Issue: VA Prescription Drug Pricing Policy

Prescription Drug Pricing: Opportunities for State Legislation

The high cost of prescription drugs is a serious concern for all Americans. Despite much talk by the administration about helping those who are in need, it has done very little. Therefore, it is important for state legislatures to seize the initiative and enact meaningful legislation rather than waiting for Washington to act.

Background

What are the Issues?

- **Americans pay the highest drug prices in the world**. Humira, for example, is an anti-inflammatory drug used to treat rheumatoid arthritis and Crohn's disease. A prefilled carton with two syringes costs $2,669 in the United States, compared with $1,362 in Britain, $822 in Switzerland and $552 in South Africa, according to a 2015 report from the International Federation of Health Plans.[1]

- **The price of drugs has risen ten times the rate of inflation**. Senator Claire McCaskill said: "Can you imagine if you went to an auto dealership and last year's exact model was being sold at a 20 percent mark-up, and then you went back the next year and it had happened again?"[2] According to the 2018 McCaskill report, "12 out of the 20 most commonly prescribed brand-name drugs for seniors had their prices increased by over 50 percent in the five-year period."[3]

  At least 25 prescription drugs were launched in 2018 at prices exceeding a list price of $30,000 annually or for the course of treatment, according to an analysis for The Wall Street Journal by GoodRx.[4]

  The cost of insulin—a drug used by people with diabetes—doubled between 2012 and 2016, according to the Health Care Cost Institute.[5] The price of Humira has risen from about $19,000 a year in 2012, to more than $38,000 in 2018, after rebates, according to SSR Health, a research firm. That's an increase of 100 percent for a year's supply.[6]

  Specialty drugs for rare and serious diseases as well as generic drugs are some of the most expensive and overcharged medications. In early May 2019, 44 states filed a lawsuit against some leading drug companies - Teva, Pfizer, Novartis and Mylan - alleging that they conspired to inflate the prices of generic drugs by as much as 1,000 percent. The scheme affected the prices of more than 100 generic drugs, according to the complaint.[7]

  Mylan's pricing for EpiPens, needed for emergency treatment of a serious allergic reaction, caused the US government to file a lawsuit, claiming that it had been overcharged. The suit was settled in August 2017 for $465 million. From 2007 to 2016, Mylan raised the list price of its EpiPen about 500%, from just under $100 to more than $600. Its generic version sells for $400.[8]

- **Why is it so hard to fix the problem?** The pharmaceutical industry is one of, if not the most, powerful lobby in Washington and in many state capitals. More lobbying money is spent on health care than any other economic sector—an astounding $280 million dollars on lobbying in 2018.[9] The industry aggressively lobbied in 2006 to prevent Medicare Part D from negotiating directly with manufacturers.[10]

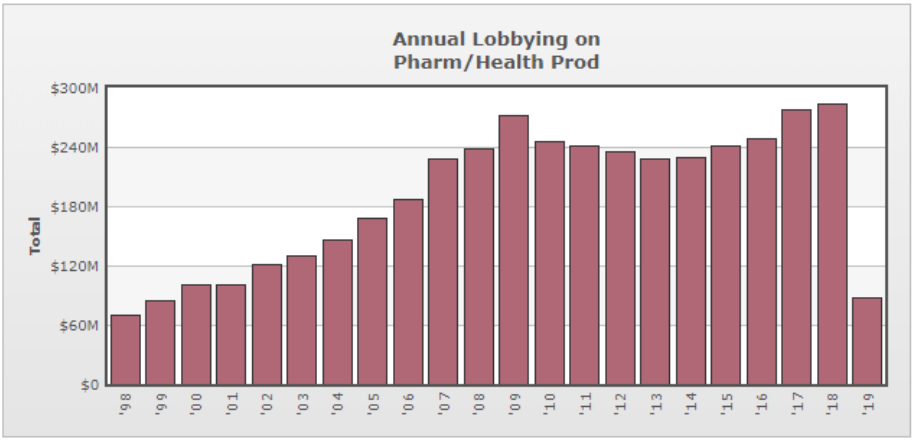

Figure 1 - 2018 Pharma Lobbying Spending *Exceeded $280M*[11]

On May 8, 2019, the administration announced a new rule that requires pharmaceutical companies to include the price of prescription drugs in television advertisements if the cost exceeds $35 per month. On June 14, 2019, three pharma companies and a trade group sued, arguing that the rule is illegal because it violates the companies' First Amendment rights.[12] The rule would have taken effect July 9th but on July 8th, a federal judge ruled that the administration could not force the disclosure of list prices in TV ads.

