Testimony of Sharon Anglin Treat
In Opposition to LD 1018, "An Act to Protect Health Care for Rural and Underserved Areas by Prohibiting Discrimination by Participants in a Federal Drug Discount Program"
Committee on Heath Coverage, Insurance and Financial Services
April 16, 2025

Senator Bailey, Representative Mathieson, and members of the Joint Standing Committee on Heath Coverage, Insurance and Financial Services. My name is Sharon Treat, and I live and work in Hallowell. I am testifying as a private citizen in opposition to this bill. Although I am a member of the Maine Prescription Drug Affordability Board, I am not here today on behalf of the board, which has not taken a position one way or the other on the LD 1018.

We can all agree that some Maine hospitals are facing real financial difficulties. The announced closure of Northern Light's Inland Hospital in Waterville is of great concern to those of us who live and work in central Maine.

We can also agree that prescription drug prices are high, and the cost of purchasing medicines is an enormous burden on both public and private insurance programs, employers and consumers. According to the Maine Health Data Organization (MDHO), from July 1, 2022 to June 30, 2023, total drug utilization costs in the state were $3.3 *billion*, up from $2.7 billion the previous year. The aggregate cost for the 25 costliest drugs was nearly $992,841,245 for 2022-2023, up from $757,322,271 the previous year.[1]

Given this reality, the question is, does it make sense to enact legislation to lock in high drug prices so that hospitals and clinics can access bigger rebates from the federal government? And if we were to do so, who benefits and who pays the costs?

Specifically, what is the impact on commercial and other payors? How much rebate revenue goes to hospitals and clinics? To what extent are for-profit middlemen, including pharmacy benefit managers and third-party administrators providing software solutions, taking a cut?

I submit that the answers to these questions are necessary if this committee is to make an informed decision on LD 1018.

Unfortunately, Maine has weak transparency requirements for the 340B program and for PBM and other third-party contractors. We do have some clues, however, based on data from other states. At our last meeting, the Maine PDAB heard a presentation on a recent report submitted to the Minnesota Legislature on data collected on the 340B program in Minnesota.[2] Minnesota has more comprehensive reporting requirements than we have here in Maine, although there remain gaps in

[1] https://mhdo.maine.gov/tableau/prescriptionReports.cshtml#Dashboard2023
[2] 340B Covered Entity Report: Report to the Minnesota Legislature, Minnesota Department of Health, Health Economics Program (November 25, 2024) https://www.health.state.mn.us/data/340b/docs/2024report.pdf

required data, including from third party administrators.[3] Despite these limitations, the Minnesota Department of Health concluded "It is clear ... that Covered Entities make significant payments to external entities, including contract pharmacies and TPAs, that directly reduce net 340B revenues." (Report at 23) Third party fees per prescription ranged from $3.50 to $10; there were other fees associated with the contract itself.

Although some entities reported no external payments, the report found the payments made by those Covered Entities with the highest external operational costs (indicated by the 90th percentile) were quite significant -- they lost about one third of their gross 340B revenue to administrators and contract pharmacies. Of particular concern, the report found that

- The top 10% (the 90th percentile) of Critical Access Hospitals (CAH) and Disease-Specific Grantees lost at least half of their gross 340B revenue to administrators and contract pharmacies.
- The top 10% (the 90th percentile) of Safety-Net Grantees lost more than all of their gross 340B revenue to administrators and contract pharmacies indicating that although these entities generated positive gross 340B revenue, they operated at a net loss as a result of their high external operational costs. (Report at 24-25)

I am not here to oppose the 340B program itself nor to object unilaterally to the use of contract pharmacies. For 10 years from 2004 to 2014, I was the executive director of a nonprofit, nonpartisan organization of state legislators who networked across state lines to identify ways to reduce the cost of prescription drugs and expand access. At that time, we welcomed the emergence of contract pharmacies as a way for Federally Qualified Health Centers, including clinics in rural Maine, to be able to provide pharmaceuticals to their patients through the 340B program.

The 340B contract pharmacy program has morphed, however, from its initial limited roots into a very large program with significant hidden costs. LD 1018 would lock in high drug prices and current third-party payments and practices in the 340B program while limiting oversight and avoiding transparency about who benefits and who pays.

Before passing LD 1018 as a fix for the financial pressures facing hospitals, I urge this committee to look at the data that's been shared with the Maine PDAB about how the 340B contract pharmacy program works and who benefits. Certainly, if any version of this legislation moves forward, it should be coupled with more effective data transparency provisions not only to understand to what extent the hospitals benefit from additional revenue, but also, the role of third party administrators and software entities.

[3] For more on the Minnesota 340B transparency law, see Nikpay S, McGlave C, Gildemeister S., "Minnesota Law Brings Transparency to the 340B Drug Pricing Program". JAMA Health Forum. 2025; 6(2):e245447. doi:10.1001/jamahealthforum.2024.5447, https://jamanetwork.com/journals/jama-health-forum/fullarticle/2829952