Consumers for Affordable Health Care

Advocating the right to quality, affordable health care for all Mainers.

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Testimony 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

Senator Bailey, Representative Mathieson, and esteemed members of the Joint Standing Committee on Health Coverage, Insurance and Financial Services. Thank you for the opportunity to provide this testimony 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.

My name is Kate Ende, and I am the Policy Director at Consumers for Affordable Health Care (CAHC), a nonpartisan, nonprofit organization that advocates the right to quality, affordable health care for every person in Maine. As designated by Maine's Attorney General, CAHC serves as Maine's Health Insurance Consumer Assistance Program (CAP), which operates a toll-free HelpLine. Our HelpLine fielded nearly 7,300 calls and emails last year from people across Maine who needed help obtaining, keeping, using, or fixing problems with private health insurance or with accessing or affording health care services. CAHC also serves as the Ombudsman program for Maine's Medicaid program, MaineCare, and helps people apply for and navigate the enrollment process for MaineCare. It is with that background that we provide these comments.

We are testifying neither for nor against today because we believe the 340B program plays an important role in supporting Maine's safety-net providers and thus helps to provide access to care to Maine people. We also believe that it is important to address some of the issues raised by proponents of this bill, such as the example given of the federally qualified health center with several service sites across multiple counties- patients should not have to travel long distances outside of their community in order to access a contract 340B pharmacy. However, we have questions about implementation and possible unintended consequences and are also concerned with the overall lack of transparency in the 340B program.

The 340B Drug Pricing Program, established by the U.S. federal government in 1992, mandates that drug manufacturers supply outpatient drugs to eligible healthcare organizations, often referred to as "covered entities," at significantly reduced prices. The goal of the program is to help these organizations extend scarce federal resources, enabling them to serve more eligible patients and offer more comprehensive services. Entities benefiting from this program include health care providers that receive certain federal grants, such as federally qualified health centers (FQHCs), family planning clinics, and Ryan White HIV/AIDS program grantees, as well as certain types of hospitals that provide care to low-income, medically underserved individuals. There is no doubt that the 340B program is an important program. However, legitimate concerns have been raised about whether the program is operating as intended.

Past annual reports of the Maine Prescription Drug Affordability Board have recommended that "the Maine Legislature require greater transparency and accountability for the 340B program in Maine".[1]

Outpatient drugs purchased by covered entities through the 340B program are usually discounted by 20-50%, with an average discount of 34% off the Average Manufacturer Price (AMP).[2] However, discounts can be much higher, and in many instances, providers can purchase drugs for as little as one penny through the 340B program. For example, data from the Maine Health Data Organization (MHDO) shows that the most costly drug in Maine is Humira. For the past four years, payers in Maine, including health insurance companies, employers and individual Mainers, have spent more on Humira than any other drug. Under the 340B program, Humira is a penny drug, which means it is available to hospitals at 1 cent per unit. During the 12-month period between 7/1/22 and 6/30/23, Maine payers spent almost $140 million on Humira, with an average cost of over $8,000 per prescription,[3] even though 340B hospitals were able to acquire the drug for pennies.

340B Hospitals typically contract retail pharmacies to help administer their 340B drugs, so even when patients don't physically fill their prescription at the hospital, the hospital may still be generating revenue on that prescription. This also means that big for-profit companies that contract with 340B hospitals, including contract pharmacies, like CVS, as well as third-party administrators (TPAs) are also profiting from the 340B program.[4] In fact, according to CVS, if 340B entities (such as hospitals) were to reduce their contract pharmacy arrangements or reduce their use of CVS's administrative services, these changes to 340B "could materially and adversely affect" CVS.[5] A recent report from Minnesota, which enacted transparency reporting requirements for 340B entities, shows that at least 16% of 340B in the state went to contract pharmacies and TPAs. More data is needed to fully understand how much 340B revenue in Maine is flowing to large, for-profit corporations.[6]

The 340B statute states that the intention of the program is to "stretch federal resources as far as possible reaching more eligible patients and providing more comprehensive services." Some covered entities pass on 340B savings directly to their patients, while others may charge patients and third-party payers, such as private health plans, full price for 340B drugs. Covered entities can use revenue generated through the program "to expand the number of patients served, increase the scope of services offered to low-income and other patients, invest in capital, cover administrative costs, or for any other purpose," since the federal 340B statute doesn't dictate or limit how covered entities use 340B revenue.[7] Some covered entities that are federal grantees have restrictions on how 340B revenue may be

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[1] Maine Prescription Drug Affordability Board. 2022 Prescription Drug Affordability Board Annual Report. https://www.maine.gov/bhr/oeh/sites/maine.gov.bhr.oeh/files/inline-files/2022%20Prescription%20Drug%20Affordability%20Board%20Annual%20Report.pdf

[2] U.S. Department of Health and Human Services, Office of Inspector General. (2015). Contract pharmacy arrangements in the 340B program (OEI-12-14-00030). https://oig.hhs.gov/oei/reports/oei-12-14-00030.asp

[3] https://mhdo.maine.gov/tableau/prescriptionReports.cshtml#Dashboard2020

[5] https://d18rn0p25nwr6d.cloudfront.net/CIK-0000064803/d06cfa07-b8f8-49c0-9f5c-552a41b68e5d.pdf#page=25

[6] Minnesota's 340B Legislative Report 2024. https://www.health.state.mn.us/data/340b/docs/2024report.pdf

[7] Medicare Payment Advisory Commission. (2015). May 2015 Report to the Congress: Overview of the 340B Drug Pricing Program. https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/may-2015-report-to-the-congress-overview-of-the-340b-drug-pricing-program.pdf

used, such as FQHCs, which must use funds for purposes consistent with their federal grant requirements.[8] However, hospitals don't have these requirements.

