COMMUNITY ONCOLOGY ALLIANCE

Dedicated to Advocating for Community Oncology Patients and Practices
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March 13, 2025

The Honorable Kyle Mullica
Senate Health and Human Services
Colorado General Assembly
200 E Colfax Avenue
Denver, CO 80203

RE: COA Opposition to Senate Bill 71, Concerning Contract Pharmacies

Chair Mullica,

My name is Dr. Mark Thompson, and I serve as Medical Director of Public Policy for the Community Oncology Alliance (COA). COA is the only nonprofit organization in the United States dedicated solely to independent community oncology practices, which serve the majority of Americans receiving treatment for cancer.

On behalf of COA and the independent oncology clinics we represent across Colorado, I write to express our strong opposition to Senate Bill 71, which in our view seeks to expand the scope of the Federal 340B Drug Pricing Program beyond its intended purpose.

While COA and our members have supported the assembly's previous efforts to protect safety-net programs from the predatory practices of Pharmacy Benefit Managers (PBMs), SB 71 raises significant concerns for our patients and practices and, in our view, undermines the progress that has already made on this subject. Specifically, we are troubled by the bill's efforts to extend 340B benefits to "contract pharmacies," entities not originally intended to benefit from this program which are predominantly affiliated with or owned by PBMs.

The Federal 340B Drug Pricing Program was created to help safety-net providers such as community health centers stretch federal resources to serve vulnerable patient populations. However, over the past twenty years, the program has often been exploited by large hospitals and their affiliated contract pharmacies.

- The Health Resources and Services Administration (HRSA) estimates that hospitals now account for nearly 90% of the $44 billion in discounted drugs purchased through the program.[i]

- Under the program, many hospitals and their contract pharmacies acquire drugs at deeply discounted rates, later charging fully insured patients for these drugs at full price and pocketing the difference as revenue.[ii,iii,iv]
- Unlike Federally Qualified Health Centers (FQHCs), which are required by HRSA to reinvest savings into direct patient care, hospitals have no obligation to ensure 340B funds benefit those in most need.[v]
- Two-thirds of 340B hospitals are private, nonprofit institutions that qualify based on government contracts which require these entities to serve low-income patients.[vi] Yet, in disclosures submitted to the IRS, nearly half of hospitals pursue medical bills from patients eligible for charity care.[vii,viii,ix]
- Continued misuse of the program has further driven hospital consolidation, increasing health care costs, reducing patient choice, and severely disadvantaging independent oncology practices, which ultimately restricts patient access to affordable, high-quality cancer care close to home.[x]

Instead of addressing the program's long-standing problems, SB 71 would expand the program by recognizing contract pharmacies as extensions of covered entities, many of which are controlled by PBMs, for-profit actors notorious for anti-competitive practices that increase drug costs and limit patient choice.

- 69% of contract pharmacies have direct ties to PBMs, 53% through vertical integration and 16% through contractual obligations.[xi]
- PBMs steer patients toward their affiliated pharmacies, impose unsustainable reimbursement rates on independent practices, and limit competition, further reducing access to affordable cancer care for rural and underserved communities.[xii]

While we strongly support the original intent of the program, it has become fundamentally flawed and can only truly be reformed at the federal level. That is why our members have joined with FQHCs, patient advocacy groups, and health care providers nationwide as part of the *Alliance to Save America's 340B Program* (ASAP 340B).[xiii] Together, we advocate for meaningful, patient-centered 340B reform that ensures program savings directly benefit the nation's most vulnerable patient populations, as it was originally intended.

Rather than sanctioning a system that encourages consolidation, increases costs, and limits patient choice, we ask the assembly to consider the following:

- Reject SB 71 and join the calls to reform the Federal 340B Drug Pricing Program in Congress, ensuring that discounts directly reduce patient out-of-pocket costs.
- Enact state transparency measures requiring hospitals to disclose how 340B savings directly benefit patients in medically underserved population areas.
- Call on Congress to prevent further hospital and PBM exploitation of the program by limiting 340B participation to true safety-net providers, like FQHCs and Ryan White Clinics.

For a more comprehensive analysis of this issue, we invite you to review COA's position statement on the 340B Drug Pricing Program. If we can be of additional assistance on this issue or others impacting community oncology, please contact James Lee, COA Director of State Regulation and Policy, at jlee@coacancer.org.

Sincerely,

Dr. Mark Thompson
Medical Director of Public Policy
Community Oncology Alliance (COA)

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[i] Fein, Adam J. "The 340B Program Climbed to $44 Billion in 2021—More Than Triple the Size in 2014." *Drug Channels*, August 16, 2022. https://www.dropbox.com/scl/fi/1e1l1sox6oqqe27nsy9aj/Drug-Channels-The-340B-Program-Climbed-to-44-Billion-in-2021-With-Hospitals-Grabbing-Most-of-the-M.pdf?rlkey=o9jnqxyujl516om5o0p91wdr3&st=8rt245sx&dl=0

[ii] U.S. Government Accountability Office. *Federal Oversight of Compliance at 340B Contract Pharmacies Needs Improvement*. GAO-18-480. Washington, DC: Government Accountability Office, June 2018. https://www.dropbox.com/scl/fi/8gmjuvpc3wqg58jze7s30/GAO-18-480.pdf?rlkey=w1jeamdse3bdqr5tcjom9nx5b&st=1704js82&dl=0

