Chairman Griffith and Ranking Member Castor, thank you for the opportunity to testify about this important program. I do believe that the 340B program is very important for certain community-based hospitals that face financial challenges due to uncompensated care and paltry Medicaid reimbursements. However, when the program is characterized as simply a discount program for covered entities provided by pharmaceutical companies, the public is misled about how this program adversely impacts many other stakeholders in the healthcare system. I would like to discuss some of these stakeholders and how they are impacted.

First and foremost are patients, both uninsured and underinsured. First, for the uninsured, a population that arguably was the original justification for creating the 340B program, there is some evidence to suggest that 340B hospitals do not pass along 340B drug discounts to the uninsured population. Both GAO and the USHHS OIG have conducted surveys of 340B contract pharmacies indicating that 340B discounts are not passed on to a significant portion of patients at the pharmacy counter. Since the 340B statute contains no provision requiring that discounts be passed to the uninsured, some uninsured patients may be required to pay full price.

Also, consider the case of an underinsured patient enrolled in a high deductible commercial health insurance plan. The typical deductible in such a plan might be $2500. Suppose this patient were prescribed a biologic drug that was priced at $7000 but the 340B hospital could purchase that drug for less than $1000. Typically, this discount would not be passed along to this patient and the patient would be required by his/her health plan to pay $2500 out-of-pocket for a prescription that the hospital purchased for less than $1000. On top of that, the patient's health plan and employer would then be billed for the balance, or $4500. In this instance, the 340B program could not be considered "patient friendly."

Another stakeholder we should consider is the taxpayer. It is sometimes said of the 340B program that no taxpayer money is involved since the discounts are provided by pharmaceutical manufacturers. This is very misleading. Let's consider the case of a Medicare patient who receives a cancer diagnosis and is treated at a 340B hospital. Many new cancer drugs have price tags that are north of $200,000. So, if a 340B hospital can purchase that cancer drug at a 50% discount, or $100,000, the hospital can bill Medicare at the Part B rate, or Average Sales Price

(ASP) plus 6%. That Medicare reimbursement for the hospital could be $200,000, offering the hospital a $100,000 profit on a single prescription at the expense of the taxpayer. There is also some data to suggest that DSH hospitals participating in the 340B program have higher Part B spending per beneficiary than other hospitals, meaning that the 340B program provides an incentive for hospitals to prefer higher priced drugs. IQVIA data also points out that oncology prescriptions are the most common therapeutic area for 340B prescriptions.

Another group of stakeholders that should be considered are providers, the physicians and nurses who deliver care to patients. The 340B program provides very strong incentives for hospitals to compete with community-based specialty physician practices in areas such as oncology, rheumatology, or other specialties where high-cost drugs are typically prescribed. Here is how the Community Oncology Alliance describes the problem: "The natural consequence of the powerful economic incentives surrounding the development of hospital-based cancer clinics is the consolidation of community cancer centers into hospital outpatient departments participating in the 340B program." Because of 340B, this consolidation of community-based physician practices into hospital outpatient departments is happening very rapidly, especially in oncology.

A 2016 study from Milliman argued that the proportion of chemotherapy infusions delivered by hospital outpatient facilities tripled between 2004 and 2014, rising from 15.8 to 45.9 percent of infusions for Medicare patients, and from 5.8 percent to 45.9 percent for commercial health plan patients.

This consolidation is quite unsurprising given that hospital-linked departments can purchase drugs at significant discounts, something that community-based physician practices cannot do. The 340B program makes for a very unlevel playing field when physician practices might be competing against hospitals.

Another key stakeholder that should be considered are employers, especially small employers who might strive mightily to provide health coverage for their employees. Consider that under the 340B program some drugs that cost thousands of dollars at commercial prices can be purchased by 340B hospitals for pennies. Imagine the small employer who is handed a bill for

thousands of dollars from their health plan and, unbeknownst to that employer, the hospital had purchased that drug for a penny.

