Testimony of Trevor Putnoky
to the Joint Standing Committee on Health Coverage, Insurance and Financial Services

Neither for nor Against

LD 1018, An Act to Protect Health Care for Rural and Underserved Areas by Prohibiting Discrimination by Participants in a Federal Drug Discount Program

April 16, 2025

Good afternoon Senator Bailey, Representative Mathieson, and Members of the Joint Standing Committee on Health Coverage, Insurance and Financial Services.

My name is Trevor Putnoky. I'm the President and CEO of the Healthcare Purchaser Alliance of Maine and I'm here today to testify neither for nor against LD 1018.

The HPA is a nonprofit that represents the purchasers of health care in Maine. Our mission is to advance and support access to high-quality, affordable care. We have over 60 members, including some of the largest public and private employers and health trusts in Maine. Collectively, our members spend over a billion dollars annually providing health care for nearly one quarter of the commercially insured population in the state. Over one-quarter of that total—or more than $250 million annually—is spent on prescription medications.

Overview
We agree that the 340B program brings critical resources to providers in Maine. And we understand the desire to preserve those resources. However, LD 1018 does not merely preserve the status quo of 340B in Maine. It also includes provisions that would increase revenues to 340B hospitals from Maine employers and consumers, at a time when Maine businesses and families are already struggling to afford the cost of care. Specifically:

- §7704 sets a minimum reimbursement for 340B pharmacies, but it's unclear what that minimum is based on. Is it the highest non-340b pharmacy rate? The lowest? An average? Without more clarity we can't estimate how that provision would impact costs to employers and consumers.
- §7704 also appears to prohibit employers from incentivizing members to use non-340B sites of care when it comes to administering infused drugs. Employers are not steering care based on 340B status, but they are steering care based on price, and hospitals tend to be the most expensive setting (despite being able to acquire some of the infused drugs at steep discounts). Many of our members have benefit designs that prefer non-hospital infusion clinics, and preventing this design would increase costs for the plan and the consumer.
- Similarly, §7704 appears to prohibit plan sponsors from using narrow networks that favor non-340B pharmacies. Just like infusions, no one is steering based on 340B status; they are steering based on cost, and there is significant variation in cost from pharmacy to pharmacy. I'm concerned this prohibition on steerage would lead to higher prices for consumers and purchasers.

While we understand that the minimum reimbursement and steering prohibitions are intended to address discrimination based solely on a provider's status as a 340B entities, we are concerned that the existing language could be interpreted more broadly, and we respectfully request that the language be amended to make the intention clearer.

In addition to these changes, we believe that adding enhanced transparency provisions to this bill would represent an ideal middle ground. While we take no issue with the need to help struggling rural providers, we are less confident that 340B is functioning as intended when it comes to our large health systems. Current transparency requirements, which passed in the last session, do not help us understand the degree to which large PBMs and pharmacy chains are capturing 340B revenue. While there is no doubt that 340B revenue helps to maintain rural access, it is important to understand that these dollars are not "free." The 340B program creates well documented market distortions that lead to higher costs for employers and consumers, and while that is a tradeoff many employers are comfortable making, we feel that transparency is needed to ensure that providers are holding up their end of the bargain.

Background

The federal 340B program allows certain hospitals and other entities serving low-income and other at-risk populations to purchase drugs at deep discounts—on average, about 35 percent below the average sales prices hospitals would otherwise pay,[1] and in some instances, for just pennies. Such price breaks help these entities to cover the costs of serving low-income and other at-risk populations. But these entities also purchase drugs for their commercially insured patients through 340B, which they can then sell to those commercially insured patients at higher prices. This results in 340B entities pocketing a substantial margin on drugs they provide to commercial patients, while employers and their employees and dependents pay top dollar for drugs that were often procured at a fraction of those prices.

Here in Maine, for example, Humira is the #1 drug by total spend across the HPA's book of business, which includes over 130,000 commercially-insured lives. That one drug accounts for over 10 percent of what our members spend on pharmacy overall. Yet under 340B's pricing formula, Humira is a penny-priced drug, available for 340B hospitals to purchase as little as 1 cent per unit, which means that, at times, hospitals are acquiring, for literally pennies, the drug that is costing Maine employers an average of $8,304 per patient per month. And it's not just employers who are paying those costs. When employees and dependents fill a Humira prescription acquired through the 340B program, they face that same $8,304 price tag before their deductible is met, as well as copays and coinsurance thereafter— not the discounted amount that the hospital paid to acquire the drug.

These pricing disparities have become more pressing in recent years, as 340B program growth has exploded, with discounted 340B drug purchases increasing from $24 billion in 2018 to $66 billion in 2023.[2] In Maine, for instance, 85 percent of hospitals participate in 340B,[3] along with hundreds of system-affiliated providers and many federally qualified health centers.

