



**In Opposition to Colorado SB 25-071
January 29, 2025**

Position: The Pharmaceutical Research and Manufacturers of America (“PhRMA”) respectfully opposes Colorado SB 25-071 which would require biopharmaceutical manufacturers to ship 340B drugs to all pharmacies that contract with 340B “covered entities” and by extension offer 340B pricing at these locations. 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.

The 340B hospital 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 seven times as much as independent physician offices for the sale of medicines administered to commercially insured patientsⁱ 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.ⁱⁱ

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.^{iii,iv} 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. 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.

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. 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. This resulted in billing the North Carolina State Health Plan for Teachers and State Employees a price markup that was 84.8% higher than North Carolina hospitals outside of the 340B program.^v

SB 25-071 will line the pockets of 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.^{vi} 340B covered entities and their contract pharmacies generated an estimated \$13 billion in gross profits on 340B purchased medicines in 2018, which represents more than 25% of pharmacies' and providers' total profits from dispensing or administering brand medicines.^{vii} Today, the program stands at \$66.3 billion, a 23% growth increase from the previous year.^{viii}

In 2023, the Minnesota Legislature passed legislation^{xii} that requires the Minnesota Department of Health (MDH) to collect and aggregate data from Minnesota providers that participate in the federal 340B program. 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^x 340B revenue of at least \$630 million for the 2023 calendar year. 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 which are estimated to account for 80% of all 340B drug spending.^{x,xi} 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.^{xii}

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 multiple federal courts across the country.

In litigation about the federal 340B statute, U.S. Courts of Appeal for the Third Circuit and D.C. Circuit have specifically found that the federal statute does not require delivery to an unlimited number of contract pharmacies.

- In January 2023, the U.S. Court of Appeals for the Third Circuit held that “[s]ection 340B [of the federal statute] does not require delivery to an unlimited number of contract pharmacies” and “Congress never said that drug makers must deliver discounted Section 340B drugs to an unlimited number of contract pharmacies.” *Sanofi Aventis U.S. LLC v. United States Dep’t of Health & Hum. Servs.*, 58 F.4th 696 (3d Cir. 2023).
- In May 2024, the U.S. Court of Appeals for the D.C. Circuit similarly held that manufacturers are not required to deliver to an unlimited number of contract pharmacies. Slip. Op. at 12, *Novartis Pharms. Corp. v. Johnson*, Nos. 21-5299, 21-5304 (D.C. Cir. May 21, 2024).

Despite ongoing activity at the federal level and in federal courts, a number of states have enacted legislation similar to SB 25-71 has serious constitutional defects and is being challenged in court. In December 2024, the U.S. District Court for the Southern District of West Virginia enjoined one of those

laws after finding that plaintiffs were likely to succeed on their claim that the law was preempted by federal law.

PhRMA respectfully opposes the provisions outlined above and appreciates your consideration prior to advancing CO SB 25-071.

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.

ⁱ Hospital Prices for Physician-Administered Drugs for Patients with Private Insurance, *New England Journal of Medicine*, 390, 4, (338-335), (2024). DOI: [10.1056/NEJMsa2306609](https://doi.org/10.1056/NEJMsa2306609)

ⁱⁱ Hunter MT, et al. "Analysis of 2020 Commercial Outpatient Drug Spend at 340B Participating Hospitals." Milliman, September 2022. https://www.milliman.com/-/media/milliman/pdfs/2022-articles/9-13-22_phrma-340b-commercial-analysis.ashx

ⁱⁱⁱ Sun C, Zeng S, Martin R. "The Cost of the 340B Program Part 1: Self-Insured Employers." IQVIA, March 2024.

<https://www.iqvia.com/-/media/iqvia/pdfs/us/white-paper/iqvia-cost-of-340b-part-1-white-paper-2024.pdf>

^{iv} Sun C, Zeng S, Martin R. "The Cost of the 340B Program Part 2: 340B Revenue Sharing." IQVIA, March 2024.

<https://www.iqvia.com/-/media/iqvia/pdfs/us/white-paper/2024/the-cost-of-the-340b-program-part-2-340b-revenue-sharing.pdf>

^v North Carolina State Treasurer. "Overcharged: State Employees, Cancer Drugs, and the 340B Drug Pricing Program." May 2024. Access: <https://www.shpnc.org/documents/overcharged-state-employees-cancer-drugs-and-340b-drug-price-program/download?attachment>.

^{vi} Conti, Rena M., and Peter B. Bach. "Cost consequences of the 340B drug discount program." *Jama* 309.19 (2013): 1995-1996.

^{vii} Berkeley Research Group. For-Profit Pharmacy Participation in the 340B Program. October 2020.

^{viii} Fein, Adam. The 340B Program Reached \$66 Billion in 2023—Up 23% vs. 2022: Analyzing the Numbers and HRSA's Curious Actions. Drug Channels. Oct. 22, 2024.

<https://www.drugchannels.net/2024/10/the-340b-program-reached-66-billion-in.html>

^{ix} MDH defines "net" as the difference between the payments received for discounted drugs (\$1.5 billion), and the cost of acquiring those drugs (\$734 million) plus payments to external administrators (\$120 million). (see p.7)

^x Spending in the 340B Drug Pricing Program, 2010 to 2021 (<https://www.cbo.gov/system/files/2024-06/60339-340B-DrugPricing-Program.pdf>)

^{xi} See 2024 Minnesota Statutes, Section 62J.461.

^{xii} Minnesota Department of Public Health, "340B Covered Entity Report," Nov. 25, 2024. <https://www.health.state.mn.us/data/340b/docs/2024report.pdf>.



April 30, 2025

The Honorable Kyle Brown, Chair
House Health & Human Services Committee
State Capitol, 200 E Colfax
Denver, CO 80203

Dear Representative Brown and Members of the Committee:

The Biotechnology Innovation Organization (BIO) and the Colorado BioScience Association (CBSA) **oppose SB 71**, which is currently before your committee. This bill would prohibit biopharmaceutical manufacturers participating in the federal 340B Drug Discount Program (“340B Program”) from establishing requirements or standards intended to ensure compliance with federal laws. BIO and CBSA have very serious concerns with these provisions, which would enact state requirements in an exclusively federal program and would preclude legitimate efforts to ensure transparency and integrity in the 340B Program.

CBSA champions Colorado’s life sciences ecosystem and the patients it serves. CBSA’s members include more than 720 life sciences companies and organizations employing more than 40,000 people in Colorado. Our life sciences community drives global health innovations that improve and save lives, from concept to commercialization. CBSA represents biotechnology and pharmaceutical, medical device and diagnostics, digital health, ag-bio and animal health, academic and research institutions, and the service provider companies that support the work of our ecosystem. CBSA remains committed to advancing affordability solutions that correct market failures, increase competition, and lower costs for patients while preserving patient access and supporting medical innovation.

BIO is the world’s largest trade association representing biotechnology companies, academic institutions, state biotechnology centers and related organizations across the United States and in more than 30 other nations. BIO’s members develop medical products and technologies to treat patients afflicted with serious diseases, delay their onset, or prevent them in the first place. In that way, our members’ novel therapeutics, vaccines, and diagnostics not only have improved health outcomes, but also have reduced healthcare expenditures due to fewer physician office visits, hospitalizations, and surgical interventions. BIO membership includes biologics and vaccine manufacturers and developers who have worked closely with stakeholders across the spectrum, including the public health and advocacy communities, to support policies that help ensure access to innovative and life-saving medicines and vaccines for all individuals.

The 340B Program was enacted in 1992 to provide steeply discounted drugs to certain qualified hospitals and clinics, collectively referred to as “covered entities,” intended to support these facilities’ care to uninsured and underinsured patients. Covered entities are able to dispense discounted drugs to patients and receive reimbursement by commercial payers at the full price, keeping the difference and providing a revenue stream for the covered entity. However, under federal law, 340B drugs cannot be subject to Medicaid rebates when dispensed to Medicaid beneficiaries (“duplicate discounts”). Additionally, 340B drugs may only be dispensed to patients of a covered entity; dispensing 340B drugs to ineligible patients is prohibited and referred to as

“diversion” from the 340B program.