[iii] Kliff, Sarah. "How a Hospital Chain Used a Poor Neighborhood to Turn Huge Profits." *New York Times*, September 24, 2022. https://www.dropbox.com/scl/fi/yo0mh7bqdazhakpa7zurg/NYT-How-a-Hospital-Chain-Used-a-Poor-Neighborhood-to-Turn-Huge-Profits-The-New-York-Times.pdf?rlkey=s3bo97sct8ulcr0g8xg32tltd&st=are80xpc&dl=0

[iv] Evans, Melanie. "A Hospital Financial Investigation: The $340B Drug Discount Program Delivers Profits, Not Necessarily to Patients." *Wall Street Journal*, December 21, 2022. https://www.dropbox.com/scl/fi/c24h9j4kk6rfasknwdmil/WSJ-Many-Hospitals-Get-Big-Drug-Discounts.-That-Doesn-t-Mean-Markdowns-for-Patients.-WSJ.pdf?rlkey=abtcoorfaq9imk0ho8ubvbgxu&st=m617v6vj&dl=0

[v] Medicare Payment Advisory Commission (MedPAC). *Report to the Congress: Overview of the 340B Drug Pricing Program*. Washington, DC: MedPAC, May 2015. https://www.dropbox.com/scl/fi/e72nil8g1kpuvpkleh1wv/MEDPAC-2015-may-2015-report-to-the-congress-overview-of-the-340b-drug-pricing-program.pdf?rlkey=6jou8b7xwo85005jw12wg456j&st=c62l7x7v&dl=0

[vi] U.S. Government Accountability Office. *Federal Oversight of Compliance at 340B Contract Pharmacies Needs Improvement*. GAO-18-480. Washington, DC: Government Accountability Office, June 2018. https://www.dropbox.com/scl/fi/8gmjuvpc3wqg58jze7s30/GAO-18-480.pdf?rlkey=w1jeamdse3bdqr5tcjom9nx5b&st=1704js82&dl=0

[vii] Levey, Noam N. “Patients Eligible for Charity Care Instead Get Big Bills.” *KFF Health News*, February 15, 2023. https://www.dropbox.com/scl/fi/duf3tu1yw7npdhrijx1dn/KFF-Patients-Eligible-For-Charity-Care-Instead-Get-Big-Bills-KFF-Health-News.pdf?rlkey=x2amdgkhr4tu7pakt3eap0rsw&st=wns8svsm&dl=0

[viii] Center for Public Health Law Research. *Patient Affordability and the 340B Program: Ensuring True Benefit for Patients*. Policy Brief, May 2022. https://www.dropbox.com/scl/fi/7awxxjrldz6qd9ggfxehf/Temple-U-PatientAffordability340B_PolicyBrief_May2022.pdf?rlkey=45zyca5yrx26rse3h89t9hb3d&st=jg21j3gl&dl=0

[ix] Ingold, John. “UCHealth Sues Hundreds of Patients over Medical Debt as Colorado Hospitals Collect Billions in Profits.” *Denver Post*, February 21, 2024. https://www.dropbox.com/scl/fi/a54u5igsk350kfszh3bn4/Denver-Post-UCHealth-sues-patients-over-unpaid-bills-often-hiding-behind-third-party.pdf?rlkey=evwfi1cgry7mcmpjsoox8yjyz&st=gsi3wxrj&dl=0

[x] Milliman, Inc. *Trends in Cancer Care: Cost Drivers and Value-Based Reimbursement in Oncology.* Milliman, 2016. https://www.dropbox.com/scl/fi/ohf3fau8zw09mit5mbqtx/Milliman-trends-in-cancer-care.pdf?rlkey=yq6evbdvdcwbwsekrpc7l9vkg&st=ymez5w6m&dl=0

[xi] Avalere Health. *PBM, Mail Order, and Specialty Pharmacy Involvement in 340B.* Avalere, March 9, 2024. https://www.dropbox.com/scl/fi/306hczecarar5tga0qwgn/Avalere-PBM-Mail-Order-and-Specialty-Pharmacy-Involvement-in-340B-Avalere.pdf?rlkey=um03wr0br68xtleu05jtjq7zf&st=wwrwf0mv&dl=0

[xii] Federal Trade Commission. *Second Interim Staff Report on the Business Practices of Pharmacy Benefit Managers*. Washington, DC: Federal Trade Commission, 2025. https://www.dropbox.com/scl/fi/tww2lpizeyxf9a33wse3n/FTC-2025-PBM-6b-Second-Interim-Staff-Report.pdf?rlkey=xvctapb6fod5j0wwkuingnc73&st=dwse7wps&dl=0

[xiii] Alliance to Save America’s 340B Program (ASAP 340B). *Working to Save America’s 340B Program.* ASAP 340B, https://www.dropbox.com/scl/fi/6sn3muplty8gw6kmtq2c4/ASAP-340B-Working-to-Save-America-s-340B-Program.pdf?rlkey=xade8q3lnkzpuivxorqj28let&st=a8c5m1u7&dl=0

Re: Re: Opposition to Colorado's SB 71

Dear Members of the Colorado State Legislature,

Thank you for the opportunity to submit testimony on behalf of the National Alliance of Healthcare Purchaser Coalitions (National Alliance) regarding SB 71 and the proposed reforms to the 340B Drug Pricing Program. This testimony is intended for inclusion in the official record of the hearing on SB 71.

