

Testimony on SB 25-124

William S. Smith, PhD

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Thank you for the opportunity to submit testimony on this important bill.

The 340B program has become enormous and is now larger than the 50 state Medicaid drug program as well as the Medicare Part B drug program. We expect that by next year, 340B will surpass in size the Medicare Part D program for seniors and become the largest federal or state drug program.

As it has grown in size, a set of perverse incentives has become apparent. Because the program generates revenue for hospitals by allowing the hospital to purchase drugs at very low prices and then receive reimbursement from Medicare or commercial insurers at much higher rates, the program provides strong incentives for hospitals to treat fully insured and higher income patients. The ability of hospitals to “pocket the spread” between the acquisition price and the insurance reimbursement price provides little incentive for the hospital to treat under-insured or uninsured patients.

Likewise, there is no requirement that the substantial discounts provided to hospitals get passed on to low-income patients. In fact, there is considerable evidence that uninsured or under-insured patients pay full price at the pharmacy counter.

Imagine if this program involved food and not medicine. Imagine if the Congress has passed a law requiring food wholesalers – purveyors of meat and vegetables – to sell to supermarkets at

substantial discounts with no requirement that those lower prices find their way to shoppers at the supermarket.

We know what the result of such a law involving food would be. Supermarket profits would soar, and shoppers would see little benefit. This is precisely what has happened with medicines in the 340B program: hospital profits have soared, and patients have seen little benefit, with most patients paying high prices for their medicine.

One economist studied the 340B program for the year 2019. What he discovered is that in 2019 hospital profits from 340B totaled \$40 billion on sales of \$67 billion. In 2023, 340B sales were \$124 billion.

It is also sometimes argued that the 340B program does not cost the taxpayer anything. This is certainly not the case. On the federal level, there seems little doubt that the Medicare program over reimburses for drugs from 340B facilities. On the state level, state employee health plans also over reimburse for drugs as a recent report from the North Carolina Treasurer's office indicated. It is also the case that state governments forego substantial revenues when 340B facilities choose to give Medicaid patients a 340B drug since the state will not capture the generous Medicaid rebate revenue from that transaction.

SB 25-124 would mitigate some of these perverse incentives and would provide important data about the functioning of the program to federal and state policy makers. First, the bill would provide needed out-of-pocket relief to low-income patients who are treated at 340B facilities. It is quite frankly outrageous that patients who are treated by hospitals that secure tens of billions in 340B revenue end up paying huge out-of-pocket sums for their care and sometimes find

themselves with medical debt. The revenue from the 340B program was intended by Congress to allow these hospitals to mitigate the healthcare costs of disadvantaged patients.

I am well aware that a number of 340B hospitals depend upon 340B revenue to keep their doors open. Do we know which hospitals they are? Do we know which hospital struggle mightily to provide charity care to disadvantaged patients and which hospitals treat 340B as a profit center?

I would argue that without greater transparency, we cannot know which 340B hospitals are “doing the right thing” and which ones are not. I have long argued that policy makers need to know how much money each hospital is taking in from 340B and exactly where they are spending those funds before we can know if the program is operating effectively. Thank you for the opportunity to submit this testimony.



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 Support for Senate Bill 124, Concerning 340B Transparency

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 cancer treatment.

On behalf of COA and the independent oncology clinics we represent across Colorado, I write in strong support of Senate Bill 124, a necessary step toward restoring transparency and accountability in the Federal 340B Drug Pricing Program. If passed, this bill will ensure that hospitals participating in 340B use program savings as intended, to reduce out-of-pocket costs for patients rather than fund hospital profits, acquisitions, and consolidation.

The 340B program was designed to help safety-net providers by ensuring that vulnerable patients have access to affordable prescription drugs. However, as the program has expanded, many large health systems have exploited it for financial gain rather than patient care. Hospitals now account for nearly 90% of the \$44 billion in discounted drugs purchased through the program, yet there is little accountability for how these savings are used. ⁱ Unlike Federally Qualified Health Centers (FQHCs), which must reinvest 340B savings into patient care, hospitals face no such requirement. ⁱⁱ As a result, many charge insured patients full price for discounted medications and pocket the difference as profit, while others use savings to fund executive salaries, marketing, and consolidation efforts rather than reducing costs for patients.

These financial incentives have fueled the rapid consolidation of independent oncology practices into hospital outpatient departments, a shift that significantly increases the cost of care. Studies show that chemotherapy infusion costs nearly double when delivered in a hospital outpatient

department compared to a community oncology clinic.ⁱⁱⁱ Patients, particularly in rural areas, must now travel farther for care while paying substantially higher costs for the same treatment. This trend is particularly concerning for cancer patients, as research has shown that longer travel distances reduce the likelihood of receiving necessary treatment.