The 340B program has grown exponentially in volume over the past decade. The 340B program has expanded in ways that no one could have foreseen. From 2015 to 2021, purchases under the program grew at an average rate of 24% per year and as of 2023 totaled \$66.3 billion.^{1, 2} 340B is now the second largest pharmaceutical program in the nation behind Medicare Part D.³ An October 2020 study found that from April 2010 to April 2020, contract pharmacy arrangements in the program grew by 4,228% from 2,321 in 2010 to 101,469 today.⁴ Because of this explosive growth in the 340B Program, it is important to ensure all appropriate federal laws are being followed and all steps are taken to prevent fraud, waste, and abuse.

Reports from patient groups, policy experts, and states show that patients are not benefiting from 340B funds and hospitals are often not using those funds to even indirectly benefit the communities they serve. To be clear, SB 71 is not about patient access or affordability. Contracting with pharmacies does not expand patient access to medications and patients are not required to fill their prescriptions at contract pharmacies. Furthermore, a recent Congressional report was released after a long investigation titled [“CONGRESS MUST ACT TO BRING NEEDED REFORMS TO THE 340B DRUG PRICING PROGRAM.”](#) The chair of the Senate HELP Committee said, “This investigation underscores that there are transparency and oversight concerns that prevent 340B discounts from translating to better access or lower costs for patients.”

In addition to 340B covered entities dispensing drugs directly to patients, the Health Resources and Services Administration (HRSA), which implements the program, has issued sub-regulatory guidance to allow covered entities to contract with outside pharmacies to dispense drugs to covered entities’ patients. However, a heightened risk for duplicate discounts and diversion at contract pharmacies exists because, unlike at covered entities’ in-house pharmacies, most of the patients visiting contract pharmacies are not eligible for 340B drugs. The federal Government Accountability Office (GAO) reports that contract pharmacies are a significant source of diversion and duplicate discounts, in part because they often do not identify patients as 340B-eligible until after the prescription has been dispensed.⁵ In fact, the GAO also notes, “66 percent of the 380 diversion findings in HRSA audits involved drugs distributed at contract pharmacies.”⁶

HRSA’s main mode of enforcing the 340B program is through random audits. They audit 200 covered entities per year, and problems with duplicate discounts and diversion are common findings in audits, as well as working with “contract pharmacies” without any actual contract in place. Colorado facilities are found to have compliance issues approximately on par with the rest of the country. A report by the federal GAO in 2018 found that 72 percent of audits had findings of noncompliance.⁷ Unfortunately, the HRSA audit program has limitations, as indicated in the title of GAO’s 2018 report: “Federal Oversight of Compliance at 340B Contract Pharmacies Needs Improvement.”

Adding further concern to compliance concerns with contract pharmacies, HRSA does not even cite audit findings of noncompliance if the noncompliance is by a contract pharmacy. In another report in 2021, GAO states, “HRSA officials told GAO that, beginning in fall 2019, the agency started issuing

¹ Fein, Adam, “What I (and Others) Told the Senate about the 340B Drug Pricing Program.” Drug Channels, August 8, 2023. Accessed September 14, 2023. <https://www.drugchannels.net/2023/08/what-i-and-others-told-senate-about.html>

² Fein, Adam, The 340B Program Reached \$66 Billion in 2023- Up 23% vs 2022: Analyzing the Numbers and HRSA’s Curious Actions.” Drug Channels. October 22, 2024. Accessed December 10, 2024.

³ Blalock, Eleanor. Measuring the Relative Size of the 340B Program, BGR Group, June 2022.

⁴ Vandervelde, Aaron, et al., For-Profit Pharmacy Participation in the 340B Program, BRG Group, October 2020.

⁵ *Drug Discount Program: Federal Oversight of Compliance at 340B Contract Pharmacies Needs Improvement*, GAO Report, June 2018.

⁶ Ibid.

⁷ Ibid.

findings only when audit information presents a clear and direct violation of the requirements outlined in the 340B Program statute. HRSA officials explained that guidance, which is used to interpret provisions of the 340B statute for the purposes of promoting program compliance among covered entities, does not provide the agency with appropriate enforcement capability. For example, *HRSA officials reported that there were instances among fiscal year 2019 audits in which the agency did not issue findings for a failure to comply with guidance related to contract pharmacies in part because the 340B statute does not address contract pharmacy use and, therefore, there may not have been a clear statutory violation*" (emphasis added).⁸

We strongly oppose this bill's provisions intended to prohibit biopharmaceutical manufacturers participating in the 340B Program from establishing requirements or standards to ensure compliance with federal laws. The use of contract pharmacies in the 340B Program simply has not been adequately policed by HRSA. It is for this reason that some manufacturers have put in place requirements for covered entities that use multiple contract pharmacies. This particular issue is currently being litigated in several federal courts, as there is no statutory requirement for manufacturers to extend 340B prices to contract pharmacies. Contract pharmacy utilization was created through sub-regulatory federal guidance (guidance that HRSA itself has acknowledged is legally unenforceable⁹). This bill's provisions are nearly identical to bills in nearly *two dozen* other states this year, which are part of an effort by covered entities to inappropriately enshrine *their* interpretation of federal law into state statutes. Yet the belief that manufacturers have no ability to establish standards and must provide discounted 340B drugs to all contract pharmacies, regardless of a history of noncompliance, has been rejected by multiple courts.

Even beyond the exclusive federal jurisdiction of the 340B Program and the multiple pending federal lawsuits, the policy contained in these provisions is flawed. Biopharmaceutical manufacturers have participated in the 340B Program for 30 years and, in doing so, provided hundreds of billions of dollars in financial support to covered entities. However, when evidence exists that certain arrangements (i.e., contract pharmacies) result in increased rates of illegal duplicate discounts and diversion of 340B drugs, it is untenable to preclude manufacturers from implementing *any* standards. In doing so, the state would be facilitating contract pharmacies' noncompliance with federal statute.

For these reasons, **we respectfully oppose SB 71 and urge your NO vote on this measure.** If you have any questions, please do not hesitate to contact us at pcastro@bio.org and agoodman@cobioscience.com

Sincerely,

/s/

Primo J. Castro
Director
State Government Affairs – Western
Region
BIO

/s/

Amy B. Goodman
VP and Counsel
for Policy + Advocacy
CBSA

⁸ Drug Pricing Program: HHS Uses Multiple Mechanisms to Help Ensure Compliance with 340B Requirements, GAO Report, December 2020.

⁹ "HRSA Urges Pharma to Continue 340B Discounts at Contract Pharmacies," *Inside Health Policy*, August 20, 2020.



April 28, 2025

Colorado State Legislature
House Health and Human Services Committee
200 E Colfax Avenue
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National Groups:

Hepatitis Education, Advocacy & Leadership
(HEAL) Group
Industry Advisory Group (IAG)
National ADAP Working Group (NAWG)

Via electronic mail

RE: SB 71 - OPPOSE

Dear Honorable Chairman Brown, Vice Chair Lieder, Members of the Colorado House Health and Human Services Committee, and your respected staff,

The Community Access National Network (CANN) writes in **OPPOSITION** to **SB 71**, which would expand the federal 340B Drug Pricing Program in Colorado without sufficient oversight to ensure the program appropriately serves patients, particularly those living with HIV and other chronic health conditions.

The Community Access National Network (CANN) is a 501(c)(3) national nonprofit organization focusing on public policy issues relating to HIV/AIDS and viral hepatitis. CANN's mission is to define, promote, and improve access to healthcare services and support for people living with HIV/AIDS and/or viral hepatitis through advocacy, education, and networking.