The National Alliance is a distinctive nonprofit organization led by healthcare purchasers, exerting both national and regional influence. We represent more than 40 regional and local employer/purchaser coalitions. Collectively, these groups provide healthcare coverage to over 40 million Americans, influencing over $400 billion in annual healthcare expenditures in the commercial market.

As an advocate for employers and purchasers across the country, we at the National Alliance believe in the critical mission of the 340B Drug Pricing Program to increase access to more affordable medications for low-income patients and communities. We strongly support Congress' original intent when it established the program in 1992 and recognize its importance today for the numerous health centers and core safety-net hospitals that serve as responsible stewards of program funds. These institutions use these resources to expand care and services, not just in specific states like Colorado, but across the nation, benefiting a broad spectrum of Americans in need.

The 340B program, thanks to minimal guardrails and a low threshold for program qualification that has not changed in over 30 years, has gone well past that intent. Today, 340B operates as a government-sanctioned arbitrage scheme, rather than the support for patients it was intended to be, and many corporate health systems exploit this loophole.

As a representative for employers, purchasers, we are worried that 340B and its distortive effects on the market are driving up costs for business leaders and working families across the state. We urge the legislature today to carefully consider 340B's impact on employers and working families before advancing any reforms, and to avoid codifying elements of the program that may have far-reaching negative effects for working families.

Background

At its core, 340B allows health systems that qualify for the program to "buy low and sell high" on prescription medicines. They can purchase drugs at a steep discount, mark them up as much as eight times, and charge working families and their health plans full list prices – pocketing the proceeds with no requirements that they are used to benefit low-income or uninsured patients.

Originally, this applied to fewer than 100 core safety net hospitals and smaller, specialized clinics serving specific vulnerable populations like those with HIV/AIDS and hemophilia.

However, over the past three decades, the program has grown exponentially. This is partially a result of policy changes, such as the federal government's whole-cloth creation of a rule in 2010, without Congressional agreement, to allow hospitals to work with an unlimited number of

It also reflects shifts in the nation's healthcare landscape more broadly, such as the expansion of Medicaid in states like Colorado. Since 2010, Medicaid has expanded dramatically, but the threshold for hospitals to qualify for 340B hasn't changed – even though that threshold is based in part on the number of Medicaid patients they serve.

Over time, hospital systems, including those in Colorado, have recognized the boost that 340B can provide to their bottom lines and capitalized on it. From its humble origins in 1992, the program has grown to become the second-largest federal drug program today, surpassed only by Medicare Part D. 340B purchases at the discounted price were nearly $54 billion in 2022 alone[1] – and the discounts ranged from 30-50% off wholesale or "list" prices, and sometimes can be low as one penny.[2]

In Colorado, substantial participation is evident with 68 hospitals involved in the 340B program[3], with health systems like **Centura Avista Adventist Hospital participating with 59** contracts, **78%** with out-of-state pharmacies.[4]

340B contributes to cost increases for employers and working families

At its current size, employers in Colorado and across the country worry that 340B is in many cases falling short of its original mission. In fact, a growing body of evidence shows that it is contributing to the rising cost of healthcare that continues to cripple Colorado businesses and working families. Despite claims by its advocates that it is "free," it increases healthcare costs for employers and their workers due to lost drug rebates.[5] New research has estimated the financial impact of the 340B program on each state.[6]

The Cost of the 340B Program

The annual financial impact on Colorado employers and workers is significant. The program increases healthcare costs for employers and their workers due to lost drug rebates with current costs around $132 million, potentially rising to $152 million if SB 71 is enacted.

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[1] https://www.drugchannels.net/2023/09/exclusive-340b-program-reached-54.html
[2] https://www.gao.gov/assets/gao-11-836.pdf
[3] https://www.coloradopolitics.com/health-care/colorado-hospitals-pharmaceuticals-340b-bills/article_029142a4-f922-11ef-9f04-8fd11e1e0929.html
[4] https://340breform.org/340b-hospitals/colorado/
[5] https://www.iqvia.com/locations/united-states/library/white-papers/the-cost-of-the-340b-program-part-1-self-insured-employers
[6] https://www.iqvia.com/locations/united-states/library/white-papers/the-cost-of-the-340b-program-to-states

Prescription drug mark-ups

At its most basic level, 340B is structured as an arbitrage system in which participants can buy prescription drugs at a steep discount, mark them up significantly, and charge commercial insurance plans the full price. These mark-ups are well documented across the country. Most notably, North Carolina's State Treasurer recently found that 340B hospitals in the state had billed the state employee health plan an average markup of 5.4 times their acquisition cost for oncology drugs.[7] While 340B is often referenced as a "costless" program to taxpayers, these mark-ups represent profits for corporate healthcare systems, on the backs of higher prices paid by working families with employer-sponsored insurance.

Impact on consolidation

340B provides strong incentives for consolidation, as hospitals are able to acquire previously independent outpatient physician offices and classify them as 340B "child sites." In doing so, they can boost profits by maximizing the spread they receive from their mark-ups through the expansion of their 340B reach to more commercially insured patients.