[1] Department of Health and Human Services Centers for Medicare & Medicaid Services, "Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; New Categories for Hospital Outpatient Department Prior Authorization Process; Clinical Laboratory Fee Schedule: Laboratory Date of Service Policy; Overall Hospital Quality Star Rating Methodology; and Physician Owned Hospitals," *Federal Register*, August 12, 2020. Available at: https://www.govinfo.gov/content/pkg/FR-2020-08-12/pdf/2020-17086.pdf.

[2] A. Fein. "The 340B Program Reached $66 Billion in 2023—Up 23% vs. 2022: Analyzing the Numbers and HRSA's Curious Actions," *Drug Channels*, October 22, 2024. Available at: https://www.drugchannels.net/2024/10/the-340b-program-reached-66-billion-in.html.

[3] Maine Health Data Organization, *Maine Hospitals Participating in Federal 340B Drug Program.* Available at: https://mhdo.maine.gov/340B_hospitals.htm.

A lot of this growth has been attributed to 2010 federal guidance that allows 340B hospitals to contract with for-profit retail pharmacies like CVS and Walgreens to provide drugs to their patients under the 340B discount program. Today, nearly 33,000 pharmacy locations—or more than half of the U.S. pharmacy industry—act as 340B contract pharmacies[4] and earn revenue from the program, which means you don't have to go to a pharmacy inside of a hospital in order to receive a prescription dispensed under the 340B program. If you have a doctor or other provider affiliated with a 340B hospital—or if you visited an emergency room at a 340B hospital—chances are that every time you fill a prescription from that provider at Hannaford, CVS, or Walgreens, that prescription is being filled through 340B, with any margin earned on that script flowing back to the 340B hospital.

40B Increases Costs for Employers and Consumers

Supporters of 340B will argue that employers and their employees and dependents are paying no more for drugs than they would pay if those drugs were acquired outside of 340B. But studies have shown that this is not the case. 340B actually increases the costs that employers and consumers pay, due to: loss of rebates, misaligned incentives around prescribing patterns, and provider consolidation.

Rebates. When a drug is funneled through 340B, employers lose any rebates that they would have earned if the drug had not been purchased through 340B. Rebates can reduce the cost of a drug by upwards of 30 percent or more, so losing rebates on all drugs purchased through 340B increases a plan's total pharmacy spend. In fact, a recent study by IQVIA found that drug costs for self-insured employers and their employees were 4.2 percent higher than they would have been, due to rebates lost because of the 340B program.[5] In Maine, IQVIA estimates those lost rebates cost employers $54 million annually.[6]

While proponents of 340B argue that rebates are not lost because manufacturers cannot tell which drugs are 340B and which are not, rebates on 340B drugs are typically contractually prohibited in PBM contracts with pharmaceutical manufacturers, where the PBM agrees not to seek a rebate on 340B drugs. The result is that an otherwise rebateable drug is processed at full price with no rebate for the plan sponsor.

Prescribing patterns. The ability of 340B entities to buy low and sell high also creates perverse incentives to prescribe medications that maximize margins—rather than equally effective generics or biosimilars that would be more affordable for the patient—because they would generate more revenue for the 340B entity. Take Humira, for instance. There are 10 biosimilar drugs available for Humira that would reduce costs for both employers and employees, but the thousands in margin that 340B entities earn on each Humira script might create an incentive for those entities to continue to prescribe the more expensive brand drug. While we don't know whether this happens in Maine since there's no transparency into the data, a 2023 study by *Health Affairs* found that 340B hospitals had a 23 percentage point reduction in biosimilar drug adoption, compared to non-340B hospitals.[7]

Consolidation. Several studies have also found that 340B has contributed to vertical and horizontal consolidation in the healthcare system, as system-owned practices (unlike independent physician offices) can implement 340B

[4] A. Fein, "Hospitals Are Relying More on PBMs to Manage Manufacturers' 340B Contract Pharmacy Restrictions: DCI's 2024 Market Analysis (rerun)," *Drug Channels,* October 2, 2024. Available at: https://www.drugchannels.net/2024/10/hospitals-are-relying-more-on-pbms-to.html.

[5] Chuan Sun, Shanyue Zeng, and Rory Martin, "The Cost of the 340B Program Part 1: Self-Insured Employers," *IQVIA,* March 12, 2024. Available at: https://www.iqvia.com/locations/united-states/library/white-papers/the-cost-of-the-340b-program-part-1-self-insured-employers.

[6] "The Cost of 340B to Maine," *IQVIA*.