While CANN is primarily focused on policy matters affecting access to care for people living with and affected by HIV, we stand in firm support of all people living with chronic and rare diseases and recognize the very reality of those living with multiple health conditions and the necessity of timely, personalized care for every one of those health conditions. The 340B Drug Pricing Program is of profound importance to our community.

SB 71 undermines the well-recognized need for reform to align 340B with its original intent because the bill seeks an avenue to [expand 340B contract pharmacy arrangements without limitation](#) – particularly, limitations necessary to ensure proper transparency and accountability.

Abuse is rampant in the 340B Drug Pricing Program, as has been outlined in a [recent report from Chairman Bill Cassidy of the Senate Health, Education, Labor and Pensions Committee](#) (HELP) which requested a comprehensive understanding of where the dollars generated by this program flow and how such revenue benefits patients. The information gathering included letters requesting

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information and data from hospital covered entities, Health Centers, Large for-profit chain pharmacies, and pharmaceutical manufacturers.

IRA and 340B Discount Duplication Concerns - Unclear Definition of “Restriction”

Of the issues outlined within the report is the failure for provider specific de-duplication of discounts between 340B and the Inflation reduction Act’s drug price negotiation program (MFP). The Centers for Medicare and Medicaid has absolved itself of any responsibility of oversight and prevention of prohibited duplicate discounts. The report rightly highlights CMS’ failure by quoting the agency directly: “[CMS]...expects providers to submit accurate claims and *utilize correct modifiers*.” [emphasis added]. The language of SB 71 does not appropriately define “restriction” and the Committee has an obligation to ensure this definition is sufficiently enforceable. Is a claims modifier a “restriction”, given many CE’s objections to utilizing the same?

Indeed, the plain language of the bill, at 6-29-105.(1)(b) states plainly, “A manufacturer shall not directly or indirectly require...claims or utilization data...”. Federal law does not “require” such claims modifiers as related to IRA rebates but merely suggests this action should *already* be going on. The Colorado legislature should clarify its intent and the language of the bill to expressly *allow* such claims data collection in order to prevent and detect duplicate discounts.

“Revenue is revenue.” Or How Entities Can and *Do* Avoid Responsibility to Use 340B Revenue to Serve Patients

In Bon Secours Mercy Health (BSMH) response to Senator Bill Cassidy’s request for information when asked how 340B revenues were used (ie. exec compensation v patient benefit and charity care), their response was "we don't segregate revenue. revenue is revenue."

Based on written responses and the accompanying documents produced pursuant to Chairman Cassidy’s investigation, BSMH and Cleveland Clinic each generated hundreds of millions of dollars in 340B savings and revenue from the 340B Program between 2018 and 2023. In responses to Chairman Cassidy’s letter, both BSMH and Cleveland Clinic explained that it “does not directly pass on all savings generated from the 340B Program to patients in the form of savings on health care expenses.”

One common claim made to legislators is that providers, pharmacists, and/or payors are unaware of the value of a 340B discount, preventing them from applying these savings to patients’ out-of-pocket costs. However, this claim is false. Many 340B entities employ “third-party-administrators” (TPAs). These TPAs are often vertically integrated with pharmacy benefit managers (PBMs) and contract pharmacies. TPAs provide electronic medical record systems integrations, allowing providers to know the approximate or exact value of 340B revenue a specific medication will generate while seeing a patient—before the patient even reaches a pharmacy counter. In CVS’s response to Senator Cassidy they raked in more than 350 million in TPA fees, highlighting the need for accountability and transparency.

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Overall, the agreements between the contract pharmacies, TPAs, and covered entities reflect a proliferation of fees across various services and settings. With multiple for-profit entities receiving substantial financial benefits, the incentives are aligned to exert more payment pressure on covered entities, thereby diverting resources from the 340B Program's intended purpose of allowing covered entities to stretch scarce federal resources as far as possible.

There is ever growing evidence that manufacturer mandates add unnecessary burden to already strained state budgets as outlined by the [North Carolina treasurer's report](#), and in the case of Tennessee, adding \$7,452,700 to state expenditures as outlined by the fiscal note on the state's manufacturer mandate bills [HB 1242 & SB 1414](#), while Texas's fiscal note estimates that unlimited contract pharmacy agreements will [make the state's HIV program insolvent by 2027](#).

Chairman Cassidy's investigation underscores that there are transparency and oversight concerns that prevent 340B discounts from translating to better access or lower costs for patients. Congress needs to act to bring much-needed reform to the 340B Program, **SB 71** as written, stands in opposition to ensuring patients benefit from this federal program that intended to reach more patients, and provide more comprehensive services.

To be clear, CANN supports a strong 340B program. When 340B operates the way it is intended, safety-net providers thrive and vulnerable communities, families, and individuals gain access to healthcare they might otherwise not have. CANN welcomes discussion on instituting appropriate guardrails into legislation within the appropriate limitations of state powers associated with this federal program.

We would be happy to discuss this legislation or any other matters of public health, please feel free to reach out by email or phone at kalvin@tiican.org, 913-954-8816, or jen@tiicann.org, 313-333-8534.

Respectfully submitted,



Sincerely,
Kalvin Pugh
Director of State Policy, 340B
Community Access National Network (CANN)

On behalf of
Jen Laws
President & CEO
Community Access National Network



COMMUNITY ONCOLOGY ALLIANCE

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April 30, 2025

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

RE: Opposition to Senate Bill 71, Concerning Contract Pharmacies

Chair Brown,

On behalf of COA and the independent community oncology practices we represent across Colorado, I write to express our strong opposition to Senate Bill 71.

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 solely dedicated to independent community oncology practices, which serve the majority of Americans receiving cancer treatment.

SB 71 proposes to expand the use of contract pharmacies under the federal 340B Drug Pricing Program without enacting the necessary oversight, accountability, or transparency measures to prevent continued misuse of the program.

As written, this legislation ignores the well-documented concerns that the 340B program, originally designed to help safety-net providers serve vulnerable patients, is now routinely exploited by large hospitals and for-profit pharmacy benefit managers (PBMs) through expansive contract pharmacy arrangements. These arrangements often generate significant revenues for health systems and corporate intermediaries, without ensuring that patients benefit through lower drug prices or better access to care.

We remain particularly concerned about the following issues:

- Hospitals and their contract pharmacies, many of which are tied to PBMs, now dominate 340B drug purchasing, despite having no requirement to pass savings on to patients.
- PBMs leverage these arrangements to steer prescriptions toward affiliated pharmacies, increasing costs and reducing provider competition.
- Independent community oncology practices, especially in rural or underserved communities, are increasingly unable to compete as 340B revenue is funneled to large hospital systems, contributing to consolidation and the erosion of community-based independent cancer care.

- According to Milliman, hospital outpatient departments tripled their share of chemotherapy infusions between 2004 and 2014, a shift associated with higher care costs and no demonstrated improvement in patient outcomes.¹

Rather than helping vulnerable populations, SB 71 would allow continued expansion of contract pharmacy arrangements, enabling PBMs and large hospital systems to deepen their control over the drug distribution pipeline in Colorado, at the expense of transparency, patient access, and community-based independent oncology care.

COA urges the legislature to reject SB 71 and instead call for comprehensive reform of the 340B program at the federal level, where its structure can be meaningfully rebalanced to ensure patient benefit. We continue to advocate that 340B discounts should follow the patient, not simply generate institutional profits.

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)

¹ 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>



Biotechnology Innovation Organization
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April 30, 2025

Opposition SB 71

Afternoon Mr. Chair and Members of the Committee:

BIO supports the federal 340B program. It's a good program. But even good programs can be abused.

The 340B program has experienced very steep growth in recent years (23% each year, compounded), yet this growth has been primarily in areas that deviate from the program's original intent.

