Re: Senate Bill 1179, the 340B Drug Pricing Program

Dear Members of the Michigan State Legislature,

Thank you for inviting me today to appear before you on behalf of the Michigan Health Purchaser's Coalition regarding the 340B Drug Pricing Program ("340B") and the Michigan legislature's efforts to reform the program.

As an organization of businesses and unions deeply rooted in the state of Michigan, we believe in the 340B program's important mission to increase access to more affordable medicines for low-income patients and communities. We strongly support Congress's original intent when it designed the program in 1992 – and recognize its importance today for the many health centers and core safety-net hospitals that serve as good stewards of program funds and use them to expand care and services for Michiganders in need.

The 340B program, thanks to minimal guardrails and a low threshold for program qualification that has not changed in over 30 years, has gone well past that intent. Today, 340B operates as a government-sanctioned arbitrage scheme, rather than the support for patients it was intended to be, and many corporate health systems exploit this loophole.

As a representative for employers, purchasers, and the more than half of Michiganders covered by employer-sponsored healthcare, I am worried that 340B and its distortive effects on the market are driving up costs for large and small businesses and working families across the state – without providing any benefits to the patients it was intended to serve. I urge the legislature today to carefully consider 340B's impact on employers and working families before advancing any reforms, and to avoid codifying elements of the program that may have far-reaching negative effects for working families.

Background

At its core, 340B allows health systems that qualify for the program to "buy low and sell high" on prescription medicines. They can purchase drugs at a steep discount, mark them up as much as 8 times, and charge working families and their health plans full list prices – pocketing the proceeds with no requirements that they are used to benefit low-income or uninsured patients. In fact, patients' cost-sharing at 340B hospitals and their pharmacies is often based on the list price of a medicine, not the 340B-discounted purchase price.[1]

Originally, this applied to fewer than 100 core safety-net hospitals and smaller, specialized clinics serving specific vulnerable populations like those with HIV/AIDS and hemophilia – and it worked well. Federal requirements for community health centers, other "federal grantees" and certain safety-net hospitals in the program ensure affordability for patients and that every dollar of revenue is spent on patient care, meaning 340B at those entities was and is translated into direct benefits for communities in need.

[1] https://jamanetwork.com/journals/jama-health-forum/fullarticle/2821579

However, over the past three decades, the program has grown exponentially. This is partially a result of policy changes, such as the federal government's creation of a rule in 2010, without Congressional agreement, to allow hospitals to work with an unlimited number of external pharmacies. It also reflects shifts in the nation's healthcare landscape more broadly, such as the expansion of Medicaid in states like Michigan. Since 2010, Medicaid has expanded dramatically, but the threshold for hospitals to qualify for 340B hasn't changed – even though that threshold is based in part on the number of Medicaid patients they serve.

Over time, hospital systems have recognized the boost that 340B can provide to their bottom lines and capitalized on it. From its humble origins in 1992, the program has grown to become the second-largest federal drug program today, surpassed only by Medicare Part D. 340B purchases at the discounted price were nearly $66 billion in 2023 alone[2] – and the discounts ranged from 30-50% off wholesale or "list" prices, and sometimes can be as low as one penny.[3]

Today, over half of all hospitals in Michigan participate in 340B,[4,5] with multibillion dollar health systems as some of the chief beneficiaries. This system, the product of a merger between Spectrum Health and Beaumont Health, operates hundreds of 340B sites across the state.

340B contributes to cost increases for employers and working families

At its current size, employers in Michigan and across the country worry that 340B is in many cases falling short of its original mission. In fact, a growing body of evidence shows that it is contributing to the rising cost of healthcare that continues to cripple Michigan businesses and working families. At the same time, there is no requirement that the savings that 340B hospitals receive are passed on to patients in any way.

Lost rebates

Under the 340B program, the discounts accrue to the hospital, not the end purchasers of the drugs. Therefore, employers, unions and working families do not receive rebates or discounts on any prescription drugs that hospitals purchase through 340B – even as the patient may face a co-pay at the pharmacy counter based on the full price of the drug, and the health insurance they've earned pays the full, commercially negotiated rate for the prescription. This loss of rebates has been shown to raise drug costs for self-insured employers and their workers by 4.2%, equivalent to a $5.2 billion increase in annual healthcare costs compared to if employers received typical rebates on 340B prescriptions.[6] Rebates negotiated on behalf of purchasers help bring down employees' premiums and cost-sharing at the pharmacy counter, meaning the loss of those rebates due to 340B raises costs for working families.

