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April 4, 2025

Senator Ginny Lyons, Chair
Vermont Senate Committee on Health and Welfare
155 State Street
Montpelier, VT 05602

RE: Office of the Health Care Advocate Testimony in Support of H.266

Dear Chair Lyons and Members of the Committee:

Thank you for the opportunity to speak to you today about H.266—An act relating to the 340B prescription drug pricing program.

Section 1: Contract Pharmacy Protections

The HCA cautiously supports the contract pharmacy protections in Section 1 of the bill. Why cautiously?

The HCA understands that 340B revenue is a vital lifeline for many Vermont health care providers. We also know that Vermont providers rely on contract pharmacies to maximize their 340B revenue, and that restrictions on contract pharmacies by drug manufacturers have reduced that revenue. These restrictions hurt Vermonters.

At the same time, we think it needs to be acknowledged that the "contract pharmacies" issue is contentious issue—and has been ever since HRSA issued guidance stating that covered entities can utilize "unlimited contract pharmacies" a decade and a half ago.

First, drug manufacturers sued HRSA over efforts to enforce the "unlimited contract pharmacies" interpretation of 340B. That litigation went in the manufacturers' favor, with the 3rd and DC circuits allowing manufacturer restrictions on contract pharmacies to continue.

In response, states began passing contract pharmacy protection legislation similar to what is contained in H.266. And manufacturers sued those states—each of the first eight (with it being too soon to tell whether recent signers-on will also face

litigation. So far, this litigation has been favorable to the states, with the exception of West Virginia. That one exception creates the potential for a circuit split, which increases the likelihood the U.S. Supreme Court may weigh-in on the contract pharmacy issue.

That is why the HCA cautiously supports Section 1 of H.266. This is a litigious area. But while "unlimited contract pharmacies" is still permissible, we should put our Vermont providers on the strongest possible footing with respect to 340B and give them this contract pharmacy protection language.

Section 2: 340B Transparency

At the same time, this is an opportunity for the state of Vermont to learn more about the impact of 340B on our fragile state health care system. And that is what the purpose of Section 2 of H.266 is—to provide transparency into the 340B program in Vermont.

Why would transparency into 340B be helpful to Vermont policymakers? What insights might we gain? What questions are we trying to answer? Here are a few examples of the questions that could be answered with robust 340B transparency language and why it is important we answer those questions:

- How much 340B revenue are hospitals generating?
    - System-wide, at the hospital level, it is almost certainly more than $50 million annually. But we do not know precisely, and so we should ask the question.
- Where is the revenue coming from? Who is paying that $50 million plus?
    - There is a misperception that 340B revenue comes from the drug manufacturers. But no, it comes from us. That revenue is being paid first, by ordinary Vermonters (many of whom are struggling financially) through their cost sharing—most impactfully upon Vermonters with HDHPs in their deductible phase; and then that revenue is being paid by our Vermont health insurers (who are struggling); also by our local Vermont businesses that self-insure (many of whom are struggling); and also by our government payers (who are struggling).
- How much are hospitals paying others to maximize their 340B revenue?
    - When 340B was small and limited to in-house pharmacies or a small number of contract pharmacies, hospitals managed their participation on their own. Now "340B maximization" is a service

hospitals can buy—just Google it. It would be good to know how much 340B revenue is being diverted for that purpose.

- Who are hospitals paying to maximize their 340B revenue?
    - Who are these "340B maximizers"? It does not seem likely they are Vermont non-profits. We know it is likely the case that entities affiliated with the Big 3 PBMs and the national chain drug stores all have their foot in the game. But it would be good to know. We should ask. And what services are those vendors providing?
- How can we support hospitals to keep more 340B revenue in Vermont?
- What are hospitals doing with the 340B revenue?
    - The purpose of the program is to stretch scarce resources to serve as many people as possible. Are hospitals adhering to that purpose? How might access to care be impacted if 340B went away?
- What direct impacts does 340B have on patients?
    - Again, 340B revenue is being generated by patients—by people with an illness who need medication, often very expensive medication. There is no requirement that hospitals share their 340B discount with patients. But it is not prohibited either. And with that 340B revenue, are hospitals increasing their charity care?
- What can we do to support patients?

Those questions represent some of the why—why transparency is important. Why it would be worth putting hospitals through the trouble of doing this reporting for just five years.

We should <u>not</u> do window-dressing transparency. Particularly with the five-year sunset that was added in the House—and which we agree with, require this reporting for five years and see how it goes. But with just five years, Vermont should make the most of the opportunity and get the best data we can get.

With that in mind, we have some recommendations about the language that came out of the House.

Regarding Section 2, Paragraph (1)

Paragraph (1) in H.266 as passed by the House calls for hospitals to submit annually to the GMCB "the annual <u>estimated savings</u> to the hospital from participating in 340B" and it provides the method for deriving that <u>estimate</u> as "comparing the acquisition price of drugs under the 340B program to group purchasing organization pricing".

Our recommendation is to restore the original language, which you can see here on the right, and to make some improvements to that language, which have been highlighted in yellow.