Additionally, the complex, opaque, and secretive structure of the financial incentives that go into drug pricing and distribution including rebates, discounts and third-party payments, (see flow chart below) makes it exceedingly hard to change the system[13]. Each player is maximizing its profits and responding to incentives. And these incentives are definitely not in the interests of consumers.[14]

And finally, the US patent system, while successful at promoting innovation, confers years of monopoly pricing for a product. Pharma companies have taken advantage of the patent system by making minor changes to a product, (for example, getting a new patent for a new dosage amount or going from 3 times/day to 2), thus extending its patent life. In fact, 78% of "new" drug patents are secondary patents on existing drugs, not a novel new drug.

- **Pharmaceutical companies are some of the most profitable companies in the country**, yet taxpayer-funded research by the National Institute of Health contributed more than $100 billion to the 210 drugs approved between 2010 and 2016.[15]

Who is impacted?

- Nearly one in three adults have not taken full doses of medicine as prescribed due to its costs ***and*** nearly one in three consumers facing increased drug costs spend less on groceries to account for the increase.[16] According to results from a recent Kaiser Family Foundation

survey, nearly 3 in 10 people across the country skip doses or forgo filling prescriptions altogether due to high costs.

- Individuals on high-deductible plans or uninsured, as well as those with co-payments based on a percentage of the price are vulnerable to rising drug prices. Seniors taking multiple medications are impacted because they will reach the Medicare Part D "donut hole" and be out of pocket for $5,100 while in the coverage gap. People with good health insurance and fixed co-payments are not affected.

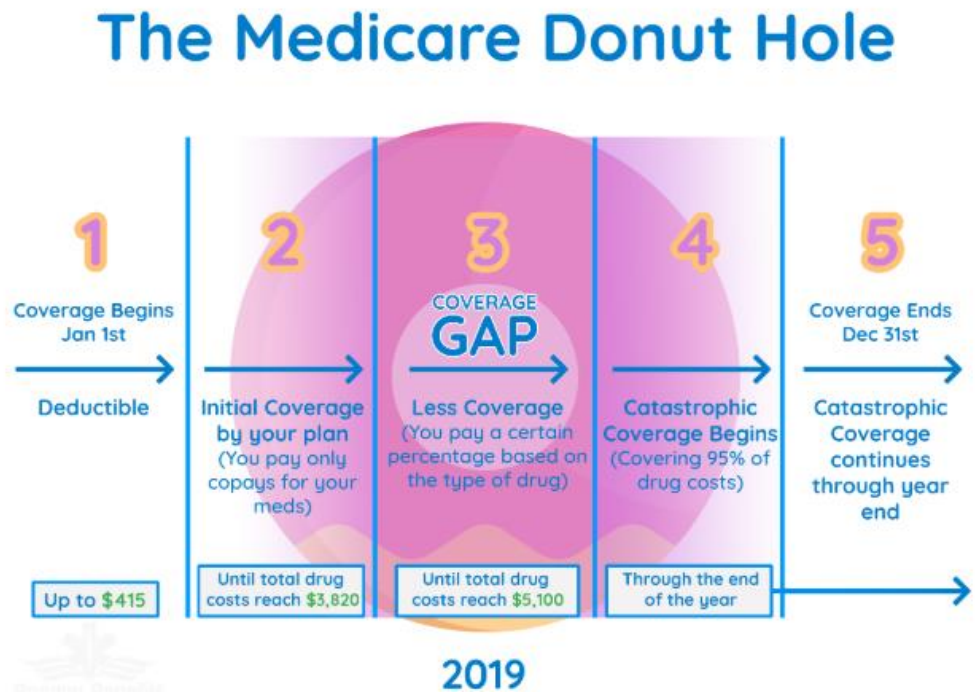

Figure 2 How the Coverage Gap Works[17]

- Individuals with rare diseases and chronic disorders that require expensive medication will typically be on the highest tier of the formulary. (See below for explanation of formulary tiers).