In recent years, Colorado has seen a significant trend of healthcare consolidation, characterized by mergers and acquisitions that have raised concerns over increasing healthcare costs and access to services. Just over half of the 83 hospitals in Colorado are now in hospital systems. [8] The Effects of Hospital Consolidation in Colorado Centura Health, which increased from 10 to 14. This consolidation trend, reflecting national patterns, has been particularly impactful in rural areas, often leading to higher healthcare prices and a reduction in service diversity due to the dwindling number of independent providers.[9] The evidence overwhelmingly shows that consolidation increases costs for patients and does not improve care;[10] It is therefore troubling for employers that 340B is a contributor to this phenomenon.

In response to increased consolidation, the Colorado legislature passed HB23-1226, requiring hospital chains to report on acquisitions and offering insights into the impacts of mergers and acquisitions[11], as well as SB23-252, which focused on efforts to increase price transparency. Given the importance that Colorado legislators place on addressing consolidation and transparency, focusing on the implications of the 340B Drug Pricing Program should also be a priority as the association between 340B and vertical consolidation in hematology-oncology, in particular,[12] is well-documented, particularly due to the fact that high-cost drugs for these

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[7] https://www.nctreasurer.com/news/press-releases/2024/05/08/state-treasurer-folwell-releases-report-finding-north-carolina-340b-hospitals-overcharged-state
[8] https://cepr.net/wp-content/uploads/2020/03/2020-03-Colorado-Hospital-Consolidation-Gaby-Biegel.pdf
[9] https://www.kunr.org/local-stories/2024-10-29/hospital-consolidation-raising-health-care-costs-mountain-west-beyond-study
[10] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6170097/
[11] https://www.cpr.org/2023/06/02/colorado-hospitals-will-have-to-hand-over-more-financial-information-under-two-new-laws/
[12] https://www.nejm.org/doi/full/10.1056/NEJMsa1706475#:~:text=Hospital%20eligibility%20for%20the%20340B,and%200.1%20(or%2033%25)

disease states yield significant 340B margins for hospitals. This is especially true for outpatient "child sites" located in wealthy areas with well-insured patients, which is often the case.[13] Research indicates that 340B hospitals markup medicines at significantly higher rates than independent physician offices.[14]

Hospital systems can also game the program by classifying facilities in wealthy areas as "child sites" of their hospitals that serve low-income patients. While the Bon Secours system in Richmond, VA, is the most notorious example,[15] this practice is widespread in Colorado as well. This practice gives 340B hospitals both a competitive advantage and a vested interest in securing as many facilities as possible to expand their 340B reach through horizontal consolidation.

Opportunities for chain pharmacy and PBM profit

340B also encourages for-profit chain pharmacies and PBMs to profit from the program. Currently, corporate health systems are able to create unlimited networks of external chain pharmacies they can use to profit from 340B. The exponential growth of these networks since 2010 – which have zero basis in statute – is a major factor in the program's rapid expansion.

There is no requirement that these pharmacies be located in low-income communities or that they provide medicines to patients at affordable prices. In fact, research has found they are expanding in increasingly wealthier, predominantly white, and better-insured areas. This enables health systems to further augment the number of prescriptions they can purchase at 340B discounts, which they can then mark up and bill employers and families at full commercial prices.[16]

Colorado is no exception to this rule, with only 25% of contract pharmacies located in medically underserved areas.[17] Additionally, Colorado 340B hospitals have 1,118 contracts with 340B pharmacies, 49% of which are with out-of-state pharmacies.[18] Clearly, such locations are being used to drive extra revenue to healthcare systems rather than improve access for low-income Coloradans. House Bill 2716 seeks to refocus the 340B program to its original intent to aid communities and patients most in need. It does this by requiring detailed reporting on the use of 340B profits for reducing out-of-pocket costs for low-income patients, the provision of charity care, and the operational transparency with contract pharmacies, ensuring that the funds from this program directly benefit the low-income patients and communities originally intended to be

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[13] https://avalere.com/insights/340b-hospital-child-sites-and-contract-pharmacy-demographics
[14] https://jamanetwork.com/journals/jama-health-forum/fullarticle/2807907
[15] https://www.nytimes.com/2022/09/24/health/bon-secours-mercy-health-profit-poor-neighborhood.html
[16] https://jamanetwork.com/journals/jama-health-forum/fullarticle/2807907
[17] https://cdn.aglty.io/phrma/fact-sheets/340b/%20Fact%20Sheet%20-%20340B%20State%20Profiles%20-%20Colorado%20-%202024.pdf
[18] https://340breform.org/340b-hospitals/colorado/

served.[19] Legislation like this is imperative to help curb some of these egregious practices and promote better access to healthcare for vulnerable populations.

Incentives for prescribing higher-cost medicines

Finally, 340B has been shown to drive providers to prescribe higher-priced drugs. Healthcare systems can make a larger 'spread' from more expensive, brand name drugs than the lower-cost, equally effective biosimilar. A study published in *Health Affairs* found that 340B program eligibility was associated with a 22.9 percentage point reduction in biosimilar adoption between 2017 and 2019.[20] Another analysis found that between 25% and 56% of corporate health systems only list prices for the innovator product, and very few offer all available biosimilars.[21]

All of these distortive effects raise costs for employers and their employees, without any requirements that 340B funds benefit low-income communities. In fact, 73% of Colorado hospitals provide below-average levels of charity care, and University of Colorado Hospital devotes just 1.5% of its operating costs to charity care.[22]

The Impact of SB 71

Employers and lawmakers in Colorado have made great strides to introduce more transparency in the healthcare system in order to help bring down costs. SB 71 would represent a step backward. It would exacerbate 340B's upward pressure on costs for working families without doing anything to promote access or affordability for low-income patients.

