Meg Garratt-Reed, Executive Director
Office of Affordable Health Care

April 16th, 2025
Senator Donna Bailey
Representative Kristi Mathieson
Members of the Joint Standing Committee on Health Coverage, Insurance, and Financial Services
Cross Building, Room 220
100 State House Station
Augusta, ME 04333

Senator Bailey, Representative Mathieson, and members of the Joint Standing Committee on Health Coverage, Insurance, and Financial Services;

I am Meg Garratt-Reed, Executive Director of the Office of Affordable Health Care.

While the Office appreciates the intent of the bill to protect a key source of financial support for safety net providers, I encourage you to exercise caution and consider the impact of this bill on the overall affordability and transparency of our health care system.

I want to begin by acknowledging what an important program 340B is for health care providers serving large numbers of uninsured and low-income Mainers. We support 340B and know that it provides critical relief to organizations that are truly part of the safety net.

What is at issue today is the very significant growth of the program, particularly in the last fifteen years, and lack of transparency into that growth, which impacts the affordability of health coverage for businesses and individuals in the state. Given time restraints I won't review all the data about program growth in these comments, but I have included an appendix to my testimony that provides an overview of some of the key points, all of which are drawn from neutral sources.

The most important point I'd like to convey with my time today is that this issue is not as simple as a choice between health care providers and pharmaceutical manufacturers. If it were, I'd be here testifying in full support.

I think we all know that the problem with our health care system can't be that we are not spending enough money. As I've shared in prior presentations, health care spending in Maine exceeds 20% of Gross State Product, with the largest share going to hospitals.

It's our strong belief, therefore, that a major part of the problem is how that money is distributed, and the incentives that are created by our reimbursement systems. My concern about 340B is that the program, as currently structured and regulated by the federal government, doesn't effectively target providers most in need of financial support because of their patients' needs, but rather those with the resources to most strategically participate. Additionally, increasing involvement by third party entities, like large chain pharmacies and Third Party Administrators, raises questions about the extent to which for-profit organizations are profiting from the administrative complexity of the program.

This would be less concerning if the funding were truly all coming from the profits of pharmaceutical manufacturers, but unfortunately, as with many issues in health care, the reality is not so black and white. Employers and people with commercial insurance in Maine are likely paying more for prescription drugs as a result of the growth of the program, because insurers can not claim rebates for drugs that have been sold at the 340B discount price.

Before contemplating a law that would codify a broadening of this program at a state level, I would strongly encourage the committee to require covered entities to report data to the state that would allow for greater transparency into how the program is operating in Maine, including reimbursement amounts for 340B drugs as well as payments to third parties related to the administration of the program. The committee could also narrow the bill to focus on protecting contract pharmacy relationships for covered entities serving the most uninsured and low-income residents, or those with limited pharmacy access in their areas.

Thank you for your time, and I welcome any questions.