- Individuals suffer financially with deteriorating results. After a Forbes article about the price of EpiPens, the magazine received many letters from readers. One commenter said: "My mom stopped carrying hers because her insurer won't pay for it." And another: "In the US my sister got one. After insurance paid their bit, it was $600." One MD who responded said: "I have a mom who has to pay full price because of a high deductible plan."[18]

  Catherine Horine is another example of the many desperate individuals waiting for the government to act. She is a 63-year-old lung transplant recipient from Wheeling, Ill, who finds herself struggling to avoid financial ruin. "Every month I pay $1,000 for my prescriptions – that is exactly half of my monthly income. It should not cost me everything I have to stay alive," Horine said. She was diagnosed with a rare lung disease and received a life-saving lung transplant in 2014. She later sold her home and moved in with her parents. "I just don't understand why medications – especially like some of the pills I take that have been around for decades – have to be so expensive. And people are rationing insulin. It makes no

sense." she said. "It's hard to know what my future holds. I hate the thought of having to use the money from my mom's retirement account."[19]

Who Makes Money from Prescription Drug Sales?

The flow of prescription drug shipments and payments

The sale, shipment and payment of prescription drugs goes through a complicated set of channels involving the drug manufacturer, the wholesaler/distributor, the pharmacy benefit managers and the pharmacies. The following chart describes the paths of the physical flow of the drug and the various payment flows.

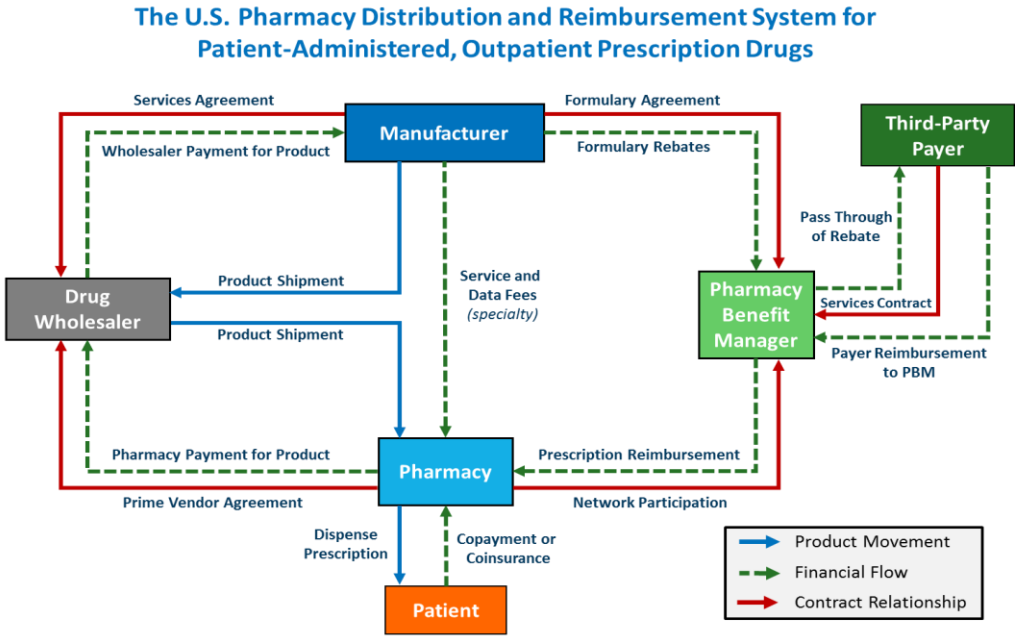

Chart illustrates flows for patient-administered, outpatient drugs. Please note that this chart is illustrative. It is not intended to be a complete representation of every type of financial, product flow, or contractual relationship in the marketplace.
Source: Fein, Adam. J., *The 2016 Economic Report on Retail, Mail and Specialty Pharmacies*, Drug Channels Institute, January 2016.
(Available at http://drugchannelsinstitute.com/products/industry_report/pharmacy/)

