Maine Primary Care Association | Maine Hospital Association (MHA) | MSHP Maine Society of Health System Pharmacists | Maine Pharmacy Association

Coalition to Protect Health Care for Rural and Underserved Communities

For over 30 years, the 340B Drug Pricing Program has increased access to care for rural and underserved communities. Efforts to restrict this program only serve to increase profits for pharmaceutical companies at the expense of patient care across Maine.

MYTHS VS FACTS

340B was intended to deliver discounted drugs directly to patients.

340B was created to allow safety-net providers to buy outpatient medicines for less. They use the savings to stretch resources so they can provide a variety of services, drugs, and better care to patients who can't always pay.

340B uses taxpayer money.

340B is not funded by taxpayers. Instead, drug companies sell drugs to providers at discounted prices, allowing them to stretch their existing funding even further. A government agency, the Office of Pharmacy Affairs, receives a small congressional appropriation to administer the program.

340B covered entities "mark up" the amounts they charge for dispensing 340B drugs, driving up costs.

Payers do not reimburse covered entities any more for 340B drugs than they do for non-340B drugs and contract pharmacies do not set pricing based on 340B. The differences in 340B drug acquisition costs and reimbursements generate savings for safety-net providers.

Partnerships with community and specialty contract pharmacies generate additional savings. This is precisely how Congress intended the program to work, creating savings that can be reinvested into care for low-income and rural patients.

340B also helps restrain drug costs due to penalties imposed on drugmakers that repeatedly increase their prescription drug prices faster than inflation, resulting in an estimated $7 billion reduction over 5 years in Medicare Part D spending alone.

Contract pharmacy legislation will increase health care costs for employers and state & local government due to lost rebates.

In reality, pharmaceutical companies have entered into *voluntary* rebate agreements with Pharmacy Benefit Managers (PBMs) for a long time. PBMs can negotiate in contracts how much, if any, of the rebates received from PhRMA will be passed on to the payer. PhRMA has falsely claimed that Maine employers are losing millions in foregone rebates due to the 340B program (without proving any sources for their data).

Too many providers qualify for 340B.

Congress expanded the roster of eligible entities in 2011 because the program was not reaching enough providers.

Source: 340B Coalition, Maine Hospital Association, Maine Primary Care Association

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MYTHS VS FACTS

Hospitals already have enough money.

For-profit hospitals are ineligible for 340B. Only public and nonprofit hospitals that serve large numbers of Medicaid and low-income Medicare patients or are in rural areas qualify. Many of these providers operate at a loss. In Maine, 28 hospitals qualify for the program and in the most recent year these hospitals:

- Barely broke even in the aggregate; 12 of the 28 lost money
- Provided almost $200 million in uncompensated care (charity care & bad debt)
- Would have lost a combined $220 million without 340B savings
- Have seen their 340B savings reduced by 20% in the past few years

340B hospitals provide less charity care than average.

Compared to non-340B acute care hospitals, 340B DSH hospitals provide more than twice as much care to Medicaid and low-income Medicare patients. In Maine, 340B hospitals continue to provide tens of millions in uncompensated care, despite being in a financially precarious position.

340B covered entities prioritize contract pharmacy agreements in wealthy areas where they can maximize profit out-of-state, rather than underserved areas.

Rural areas across Maine are seeing increased pharmacy deserts and this is not the fault of the covered entity or a side effect of the 340B program. In fact, having access to a 340B contract pharmacy provides a chance for a pharmacy in a rural area to be more viable as that pharmacy receives a small amount more in reimbursement.

PBMs have largely moved to a national consolidated model for specialty and mail order and have limited networks in their insurance plans to drive patients to those locations.

Pharmaceutical manufacturers have limited which pharmacies in the country can buy and dispense their drugs (this is called limited distribution) and *are forcing* some 340B covered entities to enter into out of state contracts to access necessary medications for their patients.

Community Health Centers (FQHCs) don't need 340B because they are federally funded.

In Maine, federal Section 330 funds only account for 5-15% of a CHC's operating budget. The 340B program is critical to ensuring that communities have access to important care and resources. Across Maine, CHCs have lost millions due to the restrictions imposed by pharmaceutical manufacturers on 340B since 2020.

"An Act to Protect Health Care for Rural and Underserved Communities" keeps 340B savings in Maine where they belong, supporting our safety-net healthcare providers, rather than being diverted to the pockets of out of state pharmaceutical companies.

Source: 340B Coalition, Maine Hospital Association, Maine Primary Care Association