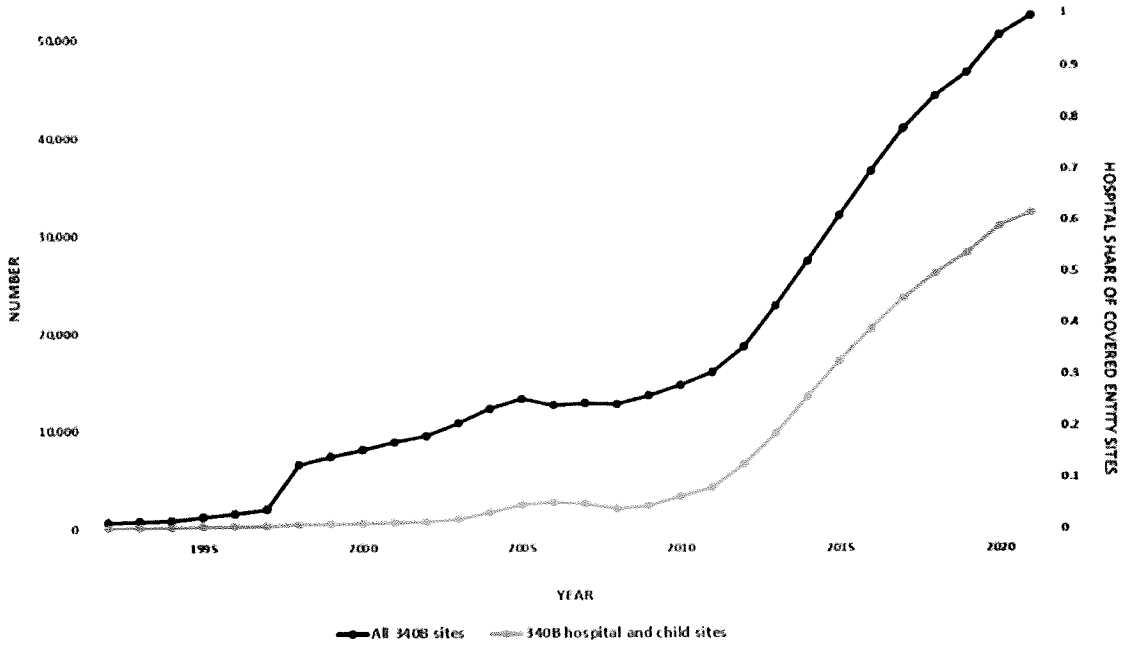
Sincerely,

Meg Garratt-Reed, Executive Director
Office of Affordable Health Care

I. In recent years, there has been massive growth in hospital participation in 340B

In the last 15 years, the size of the 340B program has grown significantly. The Affordable Care Act expanded the definition of "covered entity" eligible for the program to include Critical Access Hospitals. This change, along with an expansion of Medicaid which made many more hospitals eligible for the program using the Disproportionate Share Hospital definition, led to huge growth in the program, driven primarily by an increase in hospital and hospital affiliated sites.

Figure 1: Number of Covered Entity Sites 1992-2021[1]

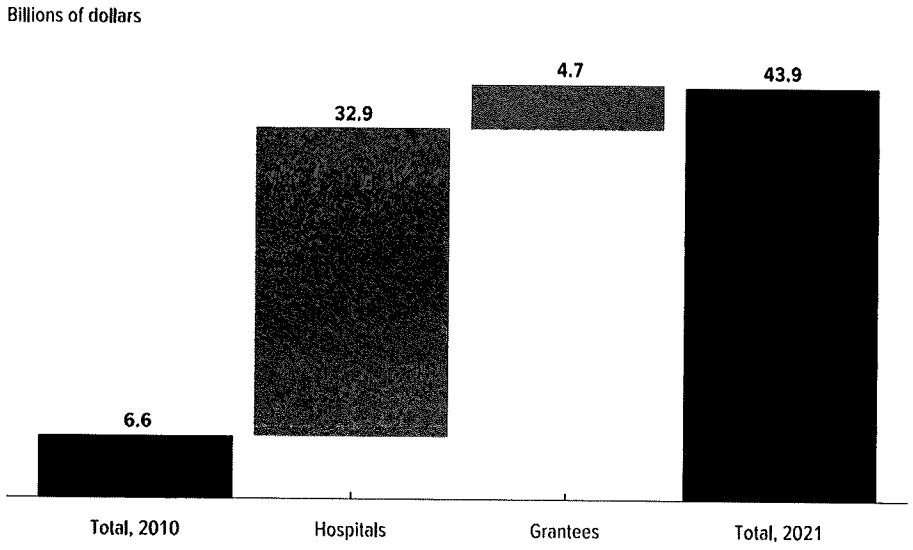


II. Growth in hospital participation, and in use of contract pharmacies, has greatly increased program spending

According to the Congressional Budget Office, 88% of the growth in spending in the 340B program from 2010 to 2021 can be attributed to drugs prescribed by hospitals and their affiliated clinics. 20% of the growth is associated with drugs distributed at contract pharmacies.

