Testimony in Support of the New York Affordable Drug Manufacturing Act (S1618; A3236)

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Senators and Assembly Members, thank you for the chance to provide testimony today in support of the New York Affordable Drug Manufacturing Act. If enacted, this legislation would give New York State an innovative tool for lowering healthcare costs for residents and responding to crises from affordability to pandemics.

My support for this legislation stems from my experiences as a practicing physician at Bellevue Hospital, as the 43rd Commissioner of New York City's Department of Health and Mental Hygiene and as Co-Chair of the Health and Political Economy Project at The New School's Institute on Race, Power and Political Economy. Each of these roles offers a perspective on the perils of our current system and on the promise of public-sector strategies to build a more affordable, accessible, reliable, and just system of health and care.

First, as a physician, I believe creating pathways to publicly manufacture and distribute essential medicines would allow New York State to invest its dollars to ensure all patients can afford the care they need.

At Bellevue Hospital, the nation's oldest public hospital, I see both the perils of high drug prices and the promise of public leadership every week. I remember one patient who arrived in diabetic crisis. His mouth was parched and his breath was tinged with the sweet smell of ketones; all because he had to ration his insulin. The painful irony was that his ICU stay, with all its cost and suffering, was entirely preventable if he had had access to affordable insulin.[1]

Sadly, my patient's experience was not unique. An analysis of 2021 National Health Interview Survey data found 20% of US adults with diabetes younger than 65 rationed their insulin.[2] Even this data likely does not capture the full scope of challenges high drug prices impose on patients. In their 2024 Out-of-Pocket Expenses survey, T1International, a patient-led Type 1 diabetes advocacy group, found that 34% of respondents with Type 1 diabetes rationed insulin, an

[1] Notably, insulin was discovered over a century ago and the scientists who made this miraculous discovery sold their patent to the University of Toronto for $1 because they believed it would be unethical to profit from this life-saving development and wanted to ensure insulin would be broadly accessible.
[2] Fang, M., & Selvin, E. (2023). Cost-Related Insulin Rationing in US Adults Younger Than 65 Years With Diabetes. *JAMA*, *329*(19), 1700–1702. https://doi.org/10.1001/jama.2023.5747.

additional 11% had to make major budget adjustments to be able to purchase their insulin, and an additional 11% had to make minor budget adjustments.[3] Even with several recent policy changes designed to limit out-of-pocket costs, research shows cost-related insulin rationing persists.[4]

Yet patient stories also provide promising examples of how government can bring an end to unnecessary suffering. Another patient of mine walked in with a new HIV diagnosis. Within hours, we started him on treatment — thanks to publicly funded access that made the antiretrovirals he needed available the same day. Weeks later, his viral load was undetectable: proof of what's possible when we treat medicines as common goods rather than commodities.[5]

Second, as a public health leader and public servant, I believe publicly manufacturing and distributing essential medicines builds the capabilities government needs to protect public health and navigate financial and operational constraints during both normal times and times of crisis.

Serving as New York City's Health Commissioner through much of the COVID-19 pandemic, I saw the promise of public approaches on a much larger scale. While much of the pandemic is painful to reflect on, it taught us crucial lessons about government's necessary role in ensuring access to medicines and care.[6] The pandemic proved that the public sector *can* act effectively when given the authority and resources to do so, and that the ability and political will to act is essential to saving lives.

We simply wouldn't have been able to vaccinate over 6 million New Yorkers in a little over a year without public research, public investment, public delivery, and public leadership. We were also able to procure rapid tests and personal protective equipment and deliver them to places that needed them most urgently like hospitals, shelters, and schools.

The knowledge gained during that crisis should push us to consider what it might look like for government to respond with the same innovation and urgency to the more everyday challenges of affordability that patients like mine face.

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[3] Kasper, S. (2025). Out-of-Pocket Expenses and Rationing of Insulin and Diabetes Supplies: Findings from T1International's 2024 Survey. *T1International*. https://www.t1international.com/media/assets/file/2024outofpocketexpensesandrationingsurveyT1International.pdf

[4] Khan, S., Rahman, N., Nally, L. M., Warren, D. B., Branda, M. E., & Lipska, K. J. (2025). Insulin Rationing Persists Despite Policy Changes: Repeated Cross-Sectional Studies, 2017 vs 2024. *Journal of General Internal Medicine*. https://doi.org/10.1007/s11606-025-09886-9

[5] Doutre, M., Godin, M. P., Dmitriev, I., Pena-Gralle, A. P., Bergeron, A., Blais, L., & Lemire, B. (2025). Free antiretrovirals as a key tool against the HIV pandemic: A systematic review. *HIV medicine*, *26*(9), 1329–1342. https://doi.org/10.1111/hiv.70051

[6] Byrnes-Enoch, H., Afshar, N., Singer, J., Helmy, H., Otsubo, E., Jocelyn, K., & Chokshi, D. A. (2024, February 5). Lessons for Public Health Excellence from the COVID-19 Pandemic: A Perspective from New York City - NAM. National Academy of Medicine; National Academy of Medicine. https://nam.edu/perspectives/lessons-for-public-health-excellence-from-the-covid-19-pandemic-a-perspective-from-new-york-city/

Finally, as Co-Chair of the Health and Political Economy Project (HPEP), I believe public options can reshape the exorbitant drug prices and perverse incentives we see throughout the pharmaceutical value chain by strengthening and building initiatives that can *compete with and discipline* extractive market actors.

My HPEP colleagues and I are excited to be working with partners across the country to reimagine our pharmaceutical system with this principle in mind. We see public sector strategies, from manufacturing initiatives like CalRx[7] to procurement initiatives like ArrayRx[8], as innovative steps on the path towards a more accessible and resilient health system. Enacting the New York Drug Manufacturing Act would be an equally important step.

The New York Drug Manufacturing Act directly responds to these challenges. By putting New Yorkers' needs above private profit, it treats medicines as common goods rather than commodities. By expanding New York State's production and distribution capabilities it prepares the State to weather current operational and fiscal realities as well as future crises. And by creating an entity that can compete with and discipline extractive actors along the pharmaceutical value chain, it creates a strategy that can help realign our healthcare system towards affordable, accessible patient care. Legislators ought to model the overall costs, including downstream savings, of the bill to assess the full fiscal impact. Ultimately, public strategies like the New York Drug Manufacturing Act can protect providers and patients from supply shortages and soaring prices, and augment the government's ability to both regularly serve residents and swiftly respond to crises.

Thank you for the opportunity to provide testimony, and for your work on this important issue.

[7] Socal, M.P., Pegany, V., & Ghaly, M. (2022). When States Step Up: California and the Case for State-Led Insulin Manufacturing. *Annals of Internal Medicine*, *175*(12), 1756–1758. https://doi.org/10.7326/M22-2339

[8] Lamour, S., Sahai, R., Shen, H. (2026) *Exploring a Public Option in Pharmacy Benefit Management: A research and advocacy "toolkit"*. T1International and NYU School of Law Science, Health, & Information Clinic.