Despite the program's expansion, 340B hospitals have not meaningfully increased their provision of charity care. Nearly half of nonprofit hospitals pursue medical debt collections against patients eligible for financial assistance, further demonstrating the need for transparency and accountability.^{iv, v, vi} Without proper oversight, 340B has strayed from its original mission, becoming a hospital profit center rather than a true safety-net program.

Senate Bill 124 offers a patient-centered solution that addresses these critical issues. It requires that hospitals direct the majority of their 340B profits toward lowering prescription drug costs and health care expenses for low-income patients, ensuring that discounts truly benefit those in need. The bill also introduces mandatory public reporting to prevent further misuse of program savings and prohibits hospitals from using 340B funds for executive bonuses, lobbying, or public relations campaigns. These safeguards restore accountability and ensure that hospitals participating in the program uphold its original intent.

Colorado has an opportunity to lead the nation in ensuring 340B functions as intended, prioritizing patients, not hospital profits. By passing SB 124, the General Assembly will protect patient access to affordable, high-quality care at independent oncology clinics, and restore the integrity of a program that was meant to serve the most vulnerable.

We strongly urge the Colorado General Assembly to pass SB 124 and ensure that 340B savings finally reach the patients they were meant to help. 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.

Thank you,

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

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 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>

ⁱⁱⁱ 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>

^{iv} 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>

^v 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>

^{vi} 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>



Dear Senators:

As advisor and director of Our Health Equity, I am writing to you in support of SB124. 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 84% of Coloradans support requiring hospitals to use 340B discounts to reduce patient drug costs (see graphic on p. 2).

Also, 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. SB124 does just that, by requiring covered hospitals to use 55% of 340B revenues to cover out-of-pocket patient costs for medicines.

Colorado has the unique opportunity to pioneer health equity in America, and SB124 is an important step in improving healthcare access for underserved Coloradans. For too long, the 340B program has been used to line the pockets of large hospital networks, leaving the patients they are meant to serve behind.

The 340B program was designed to help eligible safety-net providers generate funds to serve low-income and uninsured patients better. However, minimal oversight and transparency requirements allow covered entities and contract pharmacies to make a profit without reinvesting in charity care in high-need communities.

Expansions of the 340B program, like SB71, enable these hospital systems to continue exploiting the system while driving up costs for patients in underserved and impoverished communities.

The provisions in SB124, like ensuring that 340B dollars directly reduce patient out-of-pockets expenses will ensure that 340B profits are directed to the communities and individuals that will benefit most. Additionally, requesting the state to study the costs of the 340B program will provide meaningful transparency and could dramatically improve the state of health equity in Colorado.

By implementing these guidelines, the 340B program will cease to profit from the communities it is designed to serve and stop 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, and SB124 provides you with a roadmap to protect and prioritize patients' needs.

I urge you to pursue significant changes in the organization and oversight of the 340B program to ensure it serves high-need communities. Supporting SB124 will ensure that fewer patients are left behind in favor of profits.

Thank you,

A handwritten signature in black ink, appearing to read 'Laura Brod Hameed'.

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

**84% of Coloradans Support
Requiring Hospitals to Use
340B Discounts to Reduce
Patient Drug Costs.**



Support SB124. Not SB71.

Dear Members of the Senate Health & Human Services Committee

On behalf of the steering committee member of Front Range Pharmalogic, I write this letter to ask for your support of Senate Bill 25-124, Reducing Costs of Healthcare for Patients.

Front Range Pharmalogic is a community organization that works to increase affordability and accessibility of prescription medicines.

Over the last five years we have engaged with local organizations, community leaders and policy makers to call attention to the rising plight of Coloradans who rely on life-saving drugs.

In that time, much talk and posturing has been devoted to addressing the rising cost of drugs. But all too often the solutions proposed and passed have more to do with the industries and special interests that dominate debates about healthcare as opposed to the patients and consumers who ultimately bear the brunt of rising healthcare costs.

We have recently learned about, and have worked to better understand, growing concerns over abuse of the 340B federal drug discount program. It is shocking to see that over the last five years the value of medicines delivered through the program has doubled, with total value now approaching \$100 billion!

Even more shocking, however, is to learn that there is rampant and growing abuse of the benefits supposedly intended for low income, rural and at-risk patients. The discounts that hospitals and drug middlemen receive from the federal mandate in the 340B program are supposed to go to low-income families.

Instead, we have read dozens of reports in the media and on-line showing that hospitals and PBMs (another corrupted segment of the health care system) pocket billions in 340B profits, with practically zero accountability.