Safety net clinics make up only a small minority of the 340B program—DSH hospitals alone account for about 80% of those sales.

Instead, hospitals and for-profit chain pharmacies have found out how to game the system by expanding into affluent neighborhoods.

Contract pharmacies have long been used when clinics do not have their own outpatient pharmacy. Since 2010, the number of contract pharmacy arrangements in 340B increased from 2,000 to 194,000.

This truly wild amount of contract pharmacies put into place wasn't done to increase patient access, it was done to profit and expand more. Patients can obtain their medicines at any pharmacy they want—whether it is a contract pharmacy or not, it doesn't matter to the patient—their medicines are covered by insurance and almost no patient ever sees any of the 340B discount.

“HRSA's oversight of the 340B program is inadequate.” That is not my opinion or BIO's position, that was the conclusion of the federal Government Accountability Office.

The Health Resources and Services Administration's main compliance tool is the use of random audits, but only 200 entities per year are audited,

which represents about 0.33 percent of covered entities. *HRSA has stated publicly that they do not have the authority to cite for noncompliance by contract pharmacies.*

Despite well-documented limitations with enforcement, 65 to 70 percent of audits find covered entities as noncompliant.

This is why manufacturers have initiated 340B integrity programs and why this bill's prohibition against any conditions or any data submission requirements are wholly unreasonable and bad public policy.

There are many documented problems with oversight, accountability, and transparency in 340B, so we must oppose efforts that attempt to eliminate or prevent the limited oversight and accountability that does exist.

Thank you.

Primo Castro
Director, State Government Affairs – Western Region
The Biotechnology Innovation Organization (BIO)



April 30, 2025

The Honorable Representative Kyle Brown
Colorado State House
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Lilly USA, LLC

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Dear Representative Brown,

I am writing to express Eli Lilly and Company's opposition to Senate Bill 71 (SB 71), which proposes to alter the federal 340B program by requiring that pharmaceutical manufacturers extend federal 340B discounts to for-profit contract pharmacies. Not only would SB 71 expand the 340B program – a program that recent studies have shown results in higher costs for patients and payers – but it would also intrude into an exclusively federal program, making it patently unconstitutional. In fact, West Virginia was recently enjoined from implementing a similar proposal. For these reasons, we encourage the legislature to focus on reforms that help ensure patients benefit from the discounts and rebates that are paid into the healthcare system.

1. Although the 340B program has exponentially expanded,¹ patients do not benefit from the 340B program. In fact, patients' costs may go up.

Recent studies demonstrate that participation in the 340B program does not result in additional patient benefit – at the pharmacy counter or otherwise. For example, the North Carolina State Treasurer's Office recently found that North Carolina 340B hospitals charged cancer patients – on average – 5.4 times more than what the hospitals paid to acquire the oncology medicines.² In addition, the New York Times recently reported that a New Mexico 340B hospital charged an *insured* patient in New Mexico more than \$2,500 for her cancer drug, more than half her take-home salary for a month. Even though the medicine's *list price* was about \$2,700, and the hospital purchased the medicine for less than \$2200, the hospital billed Mrs. King's insurance company \$22,700.³ This is consistent with our experience. 340B hospitals can purchase many of our insulins for a penny per milliliter (mL), but contract pharmacies frequently charge patients significantly more. For example, one pharmacy we interviewed charged an uninsured patient over \$500 for a vial of insulin that the pharmacy purchased for 15 cents – a markup of over 330,000%.

Although proponents of state 340B contract pharmacy bills argue that 340B profits are used to help patients in other ways, data show this is false – 340B hospitals do not spend more on charity care than non-340B hospitals. For example, the North Carolina Treasurer's Office concluded that the vast majority of 340B hospitals did not provide enough charity care to equal the estimated value of their tax exemptions and were among those that reported the **lowest investments in charity**

¹ In 2023, the number of hospitals participating in the 340B program has grown from 45 to more than 2,600. The number of contract pharmacy arrangements has grown over 9,500% from 2,300 to 220,000, and discounted purchases have reached a record \$66.3 billion. See: <https://www.gao.gov/products/gao-23-106095>; <https://www.drugchannels.net/2024/10/the-340b-program-reached-66-billion-in.html>; <https://www.drugchannels.net/2024/10/hospitals-are-relying-more-on-pbms-to.html>

² <https://www.shpnc.org/what-the-health/north-carolina-340b-hospitals-overcharged-state-employees-cancer-drugs>.

³ <https://www.nytimes.com/2025/01/15/us/340b-apexus-drugs-middleman.html>. A 340B hospital's purchase price generally will be at least 23% less than the medicine's list price.

care from 2011 to 2021.⁴ Another study found that “at least 56% of 340B profits do not go to patients in any form.”⁵ And another found that 340B hospitals make up all 10 of the non-profit hospitals found to provide the least amount of community benefit relative to the value of their tax breaks.⁶

2. Large hospitals and for-profit pharmacies are benefiting from the expansion of the 340B program through contract pharmacy arrangements – smaller hospitals and payers (including Colorado employers and taxpayers) are not.

A first of its kind report from Minnesota highlights how large hospital systems and their contract pharmacies are using the 340B program to increase their profits. The Minnesota Department of Health determined that large 340B hospitals benefited the most from the program, accounting for only 13% of all entities **but comprising 80% (approximately \$500 million)** of state 340B revenue.⁷ Additionally, the report found that one out of every six dollars in 340B profit went to for-profit contract pharmacies or other vendors, underscoring the significant share of financial benefits captured by these entities. In fact, certain small grantees **reported losing money** on 340B purchases as a result of payments to contract pharmacies and other vendors.

One state concluded that “[t]oo many hospitals have converted the 340B drug discount program into a profit center at the expense of state employees, cancer patients, and taxpayers.”⁸ For example, North Carolina found that 340B hospitals charged higher rates – billing 84.8% higher prices on average than non-340B hospitals. And recent studies revealed that the growth in 340B provider participation drove an increase in Medicaid spending of \$1100 per patient,⁹ and over \$32 billion per year.¹⁰

The rapid expansion of 340B also has significant impact on Coloradans. For example, a recent study found that the program is **costing Colorado employers and workers over \$132 million annually**, \$20M of which is associated with the state’s government health plans.¹¹ This number is expected to *increase* to \$152M annually if SB 71 passes. Another study built on this analysis and found that the 340B program is costing Colorado over \$6 million annually in lost tax revenue, driven by increased expenses for health plans which decreased taxable income for affected employers and workers.¹²

⁴ <https://www.shpnc.org/documents/overcharged-state-employees-cancer-drugs-and-340b-drug-price-program/download?attachment>

⁵ N. Masia and F. Kuwonza, Health Capital Group, Measuring the 340B Drug Purchasing Program’s Impact on Charitable Care and Operating Profits for Covered Entities, 2022.

⁶ Lown Institute 2022 Hospitals Index, <https://lownhospitalsindex.org/2022-fair-share-spending/>. See also New England Journal of Medicine, “Consequences of the 340B Drug Pricing Program.” (2018). [Consequences of the 340B Drug Pricing Program | NEJM](#) (finding that although 340B hospitals purchase drugs at steep discounts the “[f]inancial gains for [340B] hospitals have not been associated with clear evidence of expanded care or lower mortality among low-income patients.”).

⁷ The report excluded physician administered drugs, which the state believed resulted in under reporting of 2-3X 340B revenues. <https://www.health.state.mn.us/data/340b/docs/2024report.pdf>.

⁸ <https://www.shpnc.org/documents/overcharged-state-employees-cancer-drugs-and-340b-drug-price-program/download?attachment> (emphasis added).

⁹ Jung, J., Xu, W.Y. and Kalidindi, Y. (2018), Impact of the 340B Drug Pricing Program on Cancer Care Site and Spending in Medicare. Health Serv Res, 53: 3528-3548. <https://doi.org/10.1111/1475-6773.12823>.