The physical flow of product is straightforward: the manufacturer sells the drug to a wholesaler/distributor, which then sells it to the pharmacy. The pharmacy dispenses the drug to a patient who makes a copayment, if insured. The remainder of the payment is made to the pharmacy by the Pharmacy Benefit Managers, who are then reimbursed by the health insurer.

The Pharmacy Benefit Managers (PBM) are the "middlemen" in the distribution chain They provide services to health insurers: insurance companies, Medicare Part D and employers (third party payer in chart above) under confidential contracts. PBM services include:[20]

- Develop and maintain lists, or formularies, of covered medications for health insurers and decide what to charge the patient, thus influencing which drugs individuals use.
- Use their purchasing power to negotiate rebates and discounts from drug manufacturers for health insurers, most of which they pass through to the health insurer.
- Contract directly with individual pharmacies to reimburse for drugs dispensed to the patient.

Most plans separate the medications they cover into four or five drug formulary tiers. These groupings start from tier 1, the lowest cost-sharing or co-payments that contain preferred generic drugs, to tiers 4 or 5, the most expensive tiers that contain specialty drugs for rare diseases or high-priced cancer drugs. Frequently for tiers 4 or 5, enrollees are required to pay a percentage of the list price of the drug.

While PBM's have negotiated favorable rebates for the health insurers, they have an incentive to favor higher priced drugs as the rebates are generally calculated as a percentage of the list price, (also known as the "wholesale acquisition cost" or WAC). ***And PBMs are paid a percentage of the rebates in many contracts***. PBMs also negotiate on behalf of smaller, independent pharmacies which join a network to benefit from higher volume of drug purchases to get better prices.

A controversial practice known as "***spread pricing***" also involves PBMs. This occurs when PBMs are reimbursed by health insurers at a higher price for generic drugs than what the PBMs actually pay pharmacies for these drugs. The PBMs then keep the difference. A lack of transparency allows this to happen: the payment schedules that PBMs generate for pharmacies are kept confidential from health plans. Thus, PBMs have a significant behind-the-scenes impact in determining drug costs and patients' access to medications.

What has Virginia Done to Fix the Problem? Key VA Legislation and bills introduced:

- During the 2019 session, Senator John Edwards (D-Roanoke) introduced SB 1308: "Prescription drugs; price gouging prohibited". The bill prohibits unconscionable price increases in the price of essential generic drugs and authorizes the Secretary of Health and Human Resources to establish an enforcement mechanism. The bill was passed by indefinitely in the Education and Health committee with a letter.

- In the 2018 session, SB 933 (similar to HB 1177) was passed and signed into law: "Health insurance; copayments for prescription drugs, disclosures". Introduced by Senator Dick Saslaw (D-Springfield), the bill prohibits any contract where an insured person would have to make a copayment greater than the cash price. It also requires that any contract allows a pharmacy to disclose to an insured the availability of a more affordable equivalent drug.

- In the 2016 session, Delegate Tim Hugo, (R-Centreville) introduced HB 1113: "Prescription drugs; price transparency". The bill requires every manufacturer of a prescription drug that has a wholesale acquisition price of $10,000 or more for a single course of treatment to report costs related R&D, manufacturing and marketing costs, and profits. The information would be published on a state-maintained website. The bill died in the Commerce and Labor committee.

What Have Other States Done?

While the federal government is considering regulations, state legislatures are becoming increasingly active in their efforts to curb prescription drug cost increases. As of June 2019, there have been 262 bills introduced to control prescription drug costs.[21] The following describes areas of opportunity and gives examples of legislation introduced and passed by other states. Areas of focus include:[22]

- Establishing drug cost review boards/commissions for information gathering and possible rate setting;

- Requiring drug price transparency;
- Prohibiting price-gouging;
- Regulating pharmacy benefit managers;
- Implementing state wholesale drug importation from Canada.

