STATEMENT

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In Opposition to North Dakota House Bill 1473
340B Prescription Drug Program
March 2025

Position: The Pharmaceutical Research and Manufacturers of America ("PhRMA") respectfully opposes North Dakota House Bill 1473 ("HB 1473"). HB 1473 would prohibit biopharmaceutical manufacturers from interfering with the acquisition of a 340B drug by a contract pharmacy on behalf of a covered entity. This type of provision not only raises constitutional concerns but also exacerbates existing problems with the 340B program without ensuring that vulnerable patients needing discounted medicines will benefit.

Congress created the 340B program in 1992 to help vulnerable and uninsured patients access prescription medicines at safety-net facilities.

Through the program, biopharmaceutical manufacturers provide tens of billions of dollars in discounts each year to qualifying safety-net hospitals and certain clinics ("covered entities"), but patients are often not benefitting. Today, large hospital systems, chain pharmacies, and pharmacy benefit managers (PBMs) are generating massive profits from the 340B program even though its intended beneficiaries were true safety-net hospitals and clinics and the low-income and vulnerable patients they treat. The 340B program has strayed far from its safety-net purpose, and Congress needs to fix the program to ensure that it is reaching its intended populations.

There is little evidence to suggest that patients have benefited from contract pharmacy growth.

Since 2010, the number of contracts with pharmacies has grown by more than 12,000%, with roughly 33,000 pharmacies participating in the program in 2024.[i] Because the program has no transparency or guardrails on how hospitals and clinics use 340B profits, the money often is not going to help low-income and uninsured patients access medicines. An analysis of contract pharmacy claims for brand medicines only found evidence that patients were directly receiving a discount for 1.4% of prescriptions eligible for 340B.[ii] Additional studies have found that 65% of the roughly 3,000 hospitals that participate in the 340B program are not located in medically underserved areas,[iii] and in North Dakota, only 38% of contract pharmacies are located in medically underserved areas. Research has also found that more than 77% of 340B hospitals provide less charity care than the national average for all hospitals, and they often spend less on charity care and community investment than the estimated value of their tax breaks as nonprofits.[iv] In fact, 88% of 340B hospitals in North Dakota are below the national average for charity care levels.[v]

The 340B markup program has become a hidden tax on employers, patients, and state employees.

Marking up the costs of 340B medicines for employer-sponsored commercial plans and patients with private insurance generates significant revenue for 340B hospitals. 340B hospitals collect 7 times as much as independent physician offices for the sale of medicines administered to commercially insured patients[vi] and average spending per patient in the commercial market on outpatient medicines was more than 2.5 times higher at 340B hospitals than non-340B hospitals.[vii]

In addition, the current design of the program directly increases costs for employers by an estimated 4.2%, or $5.2 billion, due to reduced rebates from manufacturers, and indirectly increases employer costs by incentivizing provider consolidation and use of higher cost medicines.[viii,ix] With no obligation to invest profits from 340B markups at satellite facilities into underserved communities, 340B hospitals frequently purchase independent physician offices so they can then buy more medicines and increase their 340B profits.[x] Further, incentives in the 340B program increase the use of higher-cost medicines as hospitals participating in 340B generally obtain substantially larger profits from more expensive medicines.[xi,xii]

In an unprecedented report examining 340B hospital practices in its state, the North Carolina State Treasurer found North Carolina 340B hospitals charged state employees massive markups for oncology medicines.[xiii] According to the report, North Carolina 340B hospitals charged state employees, on average, a price markup of 5.4 times the hospitals' discounted 340B acquisition cost for outpatient infused cancer medicines.[xiv] This resulted in billing the North Carolina State Health Plan for Teachers and State Employees a price markup on cancer medicines that was 84.8% higher than North Carolina hospitals outside of the 340B program.[xv]

HB 1473 will further exacerbate 340B created market distortions that increase health care spending for people with commercial insurance, which raises costs for state governments and taxpayers.

The 340B program has often been touted as cost-free to taxpayers. However, research from IQVIA found that the 340B program increases drug costs for self-insured employers and their workers by 4.2% due to lost manufacturer rebates (which reduce the price of medicines) when a 340B drug is dispensed.[xvi] IQVIA reports that employers in North Dakota pay an estimated $53.4 million more in health care costs due to foregone rebates as a result of the 340B program.[xvii]

Based on analysis by IQVIA, a state 340B contract pharmacy mandate in North Dakota is estimated to increase health care costs for employers and state and local governments by $16.4M due to additional foregone rebates.[xviii]

These higher costs also impact state budgets through both higher spending for state employees' health care and forgone tax revenue due to higher premiums for state residents. Based on analysis of recent reports by IQVIA and Magnolia Market Access indicates the 340B program increased state and local governments' health care costs by $1.9 billion (4.2%) in 2022 alone.[xix]

Additional analysis from Magnolia Market Access found that the 340B program caused a combined $7.8 billion increase in health care costs for self-insured and fully insured employers and workers in 2021,

leading to $1.8 billion in lost federal and state tax revenue. In North Dakota, the impact of lost state tax revenue was $0.5 million.[xx]

HB 1473 will line the pockets of PBMs, pharmacy chains, and large hospital systems.

