COUNCIL for CITIZENS AGAINST GOVERNMENT WASTE

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House of Representatives
Washington, D.C. 20515

Dear Representative,

The Council for Citizens Against Government Waste (CCAGW) has long called for significant reforms to the 340B drug discount program. Created in 1992 to help uninsured, impoverished individuals obtain low-cost prescription drugs, 340B has grown exponentially since 2014 according to data from the Health Resources and Services Administration(HRSA), the agency that oversees the program. The blog *Drug Channels* reported in June 2020 that discounted 340B drug purchases reached $29.9 billion in 2019, an increase of 23 percent from 2018 and more than 232 percent since 2014.

CCAGW agrees with many of the conclusions in a January 2018 House Energy and Commerce Committee report, including Congress's failure to clearly identify the intent of the program, especially the definition of a 340B patient, and require covered entities, like disproportionate share hospitals (DSH) and contract pharmacies, to report program savings and how they are used.

It is our understanding you have been asked to sign a letter intended for Health and Human Services Secretary Alex Azar regarding actions several pharmaceutical companies have taken to restrict sales to certain entities that serve 340B patients. According to a September 4, 2020 *Modern Healthcare* article, some companies are restricting 340B drug discounts for some or all of their drugs to in-house pharmacies run by 340B providers. There are questions as to whether these actions are legal, since the statute is silent on many program requirements. What these actions really represent are the continued problems with the 340B program that must be fixed. CCAGW asks that you focus on reforming the 340B program instead of signing a letter that will not solve longstanding problems.

Reforms should include contract pharmacies. According to a June 28, 2018 Government Accountability Office (GAO) report, "Federal Oversight of Compliance at 340B Contract Pharmacies Need Improvement," contract pharmacies grew from 1,300 in 2010 to nearly 20,000 in 2017. Currently, contract pharmacies number around 28,000, an amazing statistic considering the 340B statute does not authorize the use of contract pharmacies. They were created in 1996 HRSA issue guidance allowing covered entities without an on-site pharmacy to contract with one off-site pharmacy. In 2010, ensuing guidelines removed the limitation on the number of contract pharmacies a covered entity can have.

The 2018 GAO report found that HRSA only assessed the potential for duplicate discounts - utilizing both 340B and Medicaid rebates are prohibited by law - in Medicaid Fee-for-Service and not Medicaid managed care programs, which provide most Medicaid prescriptions. GAO recommended guidance for preventing and auditing duplicate discounts in Medicaid managed care programs.

A January 2020 GAO report, "Oversight of the Intersection with the Medicaid Drug Rebate Program Needs Improvement," found continued weaknesses in HRSA's oversight of contract pharmacies and the prohibition on duplicate discounts for drugs prescribed to Medicaid. Unlike Medicaid Fee-for-Service, when duplicate discounts are identified in Medicaid managed care claims, HRSA does not require the covered entities to address or repay them to manufacturers.

The draft letter to Secretary Azar incorrectly claims that "The savings created by 340B do not cost the American taxpayer a single dollar, as the savings come directly from discounts provided by the manufacturers." Several studies have shown this is not true.

A July 6, 2015 GAO report, "Action Needed to Reduce Financial Incentives to Prescribe 340B Drugs at Participating Hospitals," found that per beneficiary spending on Medicare Part B drugs, including oncology drugs, was substantially higher at 340B DSH facilities than non-340B hospitals. GAO indicated that on average 340B hospitals either prescribed more drugs or more expensive drugs then beneficiaries at other hospitals.

An April 2016 Milliman study, "Cost Drivers of Cancer Care: A Retrospective Analysis of Medicare and Commercially Insured Population Claim Data 2004-2014," analyzed trends in the overall and component costs of cancer care over 10 years and compared it to cost trends in the non-cancer population. In addition to a growing older population that is more likely to face cancer and newer and more effective therapies, the site where patients receive their chemotherapy has shifted from lower-cost physician offices to higher-cost hospital outpatient settings. Studies have shown that 340B hospitals are buying independent oncology practices, where private insurance is used, but are using their 340B discount to turn a profit.

Not too long ago, Congress was focused on the need to reform the 340B program and legislation was introduced to preserve the program for what it was intended, helping indigent people get access to important medications, and not enrich private, for-profit contract pharmacies. We urge you to refocus on this effort rather than signing the letter to Secretary Azar.

Sincerely,

Thomas Schatz