Drug Cost Review Boards

Maryland passed the country's first drug cost review board just before the end of the 2019 session after several past attempts. The bill may well become a model for other states. HB 768 creates a Prescription Drug Affordability Board with the authority to evaluate expensive drugs and recommend appropriate methods for addressing these costs; including setting upper limits on what Marylanders would pay for them:[23]

Beginning in 2022, with the approval of the Legislative Policy Committee of the Maryland General Assembly, the Board may begin to set upper payment limits for prescription drugs purchased by state, county, or local governments. In December of 2023, the Board will recommend whether the General Assembly should pass legislation to expand upper payment limits to all purchases of prescription drugs throughout the state.

The National Academy for State Health Policy (NASHP) has also written model legislation for drug affordability review: https://nashp.org/wp-content/uploads/2018/08/NASHP-RX-Rate-Setting-Model-Act.pdf

Transparency

Mandating transparency is a first legislative step to understanding drug pricing, but by itself, it does little to control prices.

California price transparency law (SB17), enacted in October 2017, applies to all drugs (brand-name and generic) with a wholesale acquisition cost of at least $40. When the price of these drugs increases more than 16 percent in the prior 12 months, or 32 percent in the preceding 24 months, manufacturers are required to report a variety of data about their business operations and costs to justify the price increases. The law is being challenged by the industry.

The National Academy for State Health Policy (NASHP) has written model legislation for drug transparency: https://nashp.org/wp-content/uploads/2019/04/Comprehensive-Transparency-Model-Legislation-final-4_22_2019.pdf

Prohibiting Price Gouging/Limiting Out-of-pocket costs

In 2017, **Maryland** passed the country's first anti-price-gouging law (SB631).[24] Several states have price-gouging legislation modeled on the Maryland law. Maryland's legislation prohibits makers of essential drugs from raising prices to "unconscionable" levels. The law applies to all off-patent and generic drugs on the World Health Organization's list of "essential medicines" – considered to be the minimum pharmaceutical treatments needed for a basic health care system. An "unconscionable" price increase is defined as an excessive price hike that is not justified by changes in production and for which consumers have no meaningful treatment alternative.

The law allows Maryland's Medicaid agency to inform the attorney general about drugs that cost at least $80 and have a wholesale cost increase of 50 percent or more in 12 months. If the attorney

general does not find an adequate explanation for the price increase, the issue can be referred to the state court, which can decide if penalties should be imposed on the manufacturer.

Maryland's law was challenged by the generic drug manufacturer industry. It was nullified in April 2018 when an appeals court held it was unconstitutional because it regulated commerce beyond Maryland's borders. After that decision, no state has successfully passed an anti-price gouging bill. On February 18, 2019, the law died when the Supreme Court formally declined to hear the appeal from the state's Democratic attorney general.[25]

State Senator Troy Singleton, **New Jersey**, introduced an innovative bill SB 977 in 2018. The bill prohibits excessive charges for drugs developed by publicly funded research. It has been pending in committee since September 2018.

California passed SB 1021 in 2018 to limit the out-of-pocket costs for those plans regulated by certain state departments. Copayments for a covered prescription drug for an individual prescription for a supply of up to 30 days are capped at $250. The bill prevents the cost of a drug copayment from exceeding the retail price. It also limits formularies to 4 tiers and has provisions to keep insurance companies from routinely placing specialty drugs on their highest pricing tiers[26].

The National Academy for State Health Policy (NASHP) has also written model legislation for drug affordability review: https://nashp.org/wp-content/uploads/2017/07/Prescription-Drugs-Rate-Setting_Model-Legislation.pdf

Regulating Pharmacy Benefit Managers

One of the more egregious practices of PBMs that was recently prohibited by Congress was known as a "gag clause". This clause was in contracts between a PBM and a pharmacy. It prohibited the pharmacy from telling a patient if a cheaper drug was available. In October 2018, Congress passed two bills that made "gag clauses" illegal: *The Patient Right to Know Drug Prices Act* and *Know the Lowest Price Act*. The bills were introduced by Senators Claire McCaskill and Susan Collins.

