTION DRUG COSTS)

March 10, 2025

Bill Name: AN ACT CONCERNING PATIENTS' PRESCRIPTION DRUG COSTS

Bill Number: CT HB6870

Testimony: ADAP Advocacy and the Community Access National Network (CANN) hereby submits the following testimony in opposition to Connecticut House Bill No. 6870 ("AN ACT CONCERNING PATIENTS' PRESCRIPTION DRUG COSTS") in the Joint Committee on Insurance and Real Estate. 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 into 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 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 . 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 HR6870 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. HR6870 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 that 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 HR6870 (Sections 1 to 10).

"Reference Pricing"

Our concerns around the use of so-called "reference pricing" as a rate-setting measure under the guise of so-called "reference pricing":

(1) HR6870, Section 11, as written, is substantially similar in design as to last year's failed effort to establish a "Prescription Drug Affordability Board" by way of rate-setting, *without* even that modicum of effort to understand the dollar flow of the drug supply chain, public health funding mechanisms, or the "shining", moral veneer of prioritizing patient "affordability".

(2) "Reference pricing" is limited in federal and federally-funded programs because legislators, writ-large, understand the distinct value private re-investment offers the American public. Indeed, the section of federal code cited is nestled within the bosom of federal programs limited to serving only the "aged and disabled" (Social Security code), not the general public. This notion of using today's profits to fund tomorrow's cures appears absent from Governor Lamont's short-sighted request. While this request should be rejected for the base, ethical, and economic cheapness of sacrificing tomorrow's lives for today's pennies, alone, more reasons follow.

(3) Beyond the easily foreseeable implications of limiting future cures investments, the statutory design offered seeks to use a rate-setting metric that is already prone to abuse and place the responsibility, including civil penalties, upon actors that do *not* control the actual ability to impose such rates. Herein, "rates" refers to the measures of "average wholesale price" (AWP). Indeed, the Federal Trade Commission (FTC) has taken great pains to highlight the role of Pharmacy Benefit Managers (PBMs) in harming patient access and state affordability of medications. In the FTC's formal complaint naming the three largest PBMs in the country, the FTC painstakingly outlines how PBMs specifically select for higher wholesale cost/higher rebate medication offerings and exclude lower-priced versions of the exact same medications. By placing the blame for list prices and thus distribution costs exclusively on manufacturers and distributors, Governor Lamont not only fundamentally misses the mark on which actor exerts excised power on drug prices, but he does so while requesting the legislature find its own profiteering off the backs of those same actors.

The following exerts display how PBMs hold the responsibility of "high-costs" at the expense of patients and manufacturers alike, which the Governor appears to be blind to:

(a) ***C. The PBM Respondents exclude low WAC versions of other drugs from formularies***
249. In addition to insulin, the PBM Respondents exclude or disadvantage low WAC versions of other drugs in favor of the high WAC versions. For example, in January 2019, Gilead Science (through a subsidiary) launched low WAC versions of its Hepatitis C medications Harvoni and Epclusa at significant discounts to the high WAC versions. Although brand companies sometimes offer low WAC versions of their drugs in response to competition from generic drugs, Gilead launched these low WAC versions unprompted by that prospect: Harvoni and Epclusa were years away from the threat of generic entry. The PBM Respondents all preferred the high WAC versions of both drugs on their 2024 flagship formularies and excluded the low WAC alternatives.

(b) 11. Worse, Respondents' tactics have effects beyond insulin. The Respondents' demand for larger rebates has also inflated list prices for other critical drugs, including treatments for autoimmune diseases and inflammatory conditions. Patients whose out-of-pocket costs are tied to these inflated list prices may spend hundreds of dollars per prescription. In some cases, the patient may pay more at the pharmacy counter than the actual cost to their commercial insurer. In other words, the insurer functionally makes a profit from the prescription instead of paying its share of the cost. ***This turns the normal insurance model on its head with the sick subsidizing the healthy, rather than the other way around (emphasis added).*** *As one PBM manager bluntly put it: "I don't see how it's justifiable to charge someone 100% of the cost of the drug."*

(during the deductible [phase]), while you receive a rebate on the backend … I can't think of any other insurance industry that works like that[.]"

(4) Lastly, the state Medicaid program, qualified clinics, and other covered entities buy treatments at a discount or otherwise receive rebates under either the 340B program or the Medicaid Drug rebate Program (MDRP) to help treat vulnerable patients, sustain public health programs, and otherwise reinvest savings to provide needy patients with medications and care they might not otherwise be able to afford. Under a "reference pricing" design, 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. Similarly, fewer dollars would be available under the MDRP to reinvest in the state's Medicaid program, shifting sustainable funding burdens more to state appropriators and away from existing funding mechanisms (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 HR6870 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 HB6870.

Respectfully submitted by,

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