[7] Amelia Bond, Emma Dean, and Sunita Desai, "The Role of Financial Incentives in Biosimilar Uptake in Medicare: Evidence From The 340B Program," *Health Affairs,* May, 2023. Available at: https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2022.00812.

pricing. A study in *The New England Journal of Medicine*, for example, found that the program has resulted in hospital-physician consolidation in hematology-oncology.[8]

Need for Transparency

Hospitals claim that the revenue they generate through 340B is used to support services to the low-income and at-risk patients they serve, consistent with the intent of the 340B program. But at least one study of 340B programs found that 340B hospitals are not necessarily providing more charity care to low-income patients than non-340B hospitals. Specifically, it found that 65 percent "of 340B hospitals provide less charity care than the national average for all hospitals, including for-profit hospitals."[9]

We have no way of knowing how Maine's 340B hospitals leverage the program to support low-income populations, and how that compares to non-340B hospitals, because there's very little data about the program available to policy makers, or to the employers who purchase drugs from hospitals at rates high above what the 340B hospitals paid for them. Nor do we know how the program impacts affordability for consumers overall, who are paying top dollar for medications that 340B entities often purchase at deep discounts. We don't know, for instance, if 340B entities pass along their discounted drug prices to low-income patients.

Maine enacted legislation in 2023 requiring 340B hospitals to report certain information to the Maine Health Data Organization. While the required reporting represents a good first step, it does not quantify the extent to which hospitals are using 340B revenues to support low income and other vulnerable populations. Instead, hospitals provide qualitative descriptions of such support. Nor are hospitals required to submit data broken out by payer type (e.g., commercial, MaineCare, uninsured) or to identify the portion of 340B revenue that is retained by for-profit contract pharmacies, which the Government Accountability Office found can be up to 20 percent of the commercial reimbursement rate[10]— a figure that doesn't even include the additional 340B revenue that's diverted to PBMs.

LD 1018

We've detailed our concerns with the current 340B program here, because not only does LD 1018 seek to lock into statute current program practices, it also appears to expand the program and exacerbate many of these issues. Specifically, the bill would make changes that would increase pharmacy drug costs at a time when Maine employers and families are already struggling to afford the high cost of health care, particularly the cost of prescription drugs, which, for our members, grew 44 percent between October 2020 and October 2024. This is more than double the trend for medical spend over the same time period.

Specifically, §7704(1) of the bill prohibits payers from reimbursing 340B entities for 340B drugs at a rate lower than that paid for the same drug to entities that are not part of 340B. But what exactly would that rate be? Reimbursement rates for the same drug can vary across providers and pharmacies; would this bill require payers to always pay 340B entities the highest of those rates? The average rate? The rate paid to any non-340B entity? It's unclear. And as noted above, the rates paid to non-340B entities are often offset by rebates that substantially reduce the net cost of a drug. Would payers be able to reimburse 340B entities the same amount non-340B entities are paid, net of rebates?

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[8] Sunita Desai and J Michael McWIlliams, "Consequences of the 340B Drug Pricing Program," The New England Journal of Medicine, January 24, 2018. Available at: https://www.nejm.org/doi/full/10.1056/NEJMsa1706475.

[9] Alliance for 340B Integrity & Reform, "Left Behind: An analysis of Charity Care Provided by Hospitals Enrolled in the 340B Drug Pricing Program," February 2022. Available at: https://340breform.org/wp-content/uploads/2022/11/AIR340B_LeftBehind_2022.pdf.

[10] GAO, *Drug Discount Program: Federal Oversight of Compliance at 340B Contract Pharmacies Needs Improvement*, June 2018. Available at: https://www.gao.gov/assets/d18480.pdf#page=56.

§§7704(5) and (6) appear to prohibit employers from incentivizing their members to use non-340B sites of care when it comes to administering infused drugs, which could raise costs for both employers and patients. Research has found that infused drugs administered at hospital outpatient facilities cost significantly more than if they are administered in a doctor's office. A *Health Affairs* study, for example, found that prices for biologics, chemotherapies, and other infused cancer drugs administered in outpatient hospital departments were double prices charged by physician offices.[11] This is consistent with an analysis HPA conducted on our book of business here in Maine, which found that the price of Remicade was 78 percent higher in hospital outpatient settings than in a physician's office.

Because of this substantial price disparity, many employers incentivize their employees to receive infusions at home, or in doctor's offices and independent clinic settings when appropriate—which saves both the plan and the patient, often thousands of dollars per infusion. But because most outpatient facilities are 340B entities, and most doctor's offices and independent clinics are not, it appears that plans would be prohibited from encouraging members to use these more affordable sites of care if LD 1018 were enacted. To be clear, employers don't encourage use of non-hospital settings because they're not 340B entities; they incentivize use of those settings because they are more affordable for the plan and for consumers.