First, the bill effectively serves as a "gag rule," a practice that the state has sought to prohibit in the past by allowing pharmacists to communicate openly and honestly about drug prices. This legislation would similarly prevent employers and the government from identifying what drugs were purchased at 340B discounts and how much corporate health systems mark them up – hampering our ability to eliminate this waste in the system and harm to our bottom line.

The bill would also lock in one of 340B's most well-documented flaws: contract pharmacy. Unlimited networks of pharmacies in wealthy, well-insured, and often far-flung regions of the state have been a key factor in the program's expansion over the past decade-plus. They have helped hospitals maximize the number of 340B prescriptions they can process through commercial insurance and, thus, their profit on the sale of discounted drugs that are not being shared with working families or the employer purchasers who provide their healthcare.

SB 71 would simply enshrine this status quo in law, perpetuating the continued unchecked expansion of the program's underlying arbitrage system, exacerbating its distortive effects on consolidation and prescribing patterns, and preventing efforts to introduce transparency into this

[19] https://leg.colorado.gov/bills/sb25-124
[20] https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2022.00812
[21] https://communityoncology.org/hospital-340b-drug-profits-report-feb-2021/
[22] https://340breform.org/340b-hospitals/colorado/

opaque program. All in all, it would raise costs for employers and working families while benefiting the corporate health systems and their chain pharmacy and PBM partners.

Conclusion

As rising healthcare premiums and insurance costs continue to increase our overall operational expenses and impact the benefits coverage we can offer our employees, we cannot support legislation that would irresponsibly increase expenses without ensuring the program works for Colorado's vulnerable communities.

Employers urge the Committee to oppose SB 71 and instead look to more comprehensive reforms that promote transparency and accountability in 340B, provide affordability protections for patients, and limit 340B's inflationary effects on healthcare spending for working families.

Sincerely,

Amanda Green
Senior Manager of Healthcare Advancement
National Alliance of Healthcare Purchaser Coalitions

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Over time, hospital systems, including those in Colorado, have recognized the boost that 340B can provide to their bottom lines and capitalized on it. From its humble origins in 1992, the program has grown to become the second-largest federal drug program today, surpassed only by Medicare Part D. 340B purchases at the discounted price were nearly $54 billion in 2022 alone[1] – and the discounts ranged from 30-50% off wholesale or "list" prices, and sometimes can be low as one penny.[2]

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340B contributes to cost increases for employers and working families

At its current size, employers in Colorado and across the country worry that 340B is in many cases falling short of its original mission. In fact, a growing body of evidence shows that it is contributing to the rising cost of healthcare that continues to cripple Colorado businesses and working families. Despite claims by its advocates that it is "free," it increases healthcare costs for employers and their workers due to lost drug rebates.[5] New research has estimated the financial impact of the 340B program on each state.[6]

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[2] https://www.gao.gov/assets/gao-11-836.pdf
[3] https://www.coloradopolitics.com/health-care/colorado-hospitals-pharmaceuticals-340b-bills/article_029142a4-f922-11ef-9f04-8fd11e1e0929.html
[4] https://340breform.org/340b-hospitals/colorado/
[5] https://www.iqvia.com/locations/united-states/library/white-papers/the-cost-of-the-340b-program-part-1-self-insured-employers
[6] https://www.iqvia.com/locations/united-states/library/white-papers/the-cost-of-the-340b-program-to-states

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In response to increased consolidation, the Colorado legislature passed HB23-1226, requiring hospital chains to report on acquisitions and offering insights into the impacts of mergers and acquisitions[11], as well as SB23-252, which focused on efforts to increase price transparency. Given the importance that Colorado legislators place on addressing consolidation and transparency, focusing on the implications of the 340B Drug Pricing Program should also be a priority as the association between 340B and vertical consolidation in hematology-oncology, in particular,[12] is well-documented, particularly due to the fact that high-cost drugs for these

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[7] https://www.nctreasurer.com/news/press-releases/2024/05/08/state-treasurer-folwell-releases-report-finding-north-carolina-340b-hospitals-overcharged-state
[8] https://cepr.net/wp-content/uploads/2020/03/2020-03-Colorado-Hospital-Consolidation-Gaby-Biegel.pdf
[9] https://www.kunr.org/local-stories/2024-10-29/hospital-consolidation-raising-health-care-costs-mountain-west-beyond-study
[10] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6170097/
[11] https://www.cpr.org/2023/06/02/colorado-hospitals-will-have-to-hand-over-more-financial-information-under-two-new-laws/
[12] https://www.nejm.org/doi/full/10.1056/NEJMsa1706475#:~:text=Hospital%20eligibility%20for%20the%20340B,and%200.1%20(or%2033%25)

disease states yield significant 340B margins for hospitals. This is especially true for outpatient "child sites" located in wealthy areas with well-insured patients, which is often the case.[13] Research indicates that 340B hospitals markup medicines at significantly higher rates than independent physician offices.[14]

Hospital systems can also game the program by classifying facilities in wealthy areas as "child sites" of their hospitals that serve low-income patients. While the Bon Secours system in Richmond, VA, is the most notorious example,[15] this practice is widespread in Colorado as well. This practice gives 340B hospitals both a competitive advantage and a vested interest in securing as many facilities as possible to expand their 340B reach through horizontal consolidation.