[1] Karen Mulligan, "The 340B Drug Pricing Program: Background, Ongoing Challenges and Recent Developments," USC Leonard D. Schaeffer Center for Health Policy & Economics White Paper, October 2021.

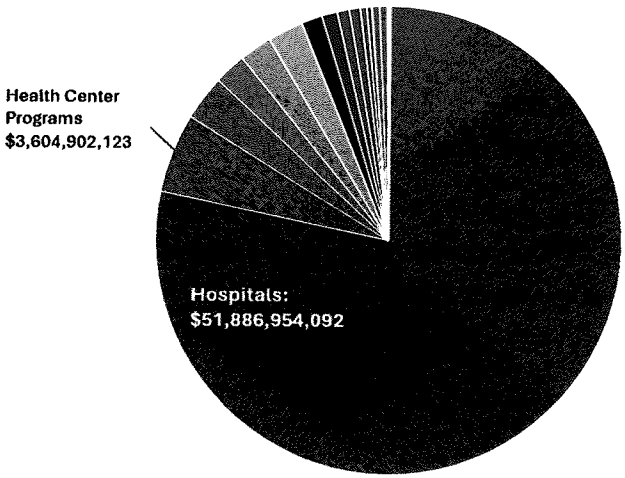
Figure 2: Growth in Spending (in Billions), by Facility Type, 2010-2021[2]



III. Hospitals now represent more than 80% of total 340B purchases nationally

The vast majority of purchases through the 340B program are now made by hospitals. Purchases by federal grantees (like FQHCs) and other organizations represent less than a quarter of spending.[3]

Figure 3: 340B Covered Entity Purchases by Entity Type, 2023



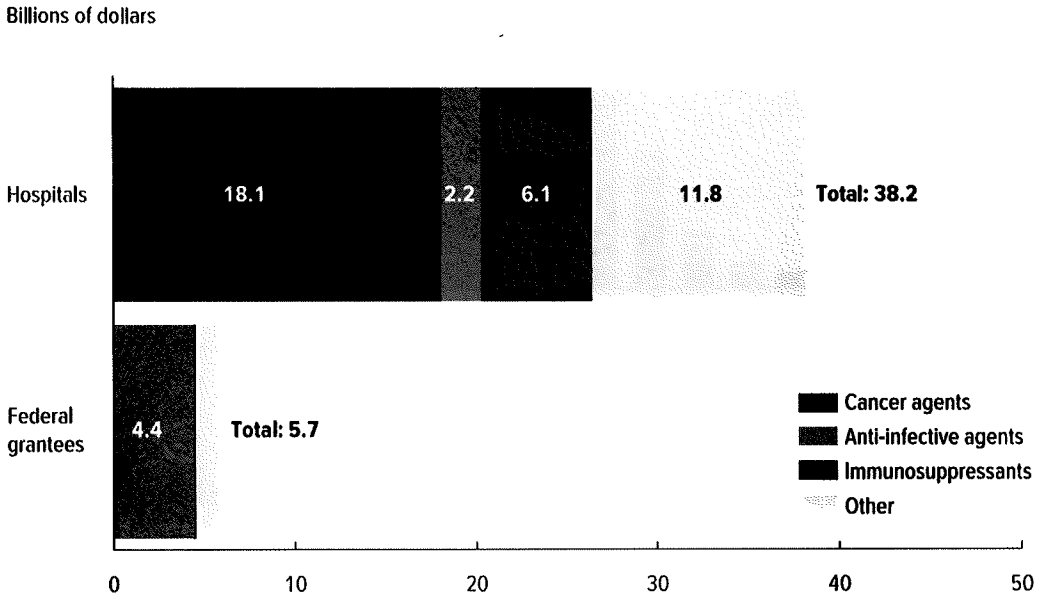
[2] Rebecca Sachs and Joshua Varci, Congressional Budget Office, "Spending in the 340B Drug Pricing Program, 2010 to 2021," Presentation at the 13th Annual Conference of the American Society of Health Economists, June 17, 2024. https://www.cbo.gov/system/files/2024-06/60339-340B-Drug-Pricing-Program.pdf

[3] OAHC visualization of HRSA data: https://www.hrsa.gov/opa/updates/2023-340b-covered-entity-purchases

IV. Hospitals are more likely than other entity types to prescribe high-cost drugs through the 340B program

The increase in 340B spending associated with hospital participation is not only volume-related, it can also be partially attributed to greater spending on high-cost drugs, particularly cancer agents.