Obviously, the 340B program impacts more stakeholders in the healthcare system than simply drug companies and hospitals. Because of the many adverse impacts upon various stakeholders, it is clear that the 340B program needs reform. The big question is how to proceed with reform. Because there are so many community-based hospitals that serve vulnerable populations that are financially dependent upon 340B, I would urge caution in proceeding with reform. We do not need more hospital closures in low-income rural and urban areas.

What I would strongly recommend is more transparency in the program. Last year, 340B sales at list prices totaled $124 billion, making the program the second-largest federal drug program. In a few short years, it seems likely that 340B sales will surpass those of Medicare, making it the largest federal drug program.

Yet, despite the massive size of the program, details on how the program actually operates are quite opaque. The legislative intent of the program was quite clear: provide 340B covered entities with additional revenue so they could better serve low-income, uninsured, and other vulnerable populations. Despite this clear congressional intent, we simply have no idea how much additional revenue individual hospitals secure through the program and the data on how hospitals spend this additional revenue is somewhat unreliable.

During 2023, Pioneer Institute sent a Freedom of Information (FOIA) request to the Health Resources and Services Administration (HRSA). We requested that HRSA provide us with the 340B revenue data from the 10 hospitals that had the largest number of 340B "contract pharmacies." HRSA replied that, while they had "located records responsive" to our request, they would not provide us with the information because, "entity-specific purchase data would remain confidential."

Moreover, the data on charity care that is available from CMS and the IRS is somewhat unreliable as a good deal of it is self-reported and there seems not to be a uniform standard on

how to report such data. When studying the issue of hospital charity care, Pioneer Institute purchased charity care data from RAND Corporation which seems to have more reliable data than the federal agencies.

Without knowing how much money hospitals are securing from the 340B program and without knowing exactly how they are spending that money, how can we judge how effectively hospitals are serving vulnerable communities and populations?

Because Pioneer Institute believes that transparency is the first step toward reform, we have engaged in our own transparency effort. You can go to the Pioneer Institute website and click on the 340B tab which will take you to a web tool that features four sets of data.

First, you can see data from HRSA that lays out the tremendous growth in the program, especially the explosive growth in the number of contract pharmacies. You can see the number of contract pharmacies linked to each hospital and where they are located. Curiously, a large number of contract pharmacies are not even located in the same state where the hospital is located. One large hospital in Boston has a contract with a pharmacy in Hawaii.

The second set of data we call out legislative mapping tool. With this tool, the user can click on any state legislative district and see the 340B resources – hospitals, clinics and contract pharmacies – located in that district. You may ask why we have not mapped this data to congressional districts? We created this data set because of our concern that too many 340B resources were being located in wealthier areas. We found that congressional districts were too large and economically diverse to draw any meaningful conclusions about whether 340B resources were deployed too heavily in wealthier areas.

The third set of data allows users to access charity care data from the RAND Corporation which we feel is more reliable than the government data on the CMS and IRS websites. Users can look at charity care trends nationally, by state and even by individual institution.

Finally, the fourth set of data on our web tool is our individual state-by-state analysis of 340B resources in all 50 states. Users can find information on charity care trends in individual states as well as information on whether contract pharmacies tend to be located in wealthier or low-income areas.

In closing, let me reiterate that the 340B program is an important component of the safety net and for some community-based hospitals, it provides an essential financial lifeline. That said, it is important to point out that a great deal of the program has been captured by the vendors in the program. For-profit pharmacy chains and PBMs are now very active in the program and make billions in profits from 340B. Some hospitals, but not all, have focused on serving wealthier communities because these communities are more likely to have a population with more generous insurance. The 340B program's deep discounts can be more easily arbitraged in these wealthier communities because hospitals can buy drugs cheaply and get reimbursed generously through Medicare or private insurance. Hospitals' ability to buy low and sell high creates misaligned incentives that tends to steer the 340B program off its mission of serving vulnerable populations.

My thanks again to the Chairman and Ranking Member for the opportunity to offer my thoughts on this program.