Opportunities for chain pharmacy and PBM profit

340B also encourages for-profit chain pharmacies and PBMs to profit from the program. Currently, corporate health systems are able to create unlimited networks of external chain pharmacies they can use to profit from 340B. The exponential growth of these networks since 2010 – which have zero basis in statute – is a major factor in the program's rapid expansion.

There is no requirement that these pharmacies be located in low-income communities or that they provide medicines to patients at affordable prices. In fact, research has found they are expanding in increasingly wealthier, predominantly white, and better-insured areas. This enables health systems to further augment the number of prescriptions they can purchase at 340B discounts, which they can then mark up and bill employers and families at full commercial prices.[16]

Colorado is no exception to this rule, with only 25% of contract pharmacies located in medically underserved areas.[17] Additionally, Colorado 340B hospitals have 1,118 contracts with 340B pharmacies, 49% of which are with out-of-state pharmacies.[18] Clearly, such locations are being used to drive extra revenue to healthcare systems rather than improve access for low-income Coloradans. House Bill 2716 seeks to refocus the 340B program to its original intent to aid communities and patients most in need. It does this by requiring detailed reporting on the use of 340B profits for reducing out-of-pocket costs for low-income patients, the provision of charity care, and the operational transparency with contract pharmacies, ensuring that the funds from this program directly benefit the low-income patients and communities originally intended to be

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[13] https://avalere.com/insights/340b-hospital-child-sites-and-contract-pharmacy-demographics
[14] https://jamanetwork.com/journals/jama-health-forum/fullarticle/2807907
[15] https://www.nytimes.com/2022/09/24/health/bon-secours-mercy-health-profit-poor-neighborhood.html
[16] https://jamanetwork.com/journals/jama-health-forum/fullarticle/2807907
[17] https://cdn.aglty.io/phrma/fact-sheets/340b/%20Fact%20Sheet%20-%20340B%20State%20Profiles%20-%20Colorado%20-%202024.pdf
[18] https://340breform.org/340b-hospitals/colorado/

served.[19] Legislation like this is imperative to help curb some of these egregious practices and promote better access to healthcare for vulnerable populations.

Incentives for prescribing higher-cost medicines

Finally, 340B has been shown to drive providers to prescribe higher-priced drugs. Healthcare systems can make a larger 'spread' from more expensive, brand name drugs than the lower-cost, equally effective biosimilar. A study published in *Health Affairs* found that 340B program eligibility was associated with a 22.9 percentage point reduction in biosimilar adoption between 2017 and 2019.[20] Another analysis found that between 25% and 56% of corporate health systems only list prices for the innovator product, and very few offer all available biosimilars.[21]

All of these distortive effects raise costs for employers and their employees, without any requirements that 340B funds benefit low-income communities. In fact, 73% of Colorado hospitals provide below-average levels of charity care, and University of Colorado Hospital devotes just 1.5% of its operating costs to charity care.[22]

The Impact of SB 71

Employers and lawmakers in Colorado have made great strides to introduce more transparency in the healthcare system in order to help bring down costs. SB 71 would represent a step backward. It would exacerbate 340B's upward pressure on costs for working families without doing anything to promote access or affordability for low-income patients.

First, the bill effectively serves as a "gag rule," a practice that the state has sought to prohibit in the past by allowing pharmacists to communicate openly and honestly about drug prices. This legislation would similarly prevent employers and the government from identifying what drugs were purchased at 340B discounts and how much corporate health systems mark them up – hampering our ability to eliminate this waste in the system and harm to our bottom line.

The bill would also lock in one of 340B's most well-documented flaws: contract pharmacy. Unlimited networks of pharmacies in wealthy, well-insured, and often far-flung regions of the state have been a key factor in the program's expansion over the past decade-plus. They have helped hospitals maximize the number of 340B prescriptions they can process through commercial insurance and, thus, their profit on the sale of discounted drugs that are not being shared with working families or the employer purchasers who provide their healthcare.

SB 71 would simply enshrine this status quo in law, perpetuating the continued unchecked expansion of the program's underlying arbitrage system, exacerbating its distortive effects on consolidation and prescribing patterns, and preventing efforts to introduce transparency into this

[19] https://leg.colorado.gov/bills/sb25-124
[20] https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2022.00812
[21] https://communityoncology.org/hospital-340b-drug-profits-report-feb-2021/
[22] https://340breform.org/340b-hospitals/colorado/

opaque program. All in all, it would raise costs for employers and working families while benefiting the corporate health systems and their chain pharmacy and PBM partners.

Conclusion

As rising healthcare premiums and insurance costs continue to increase our overall operational expenses and impact the benefits coverage we can offer our employees, we cannot support legislation that would irresponsibly increase expenses without ensuring the program works for Colorado's vulnerable communities.

Employers urge the Committee to oppose SB 71 and instead look to more comprehensive reforms that promote transparency and accountability in 340B, provide affordability protections for patients, and limit 340B's inflationary effects on healthcare spending for working families.

