Testimony of Christopher J. Morten, J.D., Ph.D., submitted in connection with the Joint Legislative Public Hearing on 2026 Executive Budget Proposal: Topic Health/Medicaid

Before the New York State Senate and New York State Assembly

Date of Testimony: February 6, 2026
Date of Hearing: February 10, 2026

Senators and Assembly Members, thank you for this opportunity to testify.

I offer this testimony in connection with the Joint Legislative Public Hearing on 2026 Executive Budget Proposal: Topic Health/Medicaid.

I testify in support of S1618/A3236, the New York Affordable Drug Manufacturing Act.

I am an associate professor of law at New York University (NYU) School of Law.[1] I hold both a law degree and a Ph.D. in organic chemistry. I practiced law before becoming a law professor. In that time, I represented many drug companies—both brand-name and generic—in matters concerning patents, regulation by the Food & Drug Administration, and other legal issues. I have published widely on pharmaceutical law and policy.[2]

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[1] The views expressed in this guide do not necessarily reflect the views of New York University or NYU School of Law, if any.

[2] Some exemplary publications follow: Reshma Ramachandran & Christopher J. Morten, *Politics, Science, and the Future of FDA Drug Regulation: FDA's Review of Mifepristone REMS as a Litmus Test*, JAMA (Jan. 12, 2026) (editorial on Sophie Dilek et al., *The US Food and Drug Administration's Regulation of Mifepristone*, JAMA (Jan. 12, 2026)), available at https://jamanetwork.com/journals/jama/article-abstract/2843714; Karim Sariahmed, Janice E. Graham, Matthew Herder & Christopher J. Morten, *Public Sector Innovation and the Constraints of "Platform Thinking": An Account of Johnson & Johnson's Viral Vector Vaccines*, 387 Social Science & Medicine 118687 (2025), available at https://www.sciencedirect.com/science/article/pii/S0277953625010184?via%3Dihub; Christopher J. Morten, Gabriel Nicholas & Salomé Viljoen, *Researcher Access to Social Media Data: Lessons from Clinical Trial Data Sharing*, 38 Berkeley Tech. L.J. 109-203 (2024), available at https://papers.ssrn.com/sol3/papers.cfm?abstract_id=4716353; Ravi Gupta, Christopher J. Morten, Yaqian Zu, Reshma Ramachandran, Nilay D. Shah & Joseph S. Ross, *Approvals and Timing of New Formulations of Novel Drugs Approved by the US Food and Drug Administration Between 1995 and 2010 and Followed Through 2021*, 3(5) JAMA Health Forum e221096 (2022), available at https://jamanetwork.com/journals/jama-health-forum/fullarticle/2792644; Reshma Ramachandran, Christopher J. Morten & Joseph S. Ross, *Strengthening the FDA's Enforcement of ClinicalTrials.gov Reporting Requirements*, 326(21) JAMA 2131-32 (2021), available at https://jamanetwork.com/journals/jama/fullarticle/2786399; Christopher J. Morten & Amy Kapczynski, *The Big Data Regulator, Rebooted: Why and How the FDA Can and Should Disclose Confidential Data on Prescription Drugs*, 109 Calif. L. Rev. 493-558 (2021), available at https://www.californialawreview.org/print/the-big-data-regulator-rebooted/; Christopher J. Morten & Charles Duan, *Who's Afraid of Section 1498? A Case for Government Patent Use in Pandemics and Other National*

I have lived most of my adult life in New York City. I currently live in Manhattan.

I represent, pro bono, the independent diabetes patient advocacy group T1International, as well as the New York #insulin4all Chapter.

I have worked with advocates at T1International for several years now to analyze "public pharma." I use "public pharma" as a shorthand phrase to describe the phenomenon of public agencies, such as state departments of health, taking on functions currently performed by for-profit companies in our health care system in the long process of getting drugs and vaccines from laboratory to factory to patient. These functions include manufacturing, distributing, and pricing prescription drugs.

In 2024, I edited and published, with T1International, a report describing state governmental public pharma initiatives around the United States.[3] In 2025, I helped to organize a panel discussion about public pharma and S1618/A3236, which brought together patient advocates, academics, public health experts, students, and Assembly Member Jenifer Rajkumar—sponsor of A3236—to analyze the bill and its potential impacts.[4]

Public pharma is but one of the "public options" emerging across essential sectors of our economy and society, such as transportation, telecommunications, and banking.[5] Across these sectors, it seems increasingly clear that nonprofit and public sector options can outcompete and outperform for-profit ones. Public pharma is especially appropriate given that our current "medicines system," which discovers, validates, manufactures, distributes, and prices drugs and vaccines, is almost entirely for-profit. Our current system is oriented around the needs of companies and their shareholders, rather than the needs of patients or public health. Our current system is terribly inefficient—ripe for new competition.