Section 2, Paragraph 1

As Passed by the House:

The annual estimated savings to the hospital from participating in the 340B program, comparing the acquisition price of drugs under the 340B program to group purchasing organization pricing. If group purchasing organization pricing is not available for a specific drug, the hospital shall compare the acquisition price under the 340B program to the price from another generally accepted pricing source.

HCA Recommendation:

(1) the aggregated acquisition cost for all prescription drugs that the hospital, or any entity acting on the hospital's behalf, obtained through the 340B program during the previous calendar year

(2) the aggregated payment amount, broken down by payer type (including Medicare, Medicaid, commercial, and uninsured) and further separated into patient cost-sharing and third-party payer contributions, that the hospital received for all prescription drugs obtained under the 340B program and dispensed and administered to patients during the previous calendar year

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Our reasoning for the recommendation is simple. If the goal of Section 2 is to have actual transparency into the 340B program here in Vermont, paragraph (1) as passed by the House does not achieve that goal. If what we want to know is—how much revenue are Vermont hospitals generating from 340B? and who are they generating that revenue from?—we should ask those questions.

That is what the HCA recommended language does. It would require hospitals to report "the aggregated acquisition cost for all prescription drugs that the hospital, or any entity acting on the hospital's behalf, obtained through 340B"—in other words, provide the hospital's actual acquisition cost for 340B drugs at an aggregate level.

And next, the language would require hospitals to report "the aggregated payment amount, broken down by payer type … and further separated into patient cost sharing and third-party payer contributions, that the hospital received for all prescription drugs obtained under the 340B and [that were]

dispensed and administered to patients"—in other words, what the hospitals were reimbursed for 340B drugs.

From those two numbers—what hospitals were reimbursed, minus what they were paid—we would know the hospital's actual 340B revenue. We would also have a breakdown of that revenue by payer type, which will help policymakers to see the relative burden of 340B on Vermont payers and on Vermont patients.

Our HCA recommendation to ask for "actual revenue" is more transparent than "estimated revenue" derived from a comparison to group purchasing organization prices. For that reason, we would encourage the committee to adopt our recommended language or something close to it.

In the House, hospitals pushed back on the "actual revenue" language as burdensome, that it would be easier to get that information from drug wholesalers, and also that, in some cases, particularly with respect to infused drugs under bundled payments, that it would be impossible for them to provide precise data.

A few quick points in response to those concerns:

- Our understanding is that many (or most) hospitals—certainly the larger ones—use third party administrators to manage their 340B participation and that data about acquisition costs and payments for 340B drugs should be readily available from their TPAs;
- Also, the HCA recommended language is based on the reporting requirements from Minnesota. If you Google "Minnesota 340B transparency report"[1] you will see that Minnesota received a greater than 90% response rate with similar language.
- Regarding administered drugs with bundled payments, Minnesota noted in their report that this was indeed an issue for them. Fortunately, Vermont gets to benefit from Minnesota's experience. If you Google, "Minnesota 340B 2025 administered drug guidance"[2] you will see how Minnesota is proposing to address this issue in 2025. We could use that guidance here in Vermont.

Regarding Section 2, Paragraph 3

In Section 2, Paragraph 3, we recommend adding to the end of the paragraph a requirement that hospitals list who their 340B vendors are and briefly describe

[1] https://www.health.state.mn.us/data/340b/docs/2024report.pdf
[2] https://www.health.state.mn.us/data/340b/docs/draftadmin2025.pdf

what those vendors do. The payment information would still be aggregated. And this language is not seeking disclosure of proprietary information either. Simply, who are the vendors and what do they do?

Section 2, Paragraph 3

As Passed by the House:	HCA Recommendation:
The aggregated payment amount that the hospital made to any other outside vendor for managing, administering, or facilitating any aspect of the hospital's 340B drug program during the previous hospital fiscal year.	The aggregated payment amount that the hospital made to any other outside vendor for managing, administering, or facilitating any aspect of the hospital's 340B drug program during the previous hospital fiscal year, followed by a list of the vendors by name and a brief description of the work performed by each vendor.

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Miscellaneous recommendations

In Section 2, paragraph 4, as passed by the House, this requests "the number of claims obtained through 340B." We agree with the GMCB that this is not useful information and would recommend their suggestion for improvement.

Similarly, in Section 2, Paragraph 5, "a description of the way hospitals use savings", we agree with GMCB that this language could be improved to elicit better information, and we would recommend the GMCB's suggestions.

Next, we agree with GMCB that hospitals should be required to attest that the information they submit is true and accurate.

Lastly, we recommend adding language to convey that GMCB is empowered to interpret and clarify the reporting language in the event there are questions about its meaning or problems with reporting—perhaps as simple as "in a form and manner prescribed by the Board" in the introductory paragraph preceding paragraph 1.

That concludes our HCA comments and recommendations regarding H.266. Thank you for your work on this bill and for considering our recommendations. We would be happy to provide additional information and testimony if it would be helpful.

Sincerely,

/s/ Charles Becker
Staff Attorney
Office of the Health Care Advocate