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[2] https://www.hrsa.gov/opa/updates/2023-340b-covered-entity-purchases
[3] https://www.gao.gov/assets/gao-11-836.pdf
[4] https://www.kff.org/other/state-indicator/total-hospitals/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D
[5] https://greatlakeswire.com/stories/657974520-87-michigan-hospitals-participate-in-federal-340b-drug-pricing-program
[6] https://www.iqvia.com/-/media/iqvia/pdfs/us/white-paper/iqvia-cost-of-340b-part-1-white-paper-2024.pdf

This is true nationwide and in Michigan. For the 4.8 million Michigan residents covered by employer-sponsored plans, 340B increased healthcare costs by $57 per beneficiary due to lost rebates, raising overall healthcare costs by $272 million per year.

Prescription drug mark-ups

At its most basic level, 340B is structured as an arbitrage system in which participants can buy prescription drugs at a steep discount, mark them up significantly, and charge commercial insurance plans the full price. These mark-ups are well documented across the country. Most notably, North Carolina's State Treasurer recently found that 340B hospitals in the state had billed the state employee health plan an average markup of 5.4 times their acquisition cost for oncology drugs.[7] While 340B is often referenced as a "costless" program to taxpayers, these mark-ups represent profits for corporate healthcare systems, on the backs of higher prices paid by working families with employer-sponsored insurance.

Impact on consolidation

340B provides strong incentives for consolidation, as hospitals are able to acquire previously independent outpatient physician offices and classify them as 340B "child sites." In doing so, they can boost profits by maximizing the spread they receive from their mark-ups through the expansion of their 340B reach to more commercially insured patients.

In the last three years alone, we have seen countless examples of high-profile consolidation in Michigan, which has affected millions of patients and more than 150,000 healthcare workers. The *Detroit Free Press* labeled this phenomenon the "dawn of the mega merger" in our state.[8] The evidence overwhelmingly shows that consolidation increases costs for patients and does not improve care;[9] It is therefore troubling for employers that 340B is a contributor to this phenomenon.

The association between 340B and vertical consolidation in hematology-oncology, in particular,[10] is well-documented, particularly due to the fact that high-cost drugs for these disease states yield significant 340B margins for hospitals. This is especially true for outpatient "child sites" located in wealthy areas with well-insured patients, which is often the case.[11] Research indicates that 340B hospitals mark up medicines at significantly higher rates than independent physician offices.[12]

Hospital systems can also game the program by classifying facilities in wealthy areas as "child sites" of their hospitals that serve low-income patients. While the Bon Secours system in

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[7] https://www.nctreasurer.com/news/press-releases/2024/05/08/state-treasurer-folwell-releases-report-finding-north-carolina-340b-hospitals-overcharged-state
[8] https://www.freep.com/story/news/health/2023/11/16/michigan-hospital-mega-mergers-corewell-henry-ford-university-michigan/71476024007/
[9] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6170097/
[10] https://www.nejm.org/doi/full/10.1056/NEJMsa1706475#:~:text=Hospital%20eligibility%20for%20the%20340B,and%200.1%20(or%2033%25)
[11] https://avalere.com/insights/340b-hospital-child-sites-and-contract-pharmacy-demographics
[12] https://jamanetwork.com/journals/jama-health-forum/fullarticle/2807907

Richmond, VA, is the most notorious example,[13] this practice is widespread in Michigan as well. According to the *Wall Street Journal*, "West Bloomfield, a northwestern suburb that has private insurance rates of 80% or higher and median household income of around $121,000 – more than three times the median income for the city of Detroit – has 14 registered 340B hospital sites. A similar-size region on the eastern side of Detroit, which includes three federally designated medically underserved areas, has none." Corewell Health in particular "owns a half-dozen 340B hospitals in the Detroit area with 55 remote sites signed up for the drug discounts, has none registered in the city of Detroit." Further, over 90% of Henry Ford Health's 467 340B child sites are in better-insured areas than their "parent" facility.[14] This practice gives 340B hospitals both a competitive advantage and a vested interest in securing as many facilities as possible to expand their 340B reach through horizontal consolidation.

Opportunities for chain pharmacy and PBM profit

340B also encourages for-profit chain pharmacies and PBMs to profit from the program. Currently, corporate health systems are able to create networks of external retail chain and mail-order pharmacies they can use to profit from 340B. The exponential growth of these networks since 2010 – which have zero basis in statute – is a major factor in the program's rapid expansion.