In 2018, 90 bills were introduced to regulate PBMs, with 21 states passing 32 bills.[27] Each state's bills have some or all of the following approaches:

- Bills requiring PBMs to be licensed by or registered with the state.
- Bills with transparency requirements that force PBMs to report certain cost information about rebates or pricing methodology.
- Bills barring PBMs from collecting copayments that are more than the total charges submitted by a pharmacy.
- Bills that require a PBM to establish a cost-sharing threshold for a drug.

The National Academy for State Health Policy (NASHP) has written 2 model legislation/bills for regulating PBMs:
Model A: https://nashp.org/wp-content/uploads/2019/02/Updated-MODEL-A-PBM-legislation-1_31_2019.pdf
Model B: https://nashp.org/wp-content/uploads/2019/02/NASHP-PBM-Model-Act-B-022019.pdf

Importation from Canada and other countries

There has been increasing interest in legalizing importation of prescription drugs from Canada. But even if a state passes legislation, the Department of Health and Human Services must give approval and thus far, it has not approved the importation of any medications.

Florida's governor just signed a bill in June 2019, which would allow the state to import prescription drugs from Canada, if federal authorities give their approval.[28] The governor cites direct support from President Donald Trump.[29]

Vermont became the first state to approve legislation to import low-cost drugs from Canada on May 16, 2018.[30] The bill, S.175, was approved in the Senate unanimously and in the House 141-2. The bill creates an importation program to purchase high-cost drugs through authorized wholesalers in Canada and make them available to Vermonters through an existing supply chain that includes local pharmacies.

Vermont Senate President Pro Tem Tim Ashe commented, "It is outrageous that a commonly used medicine like Lipitor costs 46-times more per pill in the United States than in Canada. In fact, legislative staff determined that importing just two diabetes drugs from Canada would save the state's teacher health insurance plan more than $500,000 each year." The importation program has not obtained federal government sign-off.

Colorado also joined the ranks of states approving drug importation from Canadian when they signed legislation similar to Vermont's in May 2019.[31] According to Trish Riley, executive director of the National Academy for State Health Policy, "There have been 27 different bills proposed across the country this year [for wholesale drug importation]. I think that it's an approach that makes sense to states. It's something they can do now to help their citizens."[32] The program has not obtained federal approval.

The National Academy for State Health Policy (NASHP) has written model legislation regarding the importation option: https://nashp.org/wp-content/uploads/2019/03/Wholesale-Importation-Act-FINAL-3_25_2019.pdf

Other Opportunities for Reducing Prescription Drug Pricing

- **Purchasing Consortiums:** Twenty-eight states and the District of Columbia participate in one of three multi-state purchasing pools, under which states contract with a purchasing organization to negotiate Medicaid supplemental rebates on their behalf.[33] Currently, Virginia does not belong to a multistate purchasing consortium for negotiating Medicaid supplemental rebates.[34]

  For prescription drugs purchases by the Virginia Department of Health (VDH), and a number of state agencies, the Commonwealth belongs to the Minnesota Multistate Contracting Alliance for Pharmacy (MMCAP). VDH purchases naloxone for opioid addiction treatment, certain vaccines and medications for Family Health Services through MMCAP and is able to reduce their drug costs by approximately 30% compared to the wholesale acquisition cost. Other state agencies such as mental health agencies and correctional agencies also participate in MMCAP.[35]

  The Commonwealth does not have a program of bulk purchases that reduces prices for individuals.