Fortunately, you have before you Senate Bill 124, which takes at least the initial steps toward reigning in 340B abuse. The bill directs hospitals to use 340B profits to actually lower the cost of health care for the people the program is supposed to help. What a novel idea – to have a program work the way it is supposed to.

Clearly, restoring the integrity and rooting out the rampant fraud within the 340B program should be a priority for the U.S. Congress, the Trump administration and federal regulators. However, we all know that the wheels of federal policy grind slowly. For the moment we must pass SB124 in Colorado to help patients here, now. And send a strong message that the abuse of programs by corporate profiteers is not the Colorado way.

We thank you for your efforts and your support of SB124.

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 25-124.

While we are neutral on this bill as a whole, we want to express our particular support for the transparency portion of the legislation. 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 items covered by the “Hospital transparency reporting” section (25.5-2.5-304) of this bill and, accordingly, this is the particular section of the legislation we are supporting.

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.



To: Senator Kyle Mullica, Colorado Senate Health & Human Services Chair
Senator Dafna Michaelson Jenet, Colorado Senate Health & Human
Services Vice Chair
Members, Colorado Senate Health & Human Services Committee

From: Matt Pagnotti, Co-Chair, Colorado Organizations & Individuals Responding to
HIV/AIDS (CORA); State & Local Government Relations Director, Vivent Health

Re: Opposition to SB25-124 Reducing Costs of Health Care for Patients

Colorado Organizations and Individuals Responding to HIV/AIDS (CORA) and Vivent Health appreciate the opportunity to submit testimony regarding SB25-124, enacting restrictions on use of 340B savings by certain covered entity hospitals. CORA is a statewide coalition representing the more than 15,000 Coloradans living with HIV, the countless others who are made most vulnerable to acquiring HIV, and the organizations that serve them. Vivent Health is a nonprofit provider of HIV care, prevention, and supportive services, and a member organization of CORA. Our organizations are deeply concerned about the unintended consequences on access to care from many of the provisions within SB 124 and urge the committee to vote no on this bill.

Since its inception, the 340B federal discount program has been a pivotal backbone within the response to the HIV epidemic. As Congress clearly stated when enacting the program, the intent of the 340B program is help safety net providers to “stretch scarce resources as far as possible, reaching more eligible patients and providing more comprehensive services.” Only certain nonprofit organizations serving communities that face disproportionate barriers to health care are eligible to participate, including Ryan White funded HIV service organizations and state AIDS Drug Assistance Programs. Under the statute, for-profit drug manufacturers must sell covered outpatient medications to 340B safety net providers at a discount if they want their medications to be covered by Medicare and Medicaid. These providers can then bill insurance plans and public payers for full reimbursement and are required to reinvest the resulting difference into providing services. Providers’ participation in 340B is regulated by the federal Health Resources & Services Administration (HRSA), which conducts over 200 audits of providers each year and requires annual recertification.

The 340B program is not a drug rebate program nor a patient assistance program. Safety net providers can and do use 340B savings to offer wrap around services like food pantries, case management, and housing assistance. There is no income eligibility cap on who can



receive services or assistance funded through 340B savings. This flexibility has allowed community organizations to offer comprehensive, patient-centered HIV care even as public investment has failed to keep pace with the epidemic. Additionally, these features of 340B advance sustainability among safety net providers, who are currently facing unprecedented threats to federal sources of funding.

While well-intended, SB 124 would nonetheless radically redefine the 340B program in ways that will limit assistance for vulnerable Coloradans. By setting arbitrary thresholds for the percentage of 340B savings that impacted providers would have to spend on direct out of pocket cost assistance, the bill would gut funding for wrap-around supportive services. SB 124 also imposes an unnecessary and restrictive income eligibility cap by creating a new patient definition that differs from existing federal law and regulation. Not only would this harm the people living with HIV who receive those services from the providers covered by the bill, but the reduction in comprehensive programming would place a greater burden on smaller providers not directly subject to the bill at a time when many are already struggling to meet existing needs.

SB25 124 also inaccurately and dangerously frames participation in the 340B program as harmful to Medicaid. Though it is true that Medicaid programs cannot double dip by securing rebates from drug companies on a medication that a safety net provider has already received a 340B discount for, 340B providers are partners – not competitors – with Medicaid. Covered entities use 340B savings to help meet needs and fill gaps that Medicaid can't. If hospital systems pull back on the type of services they provide through 340B savings, the resulting increase in community need and public health costs would ultimately add strain to the state's Medicaid budget.

In sum, redefining the 340B program into a one-size-fits-all patient assistance program would violate the intent of the program and make it harder for Coloradans living with and vulnerable to HIV to access comprehensive services. We urge the committee to reject SB25-124 so that safety net providers can continue to meet their communities' unique needs.