A public, nonprofit drug brand owned by New York State could provide that jolt of competition. A New York State-owned drug brand could reduce costs for New Yorkers—not just for patients with high out-of-pocket costs but for everyone who pays taxes and insurance premiums. A New York State-owned drug brand could also help create more robust, resilient supply chains,

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Crises, 23 YALE J.L. & TECH. 1-96 (2020), available at https://yjolt.org/whos-afraid-section-1498-case-government-patent-use-pandemics-and-other-national-crises.

[3] Kaila Alston, Jeannie Le, Nicole Koonce & Zelly Rosa, *PBM, Procurement, and Production: Public Pharma Strategies for States to Lower Insulin Prices*, Columbia Law School Science, Health & Information Clinic and T1International (Christopher J. Morten & Allison Hardt, eds., April 2024), available at https://actionnetwork.org/forms/publicpharma.

[4] The event was held on September 25, 2025 and was entitled "Fixing a Broken System: The Path to Public Pharma in New York." An audio recording is available at https://www.nyuengelberg.org/events/fixing-a-broken-system-the-path-to-public-pharma-in-new-york/.

[5] *See, e.g.*, Ganesh Sitaraman & Anne L. Alstott, The Public Option (2019).

reducing the risk of shortages and other disruptions devastating to patients and public health. (In 2023, I co-authored an op-ed on this point.[6])

I know that many other witnesses are submitting testimony of their own, including other academics and diabetes patient advocates in the New York #insulin4all Chapter. Their testimony will highlight the urgent problem of access to affordable insulin and other prescription drugs in New York, and the benefits of a state-owned drug brand focused on patients, public health, and public spending rather than private profit.

As such, in my testimony, I will focus on two specific points:

1. **A New York State-owned drug brand is feasible.**

While New York State does not currently operate a state-owned drug brand or manufacture and distribute medicines and other medical products on a substantial scale, it has done so in the past—including the recent past.

For example, in the early 20th century, the Wadsworth Center—part of New York State Department of Health (NYSDOH)—manufactured and distributed diphtheria antitoxin.[7] The Wadsworth Center also manufactured and distributed tetanus antitoxin.[8]

During the worst days of the COVID-19 pandemic, NYSDOH was instrumental in the development, validation, manufacturing, procurement, and/or distribution of vaccines, medicines, diagnostics, and personal protective equipment (PPE).[9] In the efforts, NYSDOH worked closely with the federal government and municipal departments, such as New York City's Department of Health & Mental Hygiene and NYC Health+Hospitals, to manage complex supply chains and distribution networks. In early 2020, the Wadsworth Center invented a test for COVID-19 that was rapidly scaled up and reproduced across the state.[10]

Other states' experiences affirm the feasibility of a state-owned drug brand. Massachusetts' MassBiologics—a state-owned nonprofit drug company—has been manufacturing and distributing medicines for over a century.[11] California's burgeoning CalRx initiative—a

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[6] Dana Brown & Christopher Morten, *Public pharma is the best solution to the ongoing problem of drug shortages*, STAT News (Aug. 9, 2023), available at https://www.statnews.com/2023/08/09/drug-shortages-public-pharma-option/.
[7] NYSDOH Wadsworth Center, Wadsworth Center History, available at https://www.wadsworth.org/about/history/.
[8] *Id.*
[9] *See, e.g.*, Federal and New York State COVID-19 Vaccination Strategy Crosswalk (Nov. 2020), available at https://sachspolicy.com/wp-content/uploads/2020/11/Vaccination-Strategy-Crosswalk_11.16.20.pdf.
[10] Food & Drug Administration, Letter of authorization of SARS-CoV-2 test developed at the Wadsworth Center (Mar. 10, 2020), available at https://www.fda.gov/media/135661/download; National Governors Association, *New York State Actions*, available at https://www.nga.org/updates/new-york/.
[11] UMass Chan Medical School, *History*, available at https://www.umassmed.edu/massbiologics/about/history/.

state-owned drug brand—is already procuring and distributing naloxone and insulin pens and has announced ambitious plans to procure and distribute albuterol inhalers and more forms of insulin.[12] CalRx has also contemplated procuring and distributing abortion medications, especially in the event of federal restrictions and disruptions of supply.[13] Indeed, now that CalRx is up and running, NYSDOH and other New York State agencies should be able to learn from and build on California's experience.

