PCMA

April 10th, 2025

The Honorable Susan Donovan
The Honorable Joshua Giraldo
Members, House Health and Human Services Committee
House Lounge - State House
82 Smith St.
Providence, RI 02903

RE: H 5634 AN ACT RELATING TO BUSINESSES AND PROFESSIONS -- DEFENDING AFFORDABLE PRESCRIPTION DRUG COSTS ACT; Opposed

Chair Donovan, Chair Giraldo and Members of the Committee

My name is Sam Hallemeier, Senior Director of State Affairs, and I am writing on behalf of the Pharmaceutical Care Management Association (PCMA). PCMA is the national association representing America's pharmacy benefit managers (PBMs). PBMs administer prescription drug plans and operate mail-order and specialty pharmacies for more than 275 million Americans with health coverage through large employers, health insurers, labor unions, and federal and state-sponsored health programs.

PCMA appreciates the opportunity to provide comments in opposition to H 5634. Our industry is concerned about 5-19.3-3 (2)(v), which would no longer require a billing modifier or claim modifier to indicate that a drug is a 340B drug.

The federal 340B Drug Pricing Program was created in 1992 to extend significant discounts on covered outpatient drugs to eligible health care providers, known as "covered entities." The federal Health Resources and Services Administration ("HRSA"), part of the U.S. Department of Health and Human Services ("HHS"), oversees the 340 Program. The intent of the program is to enable these covered entities to serve the nation's most vulnerable patient populations. Because of an unintended profit motive built into the program, discussed below, 340B program sales in 2021 reached $93.6 billion.[1] This enormous growth has, in turn, spurred the Federal government to prioritize greater transparency in how covered entities use this profit to benefit the communities they serve.[2] H 5634 would, if enacted, fundamentally undermine these needed transparency efforts by prohibiting the use of claims modifiers in the program.

The 340B Program authorizes manufacturers to enter into a pharmaceutical pricing agreement ("PPA") with the HHS Secretary, under which the manufacturer agrees to provide front-end discounts on covered outpatient drugs purchased by covered entities. These discounts average

[1] Martin, Rory, Ph.D., 340B Program Continues to Grow While Contract Pharmacy Restrictions Take Effect (April 2022), available at: (https://www.iqvia.com/locations/united-states/blogs/2022/04/340b-program-continues-to-grow-while-contract-pharmacy-restrictions-take-effect).
[2] Fiscal Year 2024 Budget in Brief, Department of Health and Human Services (March 2023), available at: (https://www.hhs.gov/sites/default/files/fy-2024-budget-in-brief.pdf).

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59% off the list price for drugs purchased at the 340B price, making the 340B program the second largest Federal prescription drug program.[3] A manufacturer that declines to enter into a PPA with the Secretary, forfeits reimbursement for their drugs under Medicaid and Medicare Part B.
Current HRSA guidance permits 340B covered entities to dispense 340B covered outpatient drugs at their own in-house pharmacy, or at one or more contract pharmacies. In a typical case in which a covered outpatient drug is dispensed at a contract pharmacy, covered entities purchase a drug at about 70 percent (%) of the average wholesale ("AWP") and supply it to their contract pharmacy for dispensing. In turn, PBMs reimburse a contract pharmacy for 100 percent (%) of the drug's AWP. The result is the contract pharmacy pocketing the 30 percent (%) reimbursement difference as profit.

Recent studies show that covered entities can earn substantial profits on specialty drugs dispensed to patients via their own contract pharmacies arrangements.[4] For example, 340B hospitals often earn mark-ups of 380 percent (380%) over an oncology drug's acquisition cost. For some drugs, the mark-ups were ten times the acquisition costs.[5] What's more, commercial health plans generally paid hospitals almost twice the wholesale acquisition cost ("WAC") list price. Because of this inherent profit motive in the 340B program (and as recognized by Federal regulators) it is imperative that greater transparency is brought to bear on the 340B program and how profit from the program is being utilized to benefit patients. Requiring that 340B covered entities include modifiers on 340B claims – such that manufacturers and payers are able to determine when a particular claim Is benefitting from savings under the 340B program – is a commonsense, practical, and logical reform that ensure the 340B program is doing what it is intended to do: benefit patients.

As the state should be aware, the use of claims modifiers in the 340B program is neither novel nor unnecessary. For example, the Medicaid statute has long authorized the Secretary of HHS to require the use of claims modifier on 340B claims in order to protect against duplicate discounts in the program.[6] It seems unconscionable that the state would attempt to prohibit a practice that the Federal government has long endorsed as a way to bring transparency to a program in desperate need of reform. By prohibiting claims modifiers, H 5634 would further shroud the significant profits of covered entities, denying the public of any way of ensuring the 340B program is benefiting the intended recipients of the program: low-income patients.

Another concern we have is with Sec. 5-19.3-3.(a)(4),(5) related to "patient choice" and preventing a patient's choice to receive drugs at a 340B entity if a health insurer, PBM, or other third-party payor places additional requirements. The patient would have no idea if a claim involves a 340B discount, especially when it is a drug subject to white bagging.

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[3] "340B Program at a Glance," Berkeley Research Group, available at https://media.thinkbrg.com/wp-content/uploads/2022/12/06082105/340B-Program-at-a-Glance-2022_clean.pdf.
[4] Aharon, Gal, Ph.D., Examining Hospital Price Transparency, Drug Profits, & the 340B Program (September 2021), available at: (http://communityoncology.org/hospital-304b-drug-profits-report/).
[5] "Examining 340B Hospital Price Transparency, Drug Profits, and Incentives," Community Oncology Alliance (September 2022), available at https://communityoncology.org/wp-content/uploads/2022/09/COA_340B_hospital_transparency_report_2_final.pdf.
[6] 42 U.S.C. 1396r–8(a)(5). *See also* 42 U.S. Code § 256b(a)(5)(A).

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Physician administered drugs are prescription drugs administered by a health care provider to a patient through injection or infusion. The physician administered drugs can be administered in a variety of settings, including a hospital outpatient setting or a provider's office. These drugs are often high priced and represent a growing share of all prescription drug spending due to the traditional buy and bill method. The traditional 'buy and bill' method bills the physician administered drug through the patients' medical benefit, making patients susceptible to high out of pocket costs. Through 'white bagging' dispensing, the physician administered prescription can be covered under the pharmacy benefit, which often has lower patient cost sharing depending on the plan benefit established by their health plan sponsor. White bagging' provides a significant cost controlling tool for employers and other health plan sponsors. Specialty pharmacies can dispense medications at a cost up to 118% lower than 'buy and bill' supplied drugs.[7] This results in meaningful savings for employers, other health plan sponsors, and government health care payors when these drugs are dispensed through a specialty pharmacy instead of a hospital or providers office via the buy-and-bill method.

Plans choose PBMs to supply the medication through white bagging to save on ingredient costs because providers typically mark up their drug prices. The decision has nothing to do with the provider's 340B participation status. Therefore, we request you strike Sec. 5-19.3-3.(a)(4) and (5).

Oppose H 5634

For these reasons, we respectfully request it be recognized that the savings generated by the federal 340B Program would not benefit patients without the use of claims modifiers and "patient choice" and preventing a patient's choice to receive drugs at a 340B entity if a health insurer, PBM, or other third-party payor places additional requirements. Instead, the language of H 5634 would bolster the profits of covered entities and their contract pharmacies.

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[7] AHIP. February 16, 2022. *Hospital Price Hikes: Markups for Drugs Cost Patients Thousands of Dollars.* https://www.ahip.org/resources/hospital-price-hikes-markups-for-drugs-cost-patients