¹⁰ <https://www.healthcapitalgroup.com/340b-and-total-medicaid>

¹¹ <https://www.iqvia.com/locations/united-states/library/white-papers/the-cost-of-the-340b-program-to-states>

¹² https://www.magnoliamarketaccess.com/wp-content/uploads/340B-Tax-Impact-Analysis_2025.01.23.pdf

3. State proposals to modify the federal 340B program are unconstitutional.

SB 71 would expand the ability of for-profit pharmacies and large hospital systems to use the 340B program to generate profit at the expense of patients. Doing so raises significant legal concerns, both under the United States Constitution and in light of several recent court rulings. In particular, recent rulings in the D.C. Circuit Court and the Third Circuit Court have affirmed that pharmaceutical manufacturers can impose restrictions on contract pharmacies.

In addition, on December 17, 2024, a federal district court judge ruled that West Virginia's contract pharmacy law (SB 325) is unconstitutional and officials cannot enforce the law while three drug industry legal challenges play out.¹³ SB 325, like the Colorado bill, would have required that manufacturers extend discounts to contract pharmacies. The court was concerned with the state's attempt to prohibit certain manufacturer requirements, stating the "340B Program certainly did not establish a system where the fox guards the hen house." Colorado's proposed SB71 attempts to impose similar restrictions on manufacturers and is inconsistent with rulings in West Virginia and the Third Circuit.¹⁴

4. Lawmakers should focus on reforms that benefit patients.

While we commend lawmakers for focusing on transparency within the 340B program, we firmly believe that allowing unlimited contract pharmacies is misguided. The state should first understand how the program is functioning and impacting patients and state payers to help ensure policies are well informed and will benefit patients. In addition, Lilly supports other state policies that make medicines more affordable for patients such as first dollar coverage for insulin, cost-sharing based on net price. We encourage the legislature to evaluate other policies that have a more direct impact on patients' out-of-pocket experiences. We welcome the opportunity to speak with you about these policies.

* * * * *

We appreciate the opportunity to express our views on SB 71. Given the bill does not advance patient drug affordability goals, and raises serious federal preemption concerns, we respectfully request that you oppose.

Sincerely,



William Reid
Vice President
State Government Affairs
Eli Lilly and Company

¹³ *Pharm. Rsch. & Mfrs. Of Am. v. Morrisey*, 2024 U.S. Dist. LEXIS 227964 (S.D.W.V. Dec. 17, 2024); See also *Sanofi Aventis U.S. LLC v. U.S. Dep't of Health & Human Servs.*, 58 F.4th 696 (3d Cir. 2023) (holding that the government cannot require manufacturers to "[deliver] discounted drugs to an unlimited number of contract pharmacies," and that "drug makers' policies [with respect to contract pharmacies] are lawful"); *Novartis v. Johnson*, No. 21-5299, (D.C. Cir. May 21, 2024) (rejecting "HRSA's position that section 340B prohibits drug manufacturers from imposing any conditions on the distribution of discounted drugs to covered entities").

¹⁴ *Sanofi Aventis U.S. LLC v. U.S. Dep't of Health & Human Servs.*, 58 F.4th 696 (3d Cir. 2023).

Aaron Broadwell, MD
President

April 25, 2025

Gary Feldman, MD
Immediate Past President

House Health & Human Services Committee
200 E Colfax Avenue, HCR 0112
Denver, CO 80203

Madelaine Feldman, MD
VP, Advocacy & Government Affairs

Michael Saitta, MD, MBA
Treasurer

Concerns re: SB 71 – Federal 340B Drug Pricing Program

Firas Kassab, MD
Secretary

Chair Brown, Vice Chair Lieder and members of the House Health & Human Services Committee:

Erin Arnold, MD
Director

The Coalition of State Rheumatology Organizations (CSRO) would like to express concerns regarding SB 71, which would address aspects of the federal 340B drug pricing program. CSRO serves the practicing rheumatologist and is comprised of over 40 state rheumatology societies nationwide with a mission of advocating for excellence in the field of rheumatology and ensuring access to the highest quality of care for the management of rheumatologic and musculoskeletal disease.

Leyka Barbosa, MD
Director

Kostas Botsoglou, MD
Director

Mark Box, MD
Director

Rheumatologic diseases, such as rheumatoid arthritis, psoriatic arthritis and lupus, are systemic and incurable, but innovations in medicine over the last several decades have enabled rheumatologists to better manage these conditions. With access to the right treatment early in the disease, patients can generally delay or even avoid damage to their bones and joints, as well as reduce reliance on pain medications and other ancillary services, thus improving their quality of life.

Michael Brooks, MD
Director

Amish Dave, MD, MPH
Director

SB 71 would allow for significant growth in the 340B drug pricing program and fails to incorporate guardrails that ensure patient access to discounted medications. Section 340B of the federal Public Health Service Act, known as the 340B drug pricing program, was created to provide discounted outpatient medications for disproportionate share hospitals (DSH) and federally qualified clinics that treat low-income and uninsured patients. However, over the past three decades, the program has grown greatly, demonstrating weaknesses in its implementation and execution.

Harry Gewanter, MD, MACR
Director

Adrienne Hollander, MD
Director

Robert Levin, MD
Director

Amar Majjhoo, MD
Director

Contract Pharmacy Expansion

SB 71 would enable greater expansion of contract pharmacies within the 340B program, without any oversight to ensure that underserved patients actually receive discounted medications from the contract pharmacies associated with DSHs. According to a 2018 U.S. Government Accountability Office (GAO) [report](#), the number of pharmacies that contract with 340B entities has increased “more than fifteen-fold” since the 2010 guidance that allows for an unlimited number of contracts. Initially these contract pharmacies were primarily located in the same communities as the covered entity. However, GAO reported that contract pharmacies are located between 0-5,000 miles away from their associated covered entity.ⁱ

Gregory Niemer, MD
Director

Joshua Stalow, MD
Director

EXECUTIVE OFFICE

Leslie Del Ponte
Executive Director

More than half of all U.S. pharmacy locations act as a contract pharmacy for a covered entity participating in the 340B program.ⁱⁱ CVS Health, Walgreens, Cigna (via Express Scripts), UnitedHealth (via OptumRx), and Walmart – all publicly traded, vertically integrated subsidiaries of pharmacy benefit managers (PBMs) – account for 75% of all

contract pharmacy relationships with 340B covered entities.ⁱⁱⁱ These pharmacies are all top Fortune 30^{iv} companies, profiting off of underserved patients through their 340B business arrangements. Clearly, access to contract pharmacies is *not* what is limiting patient access to 340B medications, and provisions within SB 71 would only allow large PBMs to continue to profit from these broken aspects of the system.

Healthcare Consolidation

The Health Resources and Services Administration (HRSA) allows 340B covered entities to register their off-campus outpatient facilities, or child sites, under their 340B designation. Covered entities, such as hospitals and their off-campus facilities, have a competitive advantage as they can purchase drugs at a 20-50% discount through their 340B status. Covered entities acquire drugs at the 340B price, while imposing markups on the reimbursement they submit to commercial health plans.

According to a [study](#) in the New England Journal of Medicine, after accounting for drug, patient, and geographic factors, price markups at 340B eligible hospitals were 6.59 times as high as those in independent physician practices. In this study, 340B eligible hospitals earned \$650.24 more per drug unit than independent physician practices. This may also have the unintended consequence of exacerbating government healthcare spending.