Figure 4: 340B Spending (in Billions), by Facility Type and Drug Class, 2021[4]

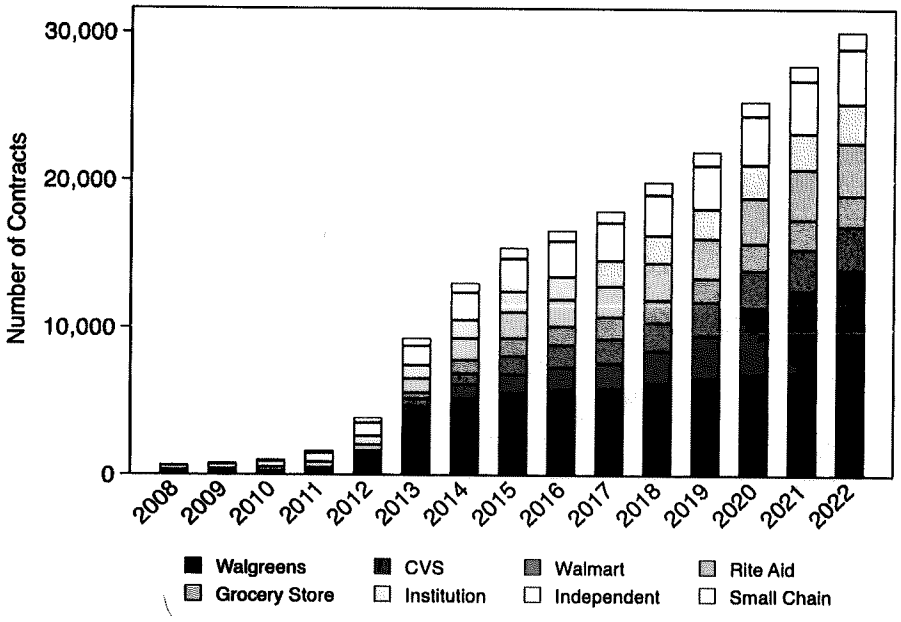


[4] Rebecca Sachs and Joshua Varci, Congressional Budget Office, "Spending in the 340B Drug Pricing Program, 2010 to 2021," Presentation at the 13th Annual Conference of the American Society of Health Economists, June 17, 2024. https://www.cbo.gov/system/files/2024-06/60339-340B-Drug-Pricing-Program.pdf

V. Large pharmacy chains have an increasing role in 340B as contract pharmacies

Two thirds of 340B contract pharmacy relationships are with the four largest pharmacy chains.

Figure 5: Trends in 340B participation by chain status, 2009–2022[5]



VI. The 340B program increases revenue when drugs for insured patients are purchased through the program

Example scenario – uninsured patient

	Without 340B	With 340B
Cost of drug	$100	$60
Reimbursement	$0	$0
Co-payment	$0	$0
Provider Revenue/Loss	-$100	-$60

Example scenario – insured patient

	Without 340B	With 340B
Cost of drug	$100	$60
Reimbursement	$100	$100
Co-payment	$10	$10
Provider Revenue/Loss	+$10	+$50

[5] Claire McGlave, John P Bruno, Elizabeth Watts, Sayeh Nikpay, 340B Contract pharmacy growth by pharmacy ownership: 2009–2022, *Health Affairs Scholar*, Volume 2, Issue 1, January 2024, qxad075, https://doi.org/10.1093/haschl/qxad075