Likewise, §7704 would prohibit payers from establishing preferred or narrow pharmacy networks that favor non-340B entities. Because reimbursement rates vary by pharmacy, payers sometimes incentivize members to purchase their medications at more affordable pharmacies, which can lower pharmacy costs for both the plan and plan members. This provision would prevent payers from incentivizing members to use a non-340B pharmacy—even if it would reduce plan costs.

Incentivizing patients to use lower cost sites of care and pharmacies is not discrimination, as health systems would have you believe; it's a mechanism that Maine's employers use to try to lower out-of-pocket costs and premiums for Maine families.

We understand that many rural hospitals and FQHCs in Maine are struggling. But they're not the only ones facing financial hardships in our state. Many Mainers—particularly the most financially vulnerable among us—are also struggling due to the ever-rising costs of health care. A survey conducted earlier this year revealed that 38 percent of Mainers reported that they skipped or delayed going to the doctor when they were sick due to costs. And nearly one-third struggled to pay for basic necessities like food, heat, or housing due to medical bills. Not surprisingly, nearly half (45 percent) of Maine households have medical debt.[12] And while Maine employers try to keep healthcare coverage affordable for their employees, they have seen premiums grow by 30 percent between

[11] James C. Robinson, Christopher M. Whaley, and Timothy T. Brown, "Price Differences To Insurers For Infused Cancer Drugs in Hospital Outpatient Departments And Physician Offices," *Health Affairs*, September 2021. Available at: https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2021.00211#:~:text=Price%20Differences%20To%20Insurers%20For%20Infused%20Cancer,Departments%20And%20Physician%20Offices%20%7C%20Health%20Affairs.&text=The%20prices%20paid%20in%202019%20by%20Blue,for%20infused%20hormonal%20therapies%20(68%20percent%20higher).

[12] Digital Research Inc., Examining Views Toward Health Care in Maine: Preliminary updated survey results, Consumers for Affordable Health Care, January 2025.

2018 and 2023,[13] and national data indicate premiums rose another 7 percent in 2024.[14] These rising costs have contributed to wage stagnation[15] and led to more cost sharing, and higher deductibles for Maine families.

The proposed expansions highlighted above may improve the financial status of some 340B entities, but they would do so at the expense of Maine employers and consumers who will face higher costs due to those provisions, which would prohibit employers and consumers from designing their health insurance plans in a manner that encourages the use of the most affordable and cost-effective medications and providers. Maine employers and families are already paying more than they can afford for health care. We do not have the luxury to pay more than we need to when more affordable options are available.

If the committee decides to move forward with LD 1018, we urge you to consider limiting the bill to FQHCs and critical access hospitals, which comprise a small fraction of the overall 340B pie. Some of the states that are considering or have pursued similar legislation this year—including New Mexico and Massachusetts—are considering narrowing their 340B legislation in a similar manner. In addition, we hope that you will consider including robust, quantitative reporting requirements that would provide policy makers, employers, and other stakeholders with a better understanding of the revenue that 340B hospitals in Maine generate from prescription sales to the state's employers and consumers, and how they use those dollars to support low-income patients and other hospital operations. Minnesota enacted comprehensive reporting legislation in 2023[16] that could provide a roadmap for Maine, if the committee is interested in pursuing additional transparency around the program.

Thank you for the opportunity to share our feedback on LD 1018. I'd be happy to answer any questions and will be available for the work session.

[13] "Average Annual Single Premium per Enrolled Employee for Employer-Based Health Insurance, Kaiser Family Foundation, Accessed February 20, 2025. Available at: https://www.kff.org/other/state-indicator/single-coverage/?activeTab=graph&currentTimeframe=0&startTimeframe=10&selectedRows=%7B%22states%22:%7B%22maine%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[14] "Annual Family Premiums for Employer Coverage Rise 7% In 2024," Health Affairs, October 11, 2024. Available at: https://www.healthaffairs.org/content/forefront/annual-family-premiums-employer-coverage-rise-7-2024.

[15] Bob Herman, "The Cost of health insurance is skyrocketing, and it's a big reason you aren't getting much of a raise," Business Insider, August 5, 2019. Available at: https://www.businessinsider.com/the-cost-of-health-insurance-is-skyrocketing-and-eating-wages-2019-8.

[16] 2024 Minnesota Statutes, 62.J.461 340B COVERED ENTITY REPORT. Available at: https://www.revisor.mn.gov/statutes/cite/62J.461. The first report required under the statute is also available. Minnesota Department of Health, *340B Covered Entity Report: Report to the Legislature,* November 25, 2024. Available at: https://www.health.state.mn.us/data/340b/docs/2024report.pdf.