The additional revenue these covered entities can pocket provides them with a cash flow advantage that physician practices and outpatient clinics will never be able to actualize. These child site clinics compete with independent community practice rheumatologists and oncologists, who prescribe many of the expensive medications available to 340B DSH, and eventually run them out of business. This uneven playing field may make rheumatology practices more susceptible to hospital acquisitions. In fact, between 2016-2022, large 340B hospitals were responsible for approximately 80% of hospital acquisitions.^v

This consolidation was also recognized in a 2022 Congressional Budget Office [report](#), which states the 340B program could encourage large healthcare systems that prescribe expensive 340B eligible medications to acquire physician practices, such as rheumatology and oncology. These acquisitions threaten the viability of rheumatology practices across the United States. We are concerned that SB 71 could lead to greater healthcare consolidation throughout the state, jeopardizing the viability of Colorado-based rheumatology practices and leading to increased costs for patients and the healthcare system in general.

Weaknesses in 340B Implementation

In recent years, rheumatologists have seen the effects of the weaknesses within the 340B program as Medicaid patients have been turned away from 340B DSH clinics for their regular treatments. Medicaid patients with chronic conditions are certainly “underserved” and do not always benefit from the discounted medications made available through the 340B program. This clearly falls outside of the original mission of the 340B program. This is just one of the weaknesses in the 340B system, particularly with large DSH systems, that reveal a failure to consistently serve patients in need, in spite of large profits that come from contract pharmacies and child site clinics.

CSRO believes that the 340B drug pricing program was created with a noble mission – to ensure that underserved, low-income and uninsured patients receive the medications they need at little to no cost. However, expanding access through unrestricted contract pharmacy access is not the solution and offers no assurances of benefit to the intended patients. Instead, to ensure the program’s success, the mission should be realigned to prioritize the patient and establish greater transparency and accountability. For more information on CSRO’s position, please visit <https://csro.info/UserFiles/file/CSRO-340B-Statement-2024.pdf>.

On behalf of practicing rheumatologists throughout Colorado, we request that you **do not advance** SB 71. We thank you for your consideration and are happy to further detail our comments to the Committee upon request.

Respectfully,



Aaron Broadwell, MD, FACR
President
Board of Directors



Madelaine A. Feldman, MD, FACR
VP, Advocacy & Government Affairs
Board of Directors

ⁱ U.S. Government Accountability Office. "[Drug Discount Program: Federal Oversight of Compliance at 340B Contract Pharmacies Needs Improvement](#)." June 2018.

ⁱⁱ Drug Channels. "[EXCLUSIVE: For 2023, Five For-Profit Retailers and PBMs Dominate an Evolving 340B Contract Pharmacy Market](#)." July 2023.

ⁱⁱⁱ *ibid*

^{iv} Fortune. "[Fortune 500](#)." 2024.

^v Avalere. "[Characteristics of Hospitals Undergoing Mergers and Acquisitions](#)." February 2023.



Colorado General Assembly
House Health and Human Services Committee
200 E Colfax Avenue
Denver, CO 80203

April 28, 2025

Re: Opposition to SB25-071

Dear Committee Members,

On behalf of the Infusion Access Foundation, I am writing to express our concerns regarding SB25-071 and its potential impact on patient access to critical infusion therapies in Colorado. While we appreciate the legislature's commitment to addressing healthcare access and affordability, we urge careful consideration of expanding the 340B Drug Pricing Program.

The 340B Drug Pricing Program was originally created to improve medication affordability for underserved patients by allowing eligible healthcare entities to purchase drugs at a discount. However, the program has deviated significantly from its intended purpose. Instead of ensuring that savings benefit patients, large tax-exempt hospitals, private equity-backed organizations, and contract pharmacies have exploited regulatory loopholes to generate substantial profits, often at the expense of the very patients the program was designed to help.

Studies show that only 35% of 340B hospitals and 23% of 340B contract pharmacies are actually located in medically underserved areas. Meanwhile, profit margins for 340B contract pharmacies are 3.3 times higher than independent pharmacies, and drug price markups at 340B hospitals are 6.6 times higher than at independent clinics. These discrepancies indicate a failure to reinvest savings into patient care, leaving many vulnerable populations struggling with high out-of-pocket costs and limited access to affordable treatment.¹

To ensure that the 340B program serves its original mission, reforms must prioritize transparency, accountability, and equity, including requiring 340B entities to demonstrate how program savings directly benefit underserved patients. Expanding or modifying the 340B program without addressing these fundamental issues risks exacerbating inefficiencies and worsening healthcare disparities.

We strongly encourage Colorado lawmakers to take a balanced approach to SB25-071, one

¹ AIR340B, Overview: <https://340breform.org/overview/>



Infusion Access Foundation

that avoids expanding the 340B program in its current state and ensures that any cost-containment measures do not inadvertently reduce access to essential infusion therapies. The Infusion Access Foundation stands ready to collaborate with policymakers to develop solutions that improve affordability without sacrificing patient access.

Thank you for your time and consideration. If you have any questions or would like to discuss these concerns further, please do not hesitate to reach out.

Sincerely,

Alicia Barron, LGSW
Executive Director
Infusion Access Foundation

Dear House 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.

On April 24, U.S. Senator Bill Cassidy, M.D., chair of the Senate Health, Education, Labor, and Pensions (HELP) Committee, [released a report](#) on the federal 340B Drug Pricing Program, detailing findings from his [years' long investigation](#) into how covered entities (certain health care facilities or programs that serve low-income patients, as designated in law) use and generate revenue from the program.

Congress created the 340B program in 1992 to allow covered entities to purchase outpatient drugs at a discounted rate “to stretch scarce Federal resources as far as possible, reaching more eligible patients and providing more comprehensive services.” Drug manufacturers are required to provide these discounts as a condition of participation in the Medicaid Drug Rebate Program.

According to a press release issued by his office, as part of his investigation into the 340B Program, Senator Cassidy requested information from hospitals, Federally Qualified Health Centers (FQHCs), contract pharmacies, and drug manufacturers to better understand how revenue flows throughout the 340B Program and how covered entities use 340B revenue to benefit patients. He found that Bon Secours Mercy Health and Cleveland Clinic, both of which are covered entities, generated hundreds of millions of dollars in 340B revenue, but do not pass 340B discounts directly to their patients.

Shockingly, the two investigated hospitals saved hundreds of millions of dollars from 340B, and their executives stated that the 340B program was not designed to provide direct savings to patients. Additionally, these hospitals report using 340B revenue on “capital improvement projects” and “community benefit programs,” but do not account for what specific expenses 340B revenue goes towards. This cavalier and unaccountable approach to 340B funds is pervasive.

Senator Cassidy’s report also found that CVS Health and Walgreens charge covered entities a complex range of fees for using their pharmacy services to dispense 340B drugs to patients. They also charge additional administrative fees for Third Party Administrator (TPA) services. These fees, which generally increase each year, divert resources from the 340B program’s intended purpose.

Clearly, the 340B program needs to be reformed—in a major way. Colorado voters agree.

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 reforms to the bill advocate for a state report and limitations on the use of savings, the provisions are not enough to prevent the large-scale exploitation that the 340B program allows for. Expansions like those in SB71 embolden hospital systems to continue to abandon the patients who need them the most in favor of the bottom line.

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 without passing those benefits onto their 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 3). 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.

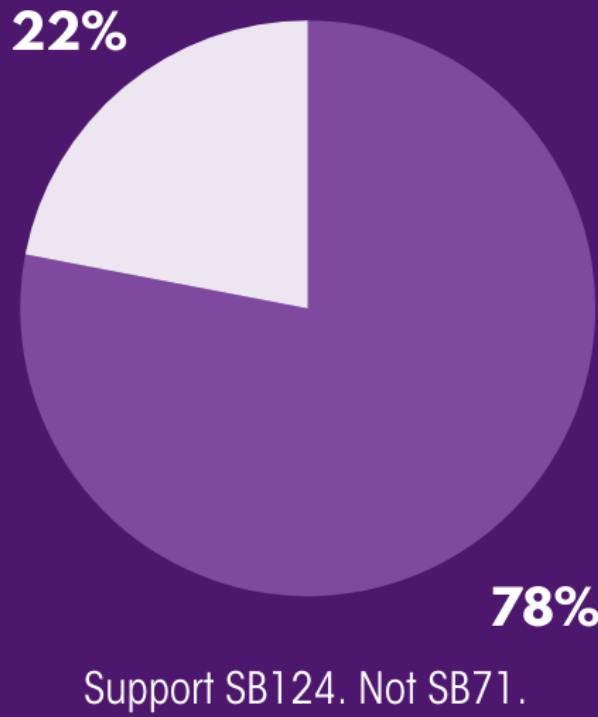
SB71 falls short because it does not explicitly ensure 340B funds are used to drive down out-of-pocket drug costs in underserved communities. Before you vote on SB71, I would be happy to set up a time to review what Coloradans believe is the proper use of 340B funds.