2. A New York State-owned drug brand could work with other public pharma initiatives.

A state-owned drug brand that manufactures and/or procures and distributes medicines is not the only public option. State governments can also create public options in pharmacy benefit management, insurance, pharmacies, and elsewhere in the health care system.

In January 2026, I edited and published, with T1International, a new report that explores public options in pharmacy benefit management.[14] The report describes how state governments can replace and regulate some of the functions of secretive, predatory for-profit pharmacy benefit managers (PBMs) with more transparent, lower-cost public options in pharmacy benefit management. Indeed, some states are already doing exactly this.

For example, public agencies in a number of states, including Washington, Oregon, Nevada, Connecticut, and Ohio, have joined a collaborative multi-state initiative called ArrayRx.[15] Among the services offered by ArrayRx is a PBM program.[16] The ArrayRx PBM program can help state and municipal employers, retired public employees' health plans, public hospitals, public universities and school districts, and other payers (even some private employers) negotiate lower prices on prescription drugs, saving money for patients and systems alike.

Our new report on public options in pharmacy benefit management explains that public PBMs and state-owned drug brands can work together, legally and practically, in synergy, to unlock more benefits for more patients and payers:

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[12] CalRx fact sheet (Oct. 2025), available at https://calrx.ca.gov/uploads/2025/10/CalRx_Fact-Sheet.pdf; CalRx School Albuterol Access Initiative, available at https://calrx.ca.gov/albuterol/.
[13] Sophia Bollag, *New proposals from Newsom seek to lower prescription drug prices and protect abortion access*, San Francisco Chronicle (May 13, 2025), available at https://www.sfchronicle.com/politics/article/newsom-abortion-drug-prices-20325259.php.
[14] Sarah Lamour, Rhea Sahai & Humphrey Shen, *Exploring a Public Option in Pharmacy Benefit Management: A research and advocacy toolkit*, T1International and NYU School of Law Science, Health & Information Clinic (Christopher J. Morten and Allison Hardt, eds., Jan. 2026), available at https://actionnetwork.org/forms/publicpbms and https://papers.ssrn.com/sol3/papers.cfm?abstract_id=6072887.
[15] ArrayRx, https://www.arrayrxsolutions.com/.
[16] ArrayRx, Pharmacy Benefit Management Program, available at https://www.arrayrxsolutions.com/Pharmacy-solutions/Employee-benefits.

> [I]t is worth considering how a public PBM would work in conjunction with other public pharma initiatives.
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> Perhaps the clearest way we may see this sort of collaboration is through a vertical "public system" to challenge, or at the very least, provide an alternative to vertically integrated private systems. As such, public PBMs would likely work with public manufacturers and distributors to help publicly-manufactured drugs reach patients by adding publicly-manufactured drugs to formularies.
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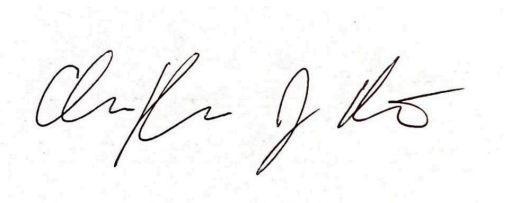
> Public PBMs could be particularly important in helping public manufacturers reach under-insured populations covered by "The Big Three PBMs" (which are integrated with insurance companies) and other private insurance. Patients on private insurance often struggle to cover co-pays, co-insurance, and high deductibles. Private drug manufacturers may also be unwilling to agree to the terms of price transparency under a public PBM system because it reduces their ability to profit from list price increases. In working with public or nonprofit manufacturers and distributors like Civica, CalRx, and MassBiologics, a public PBM will be able to prefer transparently priced, low-cost, publicly-manufactured generic and biosimilar drugs as part of its formulary. This would validate the model of public manufacturing and increase the uptake of publicly-produced or -procured drugs by patients on private insurance plans.

In my view, this potential synergy with pharmacy benefit management and other tools of public pharma is all the more reason to support S1618/A3236 and a New York State-owned drug brand.

Thank you again for your commitment to improving health in New York State, and thank you for this opportunity to testify.

Respectfully submitted,



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