New Mexico: Gov. Lujan Grisham, in April 2019, signed into law SB 131, establishing an Interagency Pharmacy Purchasing Council to investigate opportunities to consolidate public purchasers, such as various state agencies and Medicaid, to leverage their buying power to lower drug costs. The council is also identifying ways to use public purchasing to benefit individuals in the private sector and to explore partnering with other multi-state purchasing collaboratives. Additional tasks are to explore a common formulary for all state agencies, a single purchasing agreement and a common agreement for all PBMs.[36]

- **State Pharmaceutical Assistance programs (SPAP)** use state funds to help low-income or disabled residents pay for prescription drugs. Some examples are assistance with drugs not included on Medicare's full-benefit formulary, with Medicare Part D's "donut-hole", or with single diseases like HIV or kidney disease.[37]

  Virginia has an AIDS Drug Assistance Program (ADAP) for low-income residents for the treatment of HIV and related illnesses. The program provides medications, assists with insurance premiums and medication co-payments. As of February 2019, the number of enrollees was 8,141.[38]

- **California's Executive Order** N-01-19 of January 7, 2019, directs the State's Medicaid system and all state agencies to negotiate and purchase prescription drugs together. Currently, California's Medicaid enrollees participate through a number of individual managed care plans which negotiate separately. The State will create a single list of preferred drugs targeted for price negotiation. Private purchasers and other government agencies will eventually be able to participate. California expects other states to join in its program.[39]

Commentary

Prescription Drug pricing is a timely topic that all voters can relate to and a good topic for a campaign. Of the five main areas where states have introduced bills, the most likely to succeed could be a Drug Cost Review Board similar to HB768 passed by Maryland this year. However, if the intent is to campaign on a more emotional and personal level, anti-price gouging would register a very positive reaction. But with the demise of Virginia's HB 1308, introduced by Representative Edwards, and the decision that Maryland's anti-price gouging bill is unconstitutional, a different strategy to attack price gouging is necessary (see suggestion below). Campaigning on legislation for regulating PBM's, though important, might be difficult since voters are not familiar with PBMs and explanations are highly complicated. While legislation to allow importation from Canada has appeal, it is unlikely to be successful in the near future since federal approval is needed and success is out of the control of the state. (Individuals have gone to Canada to buy medications without interference from law enforcement.)

Suggestions:

1. Propose a bill similar to California's SB 1012 that limits monthly out-of-pocket co-payments for a single prescription to $250 and has restrictions on formularies. Contact California State Senator Scott Wiener to discuss details and strategy. Brady Borcherding, Legislative Director – Brayden.Borcherding@sen.ca.gov; 415-557-1300.
2. Propose an anti-price gouging bill like New Jersey's to prohibit excessive charges for prescription drugs developed with research from tax-payer money. It is an attractive proposal and it seems intuitively fair. A pharmaceutical company should not gouge us when they sell us a product that was developed with help from our tax dollars.

3. Hold a town hall meeting to talk about the problem, share ideas to garner support, and invite Claire McAndrew from Families USA to speak. This organization promotes healthcare solutions for states, and she is an expert on prescription drug pricing and is willing do presentations. She is Director of Campaigns and Partnerships. cmcandrew@familiesusa.org
4. Connect with other legislators and experts to discuss their experiences:

    - Senator Troy Singleton from New Jersey, singleton@senatorsingleton.com.
    - Representative Will Guzzardi of Illinois, Chairman of the new House Prescription Drug Affordability and Access Committee. 773-853-2570, will@repguzzardi.com.
    - Maryland Citizens' Health Initiative President Vince DeMarco: Vincent DeMarco, healthcareforall.com, 410-235-9000 or demarco@mdinitiative.org.
    - Jeff Schimbeno, MMCAP, coordinator responsible for Virginia, jeff.schimbeno@state.mn.us, 732-757-5470.