Thank you,



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

78% of Coloradans Are More Likely To Support Legislators Who Vote To Use 340B Funds to Lower Patients' Out-Of-Pocket Drug Costs.



340B Case Study: Richmond Community Hospital

How is Bon Secours supporting the underserved patients that the program was designed to help at Richmond Community Hospital?

Let's take a look...

Richmond Community Hospital

Serves Richmond's largest Black population, lacks basic resources and reliable equipment. Despite these struggles, the nonprofit hospital, owned by Bon Secours, has the highest profit margins of any hospital in Virginia.

340B In Action

Richmond Community Hospital can purchase a cancer drug for \$3,444 and bill insurance \$25,425, generating a \$22,000 profit per vial. The program clearly creates substantial revenue for the hospital, as intended. Yet, 340B hospitals such as Richmond Community Hospital are not expanding their resources to regions that need it most.

Join our campaign at

OHE
OurHealthEquity.org

Paid for by OurHealthEquity.org, a project of the Domestic Policy Caucus

¹<https://www.vhi.org/Bon%20Secours%20Richmond%20Community%20Hospital.html?tab=&?=h9880/>

²<https://storymaps.arcgis.com/stories/e51284979e494f228df0d46198aace40>

³<https://paddockpost.com/2024/10/03/executive-compensation-at-bon-secours-mercy-health-2022/>

⁴<https://bsmhealth.org/leadership/john-starcher/>

⁵<https://projects.propublica.org/nonprofits/organizations/540647482>

<https://www.nytimes.com/cdn.ampproject.org/c/s/www.nytimes.com/2022/09/24/health/how-a-hospital-chain-used-a-poor-neighborhood-to-turn-huge-profits.amp.html>

How does the 340B program work?

The 340B program allows hospitals in underserved areas to buy discounted drugs and bill insurance at full price. The program was designed to help low-income patients afford their medicines and provide access to charity care. However, large hospital chains exploit lenient transparency and reporting rules by opening clinics in wealthier areas, treating insured patients, and linking them to underserved hospitals on paper.

\$42,671,373

in net revenue in 2017 at Richmond Community Hospital after Bon Secours closed its ICU and key specialists left. This turned Community Hospital into a glorified emergency room.¹

At least 4 cases of patients not receiving proper care due to a shuttered ICU at Richmond Community Hospital between 2017 and 2021.

2

resulted in death

1

resulted in life-long cardiac issues

1

resulted in an amputation

More Than Half

the households in the neighborhoods surrounding Richmond Community Hospital do not have a car, according to research² done by Virginia Commonwealth University. Public bus routes to Saint Mary's, where patients can receive specialized care, take more than an hour.

\$4.75 million

The average annual amount spent on improvements to Richmond Community Hospital and the surrounding community from 2018-2022, according to Bon Secours.

\$11,580,768³

2022 take-home pay of John M. Starcher Jr.⁴, CEO of Bon Secours Mercy Health.

98.5%

of Richmond Community's revenue comes from program services, yet Dr. Lucas English, a former emergency department worker, claims Bon Secours was essentially laundering money from the poor hospital to its wealthier locations for profit. At the chain's St. Francis Medical Center, just 18 miles away, golf carts transport patients past marble fountains in a luxurious suburban setting.⁵



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 alone¹ – 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 program³, 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.

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 acquisitions¹¹, 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

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\(or%2033%25\)](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. SB 124 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

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.agtly.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

House Health & Human Services

04/30/2025 Upon Adjournment

SB25-071 Prohibit Restrictions on 340B Drugs

Typed Text of Testimony Submitted

Name, Position, Representing	Typed Text of Testimony
Amber Meriam Against themselves	<p>How about being the hero instead. Over in some shit hole African country there is a vaccine for tuberculosis. I cannot access the BCG vaccine, which was not the best, because it makes some people have a positive TB test. anyway tuberculosis has been out in the wild since 2024. Help the immune compromise people of Colorado not have 4-6 months they might not be able to get after the measles passes through. That shit deletes your immune system. Tuberculosis is a preventable disease and I would really like to see if I will be a grandma some day, but here we are and vaccines are needed for anyone who needs to take a TB test before starting medication</p> <p>Also I am houseless because of this. I have a pending CCRD case. I'd would get the gov and AG on this. I need to call and follow up on the complaint I filed against his legal license.</p> <p>Send money to help get my home out of jail! Your PAC can afford it.</p> <p>https://gofund.me/92fcb4a7</p>
Allen Thomas Against themselves	<p>Members of the House Committee on Health & Human Services</p> <p>I respectfully urge you to vote NO on Senate Bill 71, "Concerning Certain Practices By Persons Participating...Under the Federal 340B Drug Pricing Program."</p> <p>SB71 would worsen the very abuses it claims to address—dramatically expanding a loophole that already costs Colorado businesses, patients, and taxpayers millions. In fact, self-insured employers in our state are losing \$132 million annually due to improper 340B drug diversions—a number projected to grow to \$152 million if SB71 passes. Taxpayer-funded programs would also lose an additional \$3 million in rebates.</p> <p>Originally created in 1992 to help low-income patients via discounted drugs at community clinics, the 340B program has ballooned into a</p>