Many contract pharmacies charge a patient based on a drug's full retail price because they are not required to share any of the discount with those in need.[xxi] Big-box retailers such as Walgreens, CVS Health, and Walmart are major participants in the 340B program through contract pharmacy arrangements. North Dakota 340B hospitals have nearly 250 contracts with pharmacies outside the state. These out-of-state arrangements are not subject to North Dakota's pharmacy ownership law.

Because of vertical integration in the supply chain, PBMs now own the vast majority of pharmacies, meaning they also make a profit from contract pharmacy arrangements. Recent analysis by Avalere found that 69% of 340B contract pharmacies were associated with a PBM through vertical integration (53%) or contractual arrangement (16%). Only 16% of non-340B pharmacies were vertically integrated or affiliated with a PBM.[xxii] Notably, 44% of contract pharmacy arrangements are with pharmacies affiliated with the three largest PBMs – OptumRx, CVS Caremark and Express Scripts.[xxiii] The five largest contract pharmacy parent companies earned an estimated $2.9 billion from 340B in 2023.[xxiv] These earnings are part of the hidden tax the 340B markup program has created. The program reached $66.3 billion in 2023, a 23% growth increase from the previous year.[xxv]

In North Dakota, PBMs and large pharmacies make up 60% of contract pharmacy arrangements. PBM-owned pharmacies specifically account for 26% of all arrangements with 340B contract pharmacies in North Dakota.[xxvi]

In 2023, the Minnesota Legislature passed legislation[xxvii] that requires the Minnesota Department of Health (MDH) to collect and aggregate data from Minnesota providers that participate in the federal 340B program and prepare a report with findings for the legislature and public. The first Minnesota 340B report was released in November 2024 and provides further evidence that for-profit middlemen are profiting from the 340B program. Specifically, the report found that payments to contract pharmacies and third-party administrators (TPAs) were over $120 million, representing approximately $16 of every $100 of gross 340B revenue generated paid to external parties.[xxviii] In fact, 10% of safety-net federal grantees reported a negative net 340B revenue due to payments made to middlemen.[xxix] The top 10% of critical access hospitals and disease-specific grantees with the highest external operational costs lost at least half their gross 340B revenue to TPAs and contract pharmacies.[xxx]

The Minnesota 340B report also sheds light on the massive profits 340B hospitals retain from the 340B program. Minnesota providers participating in the 340B program earned a collective net 340B revenue of at least $630 million for the 2023 calendar year.[xxxi] Based on national data, MDH believes this figure may represent as little as half to one-third of the actual total 340B revenue for Minnesota providers due to lack of reporting from the covered entities for office administered drugs.[xxxii, xxxiii] Most entities did not report data for office administered drugs, which are estimated to account for 80% of all 340B drug spending.[xxxiv] The state's largest 340B hospitals benefitted most from the 340B program, accounting for 13% of reporting entities but representing 80%—more than $500 million—of net 340B revenue.[xxxv]

Additional analysis of the Minnesota 340B report reveals the largest single beneficiary of 340B markups was M Health Fairview University of Minnesota Health Center ("M Health Fairview"), which reported an astounding $130 million in net 340B revenue. By comparison, M Health Fairview reported higher revenue than all the state's 72 critical access hospitals, 17 community health centers, 9 Ryan White AIDS clinics, and 63 STD clinics combined.[xxxvi]

HB 1473 would require manufacturers to provide 340B-priced drugs to all pharmacies that contract with 340B covered entities.

The 340B program is a comprehensive federal program that is governed exclusively by federal law. States do not have the authority to create new requirements that are not in the federal statute or that conflict with the statute. Whether manufacturers can be required to ship drugs to contract pharmacies for 340B providers is currently being litigated in several federal courts across the country.

PhRMA respectfully opposes the provisions outlined above and appreciates your consideration prior to advancing HB 1473.

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The Pharmaceutical Research and Manufacturers of America (PhRMA) represents the country's leading innovative biopharmaceutical research companies, which are laser focused on developing innovative medicines that transform lives and create a healthier world. Together, we are fighting for solutions to ensure patients can access and afford medicines that prevent, treat and cure disease. Over the last decade, PhRMA member companies have invested more than $800 billion in the search for new treatments and cures, and they support nearly five million jobs in the United States.

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