[1] https://www.nytimes.com/2018/01/06/business/humira-drug-prices.html
[2] https://www.hsgac.senate.gov/media/minority-media/breaking-brand-name-drugs-increasing-at-10x-cost-of-inflation-mccaskill-report-finds
[3] https://www.hsgac.senate.gov/imo/media/doc/Manufactured%20Crisis%20-%20How%20Devastating%20Drug%20Price%20Increases%20Are%20Harming%20America's%20Seniors%20-%20Report.pdf
[4] https://www.wsj.com/articles/maryland-takes-step-toward-capping-drug-prices-11556616600?mod=searchresults&page=2&pos=15
[5] https://www.healthcostinstitute.org/blog/entry/price-of-insulin-prescription-doubled-between-2012-and-2016?highlight=WyJpbnN1bGluIl0=
[6] https://www.nytimes.com/2018/01/06/business/humira-drug-prices.html
[7] https://www.nytimes.com/2019/05/11/health/teva-price-fixing-lawsuit.html
[8] https://www.forbes.com/sites/emilywillingham/2016/08/21/why-did-mylan-hike-epipen-prices-400-because-they-could/#4b8f8453280c
[9] https://www.opensecrets.org/lobby/indusclient.php?id=H04&year=2018
[10] https://www.nytimes.com/2018/01/06/business/humira-drug-prices.html
[11] https://www.opensecrets.org/lobby/indusclient.php?id=H04&year=2018
[12] https://www.nytimes.com/2019/06/14/health/drug-prices-tv-ads.html
[13] https://www.drugchannels.net/2019/04/my-wall-street-journal-op-ed-dont-blame.html#more
[14] www.econtalk.org/robin-feldman-on-drugs-money-and-secret-handshakes/
[15] https://www.statnews.com/2018/02/12/nih-funding-drug-development/
[16] https://familiesusa.org/product/how-high-prescription-drug-costs-harm-families
[17] https://boomerbenefits.com/medicare-part-d-plans/the-donut-hole/
[18] https://www.forbes.com/sites/emilywillingham/2016/08/21/why-did-mylan-hike-epipen-prices-400-because-they-could/#10dc6d0c280c
[19] https://familiesusa.org/press-release/2019/frederick-isasi-testifies-ways-and-means-hearing-drug-prices-tells-congress-%E2%80%9Cyou
[20] https://www.commonwealthfund.org/publications/explainer/2019/apr/pharmacy-benefit-managers-and-their-role-drug-spending
[21] https://nashp.org/rx-legislative-tracker-2019/
[22] https://nashp.org/cha-ching-lowering-rx-costs/
[23] http://healthcareforall.com/wp-content/uploads/2019/04/Summary-of-Prescription-Drug-Affordability-Board-.pdf
[24] https://nashp.org/wp-content/uploads/2018/03/Legal-States-on-Rx-Law.pdf
[25] https://www.statnews.com/2019/02/19/supreme-court-declines-case-on-maryland-drug-price-gouging-law/
[26] https://sd11.senate.ca.gov/news/20180828-california-legislature-passes-senator-wiener%E2%80%99s-drug-co-pay-bill-extend-consumer-price
[27] https://nashp.org/comparison-state-pharmacy-benefit-managers-laws/
[28] https://www.npr.org/sections/health-shots/2019/06/18/733483431/florida-wants-to-import-medicine-from-canada-but-how-would-that-work
[29] https://khn.org/news/in-florida-drug-re-importation-from-canada-finds-new-champions-old-snags/
[30] https://nashp.org/vermont-legislature-first-in-the-nation-to-approve-rx-drug-importation-from-canada/

[31] https://www.coloradoan.com/story/news/2019/05/16/polis-signs-colorado-canadian-drug-import-bill-fort-collins/3694369002/
[32] https://www.npr.org/sections/health-shots/2019/06/18/733483431/florida-wants-to-import-medicine-from-canada-but-how-would-that-work
[33] http://www.ncsl.org/research/health/bulk-purchasing-of-prescription-drugs.aspx
[34] Correspondence with Department of Medical Assistance Services, June 24, 2019
[35] Correspondence with Virginia Department of Health, July 15, 2019
[36] https://nashp.org/new-law-enables-new-mexico-to-leverage-state-purchasing-power-to-lower-rx-spending/
[37] http://www.ncsl.org/research/health/state-pharmaceutical-assistance-programs.aspx
[38] https://q1medicare.com/PartD-SPAPVirginiaStatePharmAssistPrgm.php
[39] https://www.gov.ca.gov/2019/01/07/first-acts-as-governor/