There is no requirement that these pharmacies are located in low-income communities or that they provide medicines to patients at affordable prices. In fact, research has found they are expanding in increasingly wealthier, predominantly white, and better-insured areas. This enables health systems to further augment the number of prescriptions they can purchase at 340B discounts, which they can then mark up and bill employers and families at full commercial prices.[15]

Michigan is no exception to this rule, with over half of contract pharmacies located in high-income districts – and some even located out of state as far as California.[16] Clearly, such locations are being used to drive extra revenue to healthcare systems rather than improve access for low-income Michiganders.

Incentives for prescribing higher-cost medicines

Finally, 340B has been shown to drive providers to prescribe higher-priced drugs. Healthcare systems can make a larger 'spread' from more expensive, brand name drugs than the lower-cost, equally effective biosimilar. The GAO has reported that "there is a financial incentive at hospitals participating in the 340B program to prescribe more drugs or more expensive drugs,"[17] and academic research has found evidence of this. One study published in Health Affairs found that 340B program eligibility was associated with a 22.9 percentage point reduction in biosimilar

[13] https://www.nytimes.com/2022/09/24/health/bon-secours-mercy-health-profit-poor-neighborhood.html
[14] https://www.wsj.com/articles/340b-drug-discounts-hospitals-low-income-federal-program-11671553899
[15] https://jamanetwork.com/journals/jama-health-forum/fullarticle/2807907
[16] https://pioneerinstitute.org/wp-content/uploads/Michigan-2024.pdf
[17] https://www.gao.gov/products/gao-15-442

adoption between 2017 and 2019.[18] Another analysis found that between 25% and 56% of corporate health systems only list prices for the innovator product, and very few offer all available biosimilars.[19] As a result, drug costs are higher at 340B hospitals compared with non-340B hospitals: one study found that the average cost per prescription for a commercially insured patient was more than 150% greater,[20] and another that oncology drugs provided by newly eligible 340B hospitals cost more than $4,000 more.[21]

All of these distortive effects raise costs for employers and their employees, without any requirements that 340B funds benefit low-income communities. In fact, Michigan's 340B hospitals provide less charity care than the national average.[22]

The Impact of SB 1179

Employers and lawmakers in Michigan have made great strides to introduce more transparency in the healthcare system in order to help bring down costs. SB 1179 would represent a step backward. It would exacerbate 340B's upward pressure on costs for working families without doing anything to promote access or affordability for low-income patients.

The bill would lock in one of 340B's most well-documented flaws: contract pharmacy. Unlimited networks of pharmacies in wealthy, well-insured, and often far-flung regions of the state have been a key factor in the program's expansion over the past decade-plus. They have helped hospitals maximize the number of 340B prescriptions they can process through commercial insurance and, thus, their profit on the sale of discounted drugs that are not being shared with working families or the employer purchasers who provide their healthcare.

SB 1179 would simply enshrine this status quo in law, perpetuating the continued unchecked expansion of the program's underlying arbitrage system, exacerbating its distortive effects on consolidation and prescribing patterns, and preventing efforts to introduce transparency into this opaque program. A recent IQVIA analysis found that the bill would increase the existing costs of 340B to self-funded employers by $57.7 million, to $75 per beneficiary or $358M overall. All in all, it would raise costs for employers and working families while benefiting the corporate health systems and their chain pharmacy and PBM partners.

Conclusion

As rising healthcare premiums and insurance costs continue to increase our overall operational expenses and impact the benefits coverage we can offer our employees, we cannot support

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[18] https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2022.00812
[19] https://communityoncology.org/hospital-340b-drug-profits-report-feb-2021/
[20] https://www.milliman.com/en/insight/2020-outpatient-drug-spend-at-340b-hospitals
[21] https://jamanetwork.com/journals/jama-health-forum/fullarticle/2806517
[22] https://pioneerinstitute.org/wp-content/uploads/Michigan-2024.pdf

legislation that would irresponsibly increase expenses without ensuring the program works for our state's vulnerable communities.

Together, small and large businesses, our labor union partners and working families urge the Committee to oppose SB 1179 and instead look to more comprehensive reforms that promote transparency and accountability in 340B, provide affordability protections for patients, and limit 340B's inflationary effects on healthcare spending for working families.

Bret Jackson

Michigan Health Purchasers Coalition