Thomas A. Schatz, *President*
1100 Connecticut Ave., N.W., Suite 650
Washington, D.C. 20036
ccagw.org

February 7, 2022

Mississippi House of Representatives
Mississippi Capitol
400 High Street Jackson, MS 39201

Dear Representative,

On behalf of the 10,753 members and supporters of the Council for Citizens Against Government Waste (CCAGW) in Mississippi, I urge you to vote against H.B. 733, which is scheduled for a vote on the floor of the House of Representatives today.

H.B. 733 will make changes to the federal 340B drug program. No state should be taking action to expand, modify, or amend this program.

H.B. 733 includes price controls that will not help reduce the cost of pharmaceuticals and will instead perpetuate the adverse impact of the 340B program, which has been of concern to taxpayer advocates since 2014. The bill also institutes an $11.29 dispensing provision that would cost $275 million to Mississippi families if it is applied to the 24.3 million prescriptions billed in the commercial market. Authorizing government distortion of the healthcare marketplace will result in higher costs for all patients and put vulnerable patients with cancer or other rare diseases at risk.

Intended as a safety-net program for the indigent and uninsured, 340B, which is run by the Health Resources and Services Administration (HRSA), has undergone tremendous growth, especially since additional healthcare entities were made eligible for the program under the Patient Protection and Affordable Care Act (Obamacare).

The 340B program has grown from $9 billion in 2014 to $29.9 billion in 2019 and represents more than 8 percent of all drug sales. The program is being abused by many nonprofit hospitals and for-profit pharmacies because there is no requirement in the federal law for them to pass along the savings to the patient. Instead, they can pocket the difference between the 340B discounted price and what insurance pays. These entities look for opportunities to make a hefty profit off this safety net program. H.B. 733 does not solve this problem, which again can only be done by Congress.

The 340B program was created as part of the 1992 Veterans Health Care Act due to how Congress implemented the Medicaid Drug Rebate program in 1990. When the Medicaid drug benefit was being written, the rebate value was based on the average manufacturer price (AMP) or the difference between the AMP and the lowest price charged to any entity in the U.S. Although Congress was alerted in hearings that using an all-inclusive AMP would be a problem, they did not factor in the significant discounts that pharmaceutical companies had been voluntarily giving the Department of Veterans Affairs (VA) and non-profit entities that served the indigent and uninsured. As a result, the generous discounts that had been provided to the VA and non-profit entities disappeared.

The 1992 law created two new price control programs, the VA Federal Ceiling Price program and the 340B Drug Discount Program and excluded their prices from the Medicaid rebate calculus. These price control programs, along with those found in the Medicare Part D coverage gap, have distorted the pharmaceutical marketplace in the U.S.

CCAGW questions whether the state of Mississippi has the authority to direct the shipment of drugs or determine how 340B discounts can be utilized in this federal program and whether the state is interfering in the private contracts between employers and pharmacy benefit managers (PBM). Employers work with PBMs to design and manage their employees' drug plans that provide an important benefit and keep costs low and quality high, which may include utilizing mail order pharmacies or certain pharmacies that are in their network. Arbitrarily changing these agreements could cause drug prices to go up for employers and their employees.

The House Energy and Commerce Committee's January 10, 2018, report highlighted the weaknesses in the program. In the summary it said, "Congress did not clearly identify the intent of the program and did not identify clear parameters, leaving the statute silent on many important program requirements. … HRSA lacks sufficient regulatory authority to adequately oversee the program and clarify program requirements." Some of the problems include no clear definition of a 340B patient and nowhere in the law does it authorize the use of contract pharmacies. The use of contract pharmacies came about because of guidance written by HRSA. As a result of the ambiguity, the use of contract pharmacies is now under litigation. Because there is no clear definition, hospitals and for-profit pharmacies continue to take advantage of this program. The program is fueling hospital purchases of oncology physician offices to generate revenue.

A June 28, 2018, Government Accountability Office report noted that certain hospitals and entities are increasing their contracts with pharmacies to dispense 340B drugs and "doing so can make it harder to ensure compliance with 340B rules. For example, contract pharmacies may also fill prescriptions for the general public, increasing the risk of dispensing 340B drugs to ineligible patients." A November 2021 Xcenda report on 340B confirmed that "the program is not being used as intended to help low income and vulnerable individuals get access to low-cost prescription drugs. Instead, it is boosting hospitals' coffers and their contract pharmacies' profits that are largely located in areas that do not serve low-income people." The report's conclusions concur with a 2018 New England Journal of Medicine study that "found compelling evidence that financial gains for hospitals were not associated with expanded care or lower mortality among low-income patients. In fact, the analysis suggested hospitals use the 340B program for financial gain and act contrary to the goals of the program to serve low-income patients."

Rather than usurp Congress's responsibilities and potentially violate federal law, as well as exacerbate the wasteful spending in 340B and fail to serve low-income people, I urge you to contact your congressional delegation and ask them to reform the program, which would include providing a clear definition of a patient. CCAGW's preference is the patient is indigent, is not eligible for Medicaid, and does not have insurance. Again, we respectfully ask that you to vote against H.B 733.

Sincerely,

Tom Schatz