Sincerely,

Amanda Green
Senior Manager of Healthcare Advancement
National Alliance of Healthcare Purchaser Coalitions

Dear Senate Health and Human Services Committee Members:

As advisor and director of Our Health Equity, I write to you in opposition to SB71. Our Health Equity is a nonprofit organization committed to improving access to medicine, reforming the charity healthcare system, and ensuring that each person has access to proper nutrition and clean drinking water.

A recent poll conducted by Our Health Equity that surveyed 800 active Colorado voters indicated that 58% of Coloradans find "reducing the out-of-pocket costs and prices" for patients to be the most important use of profits gained from the 340B program. Colorado has an opportunity to improve health equity, but SB71 does little to address the areas that need it most. While the bill aims to protect 340B covered entities from exploitation and obstacles created by drug manufacturers, the true beneficiaries of this reform are not the underserved patients it is intended to help but rather the covered entities themselves.

The 340B program was designed to help eligible safety-net providers generate funds to better serve low-income and uninsured patients. However, minimal oversight and transparency requirements allow for covered entities and contract pharmacies to make a profit without reinvesting in charity care in high-need communities. SB71 will only expand the access these covered entities have to discount drugs, with only vague annual disclosures required to attempt to ensure those discounts are passed down to patients.

Instead of expanding this failing system, Colorado should prioritize extensive reforms that put patients over profits. This means:

- Requiring 340B "covered entities" to provide detailed financial statements delineating the dollars received through the 340B program and where those dollars were spent.
- Clearly define who a 340B-eligible patient is in the State of Colorado—e.g., a patient at or below 200% of the federal poverty level.
- Require that covered entities funnel 340B dollars to eligible patients and demonstrate publicly that it happens and precisely how.
- 78% of Coloradans want their legislators to do MORE to reduce hospital mark-ups (see graphic on page 2). SB71 does NOTHING to address hospital mark-ups.

Without implementing these guidelines, the 340B program will continue to profit from the communities it is designed to serve, forcing patients to pay high prices for care while covered entities and contract pharmacies benefit from 340B discounts. There is a unique opportunity to reform the 340B program, but SB71 focuses on increasing protection for covered entities instead of making meaningful changes for patients.

SB71 falls short because it does not explicitly ensure 340B funds are used to drive down out-of-pocket drug costs in underserved communities. Before you vote on SB71, I would be happy to set up a time to review what Coloradans believe is the proper use of 340B funds.

Thank you,

Laura Brod Hameed, Advisor/Director
OurHealthEquity.org
(612) 437-8836

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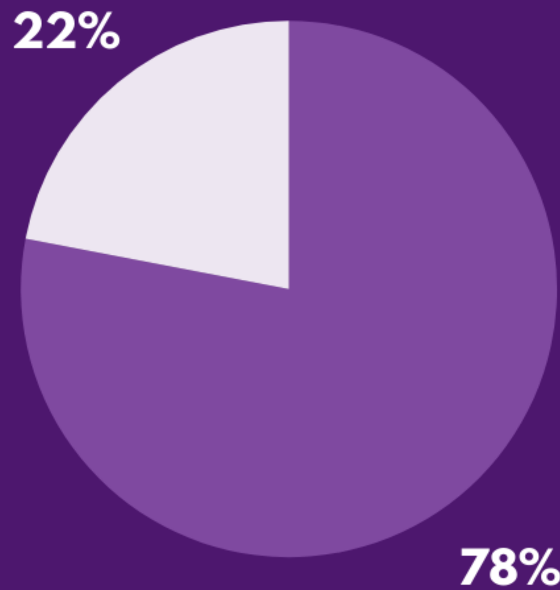
78% of Coloradans Believe The State Legislature Should Do More To Reduce Hospital Markups On Prescription Medicines For Patients.



Support SB124. Not SB71.

OurHealthEquity.org

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March 12, 2025

To the Honorable Members of the Colorado Senate Health Committee,

We, the undersigned organizations dedicated to ensuring affordable healthcare access for vulnerable populations, are writing to you today to address the critical issue of the 340B Drug Pricing Program. We believe it's essential for you to consider the program's challenges within the context of well-documented concerns about abuse and profiteering. **Therefore, we respectfully ask that you oppose SB 25-071.**

The 340B program was created in 1992 with the intent to help low-income patients and vulnerable communities access more affordable medicines. The program requires drug manufacturers to provide discounted prices on outpatient drugs to certain hospitals and clinics, known as “covered entities,” that serve a high number of uninsured, poor, or otherwise vulnerable patients. The savings from these discounts are intended to allow these covered entities to “stretch scarce Federal resources as far as possible, reaching more eligible patients and providing more comprehensive services.”

Unfortunately, as detailed in this investigative piece by the New York Times,[1] the 340B program has strayed far from its original intent. While it was meant to support safety-net providers, **many hospitals have exploited the program’s lack of clarity and oversight to generate significant profits, often at the expense of the vulnerable populations it was designed to serve**.