	<p>\$66 billion industry—driven largely by large hospital systems using national pharmacy chains to profit from drug discounts without passing savings to patients.</p> <p>Now, SB71 would lock in this abuse by granting legal cover for unchecked expansion and shielding it from oversight. Meanwhile, Colorado’s patients and small businesses continue to pay the price—with prescription costs up to 150% higher for those covered by self-insured plans.</p> <p>This bill is a giveaway to powerful hospital systems at the expense of Colorado workers, employers, and vulnerable patients. A broad coalition of respected pro-growth and taxpayer-focused organizations opposes SB71—and I urge you to join them:</p> <p>The National Taxpayers Union, which said “SB 71, a bill currently snaking its way through the statehouse, aims to expand the troubled 340B Drug Pricing Program—but instead of helping low-income patients, it could end up lining the pockets of big hospitals and pharmacies”</p> <p>Citizens Against Government Waste said, in colorful language, that “patients are being fed to the sharks. Special interests, like contract pharmacies and hospitals, are taking advantage of unclear definitions of what constitutes a 340B patient to line their own pockets with discounts meant for those in need... Patients are not getting their benefits, and taxpayers and consumers are paying the price for the abuses of the program.</p> <p>In a published opinion, the American Legislative Exchange Council (ALEC), wrote that “The (340B) program was designed to help safety-net hospitals serving large populations of low income and uninsured patients buy prescription drugs at pennies on the dollar... Rule changes by the Health Resources and Services Administration (HRSA) allowed participating hospitals to contract with an unlimited number of outside pharmacies to fill 340B prescriptions... Patients, insurers, employers and taxpayers are bearing the brunt of the cost.”</p> <p>There is no shortage of credible, well-documented evidence—dozens of reports and analyses from respected research and policy organizations—detailing the widespread abuse of the 340B program and the serious harm that proposals like Senate Bill 71 would inflict on Colorado’s healthcare system, employers, and taxpayers.</p> <p>Let’s be clear: the 340B program is a federal construct, and meaningful reform must come through Congress. That’s a position widely acknowledged on both sides of this issue. Yet instead of working toward that federal fix, the backers of SB71 are dragging Colorado into a policy overreach that grants powerful hospital</p>
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	<p>systems even more unchecked authority—without accountability, oversight, or clear benefit to vulnerable patients.</p> <p>I strongly urge a NO vote on Senate Bill 71 to stop this reckless expansion and protect Colorado from further financial and systemic harm. At the very least, this bill must be halted to give lawmakers the opportunity to pursue real solutions—rooted in transparency, responsibility, and the original mission of the 340B program.</p> <p>The General Assembly has a choice: stand with patients, small businesses, and fiscal responsibility—or give in to corporate interests pushing a broken system even further off course.</p> <p>Thank you for your time and consideration</p> <p>Allen Thomas</p>
<p>Jennifer Churchfield Against Front Range PharmaLogic</p>	<p>Chair and Members of the Committee,</p> <p>Thank you for the opportunity to speak. I respectfully urge you to vote NO on Senate Bill 71.</p> <p>This bill would worsen the very problem it claims to fix—dramatically expanding a loophole that’s already costing Colorado millions. Right now, self-insured employers lose \$132 million every year due to improper 340B drug use. If this bill passes, that number could grow to \$152 million. And taxpayer-funded programs would lose another \$3 million in rebates.</p> <p>The 340B program was created in 1992 to help low-income patients access affordable medications. But today, it’s ballooned into a \$66 billion industry—one that’s often abused by large hospital systems using national pharmacy chains. And the worst part? Patients rarely see the savings.</p> <p>Now, SB71 would lock in that abuse—removing without genuine oversight and accountability. Meanwhile, many Coloradans covered by self-insured plans are paying up to 150% more for their prescriptions under the 340B program, from a policy that is supposed to LOWER the cost of medicine.</p> <p>Let’s be honest—this bill isn’t about patients. It’s a giveaway hall pass and to powerful hospital systems that say it’s ok to continue abusing the system at an even greater rate, at the expense of small</p>

	<p>businesses, workers, and vulnerable communities. That’s why a broad coalition of business leaders, taxpayer advocates, patient groups and healthcare experts are urging you to oppose it.</p> <p>And let’s not forget—340B is a federal program. Real reform has to come from Congress. Instead of waiting for that, SB71 would pull Colorado into a dangerous policy overreach, giving hospital systems even more unchecked authority—without clear benefit to the people this program was meant to help.</p> <p>So I ask you again—please vote NO on Senate Bill 71. Let’s stop this reckless expansion and pursue real, responsible solutions like SB25-124 —ones that align with the original mission of the 340B program: helping those who truly need it.</p> <p>Thank you for your time and consideration.</p> <p>Jennifer Churchfield Chair, Front Range PharmaLogic</p>
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**Testimony of Marcia K. Horn, JD
President and CEO
ICAN, International Cancer Advocacy Network**

submitted to:

**The Health and Human Services Committee
Colorado House of Representatives
in Opposition to SB 71 re the 340B Drug Discount Program**

April 30, 2025

Mr. Chairman and Members of the House Health and Human Services Committee, thank you for the opportunity to testify in opposition to SB 71. I am Marcia Horn, President and CEO of ICAN, International Cancer Advocacy Network, a 501(c)(3) non-profit helping Stage IV cancer patients. Founded 29 years ago, we have helped more than 19,000 patients, including hundreds in Colorado.

We respectfully urge you to oppose SB 71: First the changes mandated by SB 71 would fail to lower prescription drug prices for those who were supposed to be helped by the 340B program—uninsured and low-income patients.

Second, the legislation is premature due to the reform efforts at the federal level. We believe federal reform will eventually happen. There has been a bipartisan group of United States Senators who recognize the need to reform the 340B program and restore it to its original purpose of helping lower income and uninsured patients.

Few doubt the need for meaningful 340B reform. The question is what should be done and by whom. The fundamental problem is that the discounted drug prices that were supposed to benefit uninsured and lower income patients are not getting to those groups. This has been the fault of far too many hospitals and far too many pharmacies—both of whom are supposed to be administering the 340B program to help low-income and uninsured patients.

Instead of reforming the program so that uninsured and low-income patients do receive those discounts, SB 71 would require that drug manufacturers send their product to most, if not all, pharmacies who, in turn, would sell the drugs at the

discounted price. Thus, many patients who are not eligible for the 340B discounts would receive the subsidies, while still not ensuring that those who are eligible would get them.

There are numerous examples of the current problems with how the 340B program currently operates:

The *New York Times* expose, "[How a Hospital Chain Used a Poor Neighborhood to Turn Huge Profits](#)," illustrates what is wrong and what desperately needs to be reformed in the 340B program. Here is a perfect example of where abuse and misuse of the 340B program is not only raising drug prices for everyone, but where the intended beneficiaries of the program—uninsured and low-income patients—are not receiving the discounts on drugs that they are entitled to.

In addition to the *New York Times* expose, there is ample evidence gathered by many other experts both in government and out. A [Government Accountability Office report](#) showed that more than half of the 340B hospitals examined were not passing on the discounts. An [Office of Inspector General report](#) showed that many uninsured patients are paying full price at the contract pharmacies that are supposed to be complying with the 340B program.

Today, the 340B program has morphed into a huge profit center for corporate pharmacy chains, like Walgreens and CVS who [account for 60%](#) of the contract pharmacies in the program. A [report found](#) that the average profit margin on 340B medicines dispensed through contract pharmacies was 72%, compared with just 22% for non-340B medicines.

In fact, a [report](#) by the North Carolina State Treasurer showed that North Carolina hospitals used the 340B discounts to overcharge cancer patients, state employees, and taxpayers for oncology drugs. Abuse of the 340B program isn't isolated to North Carolina; it's happening in Colorado and all across the country.

A [new study](#) by the American Cancer Society Cancer Action Network finds that the 340B program creates an incentive for hospitals to use more expensive medications, thus increasing the amount cancer patients pay in deductibles, coinsurance, and for medications.

Under SB 71, we would continue the fundamentally unjust situation in which the intended beneficiaries who are eligible for, and need, the 340B discounts, are not getting them, while those who are not entitled to the discounts are getting them.

In short, SB 71 would make the situation worse.

Mr. Chairman and Members of the Committee, on behalf of the patients we serve, and on behalf of all patients who are affected by drug pricing issues, please oppose SB 71 and let us refocus reform efforts on measures that will actually lower drug costs for all patients, especially uninsured and lower income patients.

Thank you for your consideration and for the opportunity to testify in opposition to SB 71.

Respectfully submitted,

Marcia K. Horn

Marcia K. Horn, JD
President and CEO
ICAN, International Cancer Advocacy Network



Colorado State Senate
Colorado State Capitol
200 E Colfax Ave
Denver, CO 80203

To Whom It May Concern,

The Westminster Chamber of Commerce opposes Colorado Senate Bill 71, and urges our legislators to protect consumers and small businesses by voting no.

The federal 340B legislation was intended to provide greater access and cost-savings to low-income, underserved and vulnerable populations. Unfortunately, a small handful of large hospital systems and contract pharmacies have exploited loopholes in the legislation to pad their own profits. Senate Bill 71 reduces transparency and enables those entities to further exploit the system at the expense of patients.

The bill harms consumers by making it easier for these massive hospital systems and out-of-state pharmacies to pocket 340B prescription drug savings, rather than passing the savings along to vulnerable patients from underserved populations. Further, by using this revenue to pad their profits, these large entities have an advantage over smaller, locally owned clinics and pharmacies, creating an unfair playing field in the market.

A vote against Senate Bill 71 protects Colorado's consumers and small businesses.

Thank you for your attention to this matter.

Jamie Chavez
President & CEO
Westminster Chamber of Commerce