Since the 340B program was first implemented, it has expanded to include more types of providers and to allow providers to contract with a greater number of pharmacies to administer 340B drugs to patients. The Health Resources and Services Administration (HRSA), which administers the 340B program, estimates 340B sales make up more 7% of the overall U.S. drug market.[9] In 2023, covered entities spent over $63 billion on outpatient drugs under the 340B Program, of which 80% was spent by hospitals.[10] As this program has expanded, concerns have been raised about how revenue is being used and whether it is working as intended.

A 2019 report from the U.S. Government Accountability Office highlighted issues of insufficient oversight of aspects of the 340B program, as well as the lack of information in hospital contracts about how hospitals meet obligations to provide health care services to low-income individuals.[11] A 2018 study published in the New England Journal of Medicine found there was no clear evidence that the 340B program had been associated with expanded care in hospitals or lower mortality among low-income patients.[12] A study published in *HealthAffairs* found that 340B hospitals are more likely to prescribe expensive biologic drugs rather than lower cost biosimilar alternatives, suggesting "that the program inhibited biosimilar uptake, possibly as a result of financial incentives making reference drugs more profitable than biosimilar medications."[13] A recent report from American Cancer Society Cancer Action Network that explores the intersection of 340B and Cancer Care found similar patterns in prescribing between 340B and non-340B providers, which resulted in higher out-of-pocket costs for oncology patients of 340B providers.[14]

Without clear data, it is impossible to know how the 340B program is operating in Maine. Maine's community health centers and hospitals are a vital part of our communities and provide needed medical care and services to thousands of Maine people every day. However, given health centers have more stringent reporting requirements, requiring greater transparency for hospitals is prudent and necessary to better understand how this program is operating in Maine, and potential impacts on overall health care costs. During the last legislative session, this committee and the Maine Legislature took a good first step by enacting legislation to require 340B hospitals to report certain information to the Maine Health Data Organization. However, the information required to be reported is extremely limited and is more

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[8] Ibid.

[9] Congressional Research Service. (2022). Overview of the 340B Drug Discount Program. https://crsreports.congress.gov/product/pdf/IF/IF12232

[10] Health Resources and Services Administration. (2024). 2023 340B Covered Entity Purchases. https://www.hrsa.gov/opa/updates/2023-340b-covered-entity-purchases

[11] U.S. Government Accountability Office. (2019). 340B Drug Discount Program: Increased Oversight Needed to Ensure Nongovernmental Hospitals Meet Eligibility Requirements (GAO-20-108). https://www.gao.gov/assets/gao-20-108.pdf

[12] Desai, S., & McWilliams, J. M. (2018). Consequences of the 340B Drug Pricing Program. The New England Journal of Medicine, Volume 378;6, pages 539-48. https://doi.org/10.1056/NEJMsa1706475

[13] https://www.healthaffairs.org/doi/10.1377/hlthaff.2022.00812

[14] American Cancer Society Cancer Action Network. The Intersection of 340B and Cancer Care. https://www.fightcancer.org/sites/default/files/national_documents/340b_and_cancer_care_-_final_3-12-25.pdf?utm_source=costcurve.beehiiv.com&utm_medium=referral&utm_campaign=the-wsj-just-ran-a-story-showing-how-the-lack-of-340b-oversight-is-opening-the-door-to-abuse

qualitative in nature. If this committee moves forward with this legislation, we strongly urge you to consider strengthening transparency requirements, such as by adopting more comprehensive 340B reporting requirements, such as those enacted in Minnesota.[15] We also have questions about certain provisions included in LD 1018, and about the potential unintended consequences of implementing these types of contract requirements in Maine. For example, section §7704(4) prohibits a health insurance issuer, pharmacy benefits manager or other 3rd-party payor, such as an employer, from incentivizing their members to have a drug administered at a non-340B site of care. Does this mean *all* 340B providers able to administer a given drug must be in-network? If so, what would the impact be on the ability of carriers and employers to negotiate affordable rates for consumers? For plans with a tiered network, would all 340B hospitals have to be placed at the highest tier, perhaps over other independent providers, *just* because they participate in the 340B program? If so, how would this impact-of-pocket costs for consumers?

Recent polling conducted in Maine shows that nearly half of Maine families have taken on medical debt in the last two years. Of those families with medical debt, nearly half report that a prescription drug contributed to their debt. One out of three Mainers report they have delayed filling a prescription, cut pills in half, skipped doses of medicine, or did not fill a prescription, due to costs.[16] Consumers feel the impact of expensive and rising drug costs at the pharmacy, as well as in their monthly premiums, with half of Mainers with commercial insurance reporting they are concerned they will lose their coverage because they cannot afford it.

I want to reiterate the important role that the 340B program plays in supporting safety net providers across the country and here in Maine. I also want to reiterate our support for reforms that ensure our rural providers can fully utilize the benefits of this program so that they may continue to serve people in the communities where they live. However, I would urge caution in expanding this program further without also strengthening transparency so that policymakers can better understand how this important program is operating to benefit Maine people and providers. Thank you.

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[15] Minnesota's 340B Legislative Report 2024. https://www.health.state.mn.us/data/340b/docs/2024report.pdf

[16] https://drive.google.com/file/d/1of-aZWztHbCJDGZODeqoWEVvYcokHw41/view