Here are some key concerns:

- **Lack of Requirement to Pass on Discounts:** There is no requirement that covered entities pass on the drug discounts to patients or reinvest their 340B profits into free or reduced-cost care.
- **Expansion into Wealthier Communities:** Some hospitals have expanded their 340B programs into wealthier neighborhoods, using the discounts to generate profits from commercially insured patients.
- **Exploitation of Contract Pharmacies:** There has been an unchecked growth in 340B contract pharmacies, with some hospitals using them to generate greater profits.
- **Limited Charity Care:** Many 340B hospitals do not provide sufficient charity care to justify their tax exemptions.
- **Price Markups:** Some 340B hospitals have been found to significantly markup drug prices for insured patients. In North Carolina, some hospitals billed the State Health Plan at an 84.8% higher price markup than hospitals outside of the program. A New York union health

[1] https://www.nytimes.com/2025/01/15/us/340b-apexus-drugs-middleman.html?unlocked_article_code=1.104.B0H6.ubyivpst70g7&smid=url-share

plan found that 340B hospitals were charging as much as 25 times the average sales price (ASP) for outpatient-administered drugs.

- **Lack of Transparency and Oversight:** There is a lack of transparency and public oversight regarding the profits that hospitals generate from the 340B program.

Multiple sources corroborate these concerns. A **Government Accountability Office (GAO)**[2] report found that HRSA's oversight of the program is insufficient to ensure that participating hospitals meet eligibility requirements and that contracts with state and local governments lacked specifics about obligations to serve low-income populations. The GAO also found that some hospitals were allowed to participate despite not having the required contracts with state or local governments.

A report from the **North Carolina State Health Plan**[3] found that 340B hospitals overcharged state employees, targeted wealthier neighborhoods, and recorded massive profits. The report also found that 340B hospitals had lower charity care spending than non-340B hospitals. While we recognize that the 340B program is a federal issue and best addressed by Congress, we understand that there are efforts at the state level to regulate this program. We urge you to proceed with caution, and we ask that you consider any legislation concerning 340B under the context of these well-documented concerns of hospital abuse and profiteering.

Specifically, we recommend that you:

- **Support reforms that would create meaningful hospital transparency and oversight.** This may include requirements for hospitals to report their 340B markups to Colorado patients, the state, Colorado employers and payers, and to use funds to directly lower the cost of medicine for Colorado's most vulnerable.

- **Oppose any attempt to mandate or legitimize the abuse of contract pharmacies.**

- **Encourage your congressional delegation to reform the program at the federal level.**

We believe that by considering these concerns and working toward meaningful hospital transparency and accountability, the Colorado General Assembly can help ensure that the 340B program fulfills its original intent to provide affordable medications to the vulnerable populations it was designed to serve.

Thank you for your time and attention to this important matter.

Respectfully,

Advocates for Compassionate Therapy NOW (ActNOW)
ADAP Advocacy
Biomarker Collaborative
Colorado Bioscience Association
Exon 20 Group
Colorado Springs and Southern Colorado Area Special Needs Families
Community Access National Network
Cystic Fibrosis United
International Cancer Advocacy Network (iCAN(
Lupus Colorado
MET Crusaders
Patients Rising
PDL1 Amplifieds

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[2] https://www.gao.gov/assets/gao-20-108.pdf

[3] https://www.shpnc.org/documents/overcharged-state-employees-cancer-drugs-and-340b-drug-price-program/download?attachment

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PDL1 Amplifieds

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[2] https://www.gao.gov/assets/gao-20-108.pdf

[3] https://www.shpnc.org/documents/overcharged-state-employees-cancer-drugs-and-340b-drug-price-program/download?attachment

My name is Jake Williams, CEO of Healthier Colorado. We are a nonprofit organization dedicated to providing every Coloradan with the opportunity to live a healthy life. Thank you for the opportunity to present this input on Senate Bill 25-071.

While we are neutral on this bill as a whole, we want to encourage amendment of the bill to include stronger transparency provisions. The 340B program is a critical resource for low income patients and health providers who serve this population. In 2023, the sale of 340B drugs totaled $66 billion, which is nearly 5 times volume seen just a decade earlier. As this program has experienced rapid growth, legitimate questions have been raised about its administration, particularly concerning assurance that low income patients are receiving its benefits. A *New York Times* investigation published in January of this year, for example, highlighted questionable practices focused on the maximization of 340B utilization, sometimes through third parties, for monetary purposes potentially beyond simply helping patients.

We want this program to succeed in benefiting low income Coloradans. To support that interest, we believe it is important that policymakers, especially including the Colorado General Assembly, have the data necessary to monitor its operation. We need public confidence in this program. This is especially important in an environment in which significant cuts to health care programs are being considered at both the state and federal levels.

On behalf of taxpayers, elected officials deserve to know details such as how many prescriptions are being filled with 340B drugs, how many low income patients have had their out of pocket costs decreased because of the program, as well as details concerning the use of third parties to administer the program. These are provisions included in another piece of legislation being considered by this committee, Senate Bill 25-124.

It is my understanding that amendments will be introduced to SB 25-071 today in committee that enhance the transparency section (25-3-132). While I do not have all those details, we very much welcome steps in that direction.

We recognize that health providers who serve low-income patients have a critical reliance on this program. We want to support their ability to utilize it on behalf of the population they serve. Shining an enhanced light on its operation will facilitate appropriate accountability that will hopefully help this program continue to meet its original promise to support low income patients in Colorado and beyond.

Thank you, again, for the opportunity to provide this testimony.