April 10, 2026

The Honorable Aaron Michlewitz
Chair, House Committee on Ways and Means
Massachusetts House of Representatives
24 Beacon Street, Room 243
Boston, MA 02133

VIA ELECTRONIC SUBMISSION

Re: 340B Contract Pharmacy Mandates

Dear Chairman Michlewitz:

On behalf of the Pharmaceutical Research and Manufacturers of America ("PhRMA") and the Massachusetts Biotechnology Council ("MassBio"), we write to express our opposition to the inclusion of any provisions in the House budget that would impose new state-level requirements related to the federal 340B Drug Pricing Program, including a manufacturer mandate requiring the shipment of 340B-priced drugs to contract pharmacies, similar to proposals in House bills 785, 1107, and 1296.

Proposals to codify an expansion of the 340B program raise significant fiscal concerns. **A growing body of evidence demonstrates that the 340B program and state-level manufacturer mandates increase health care costs for employers, state and local governments, and taxpayers, without ensuring that patients benefit.**

In Massachusetts alone:

- Proposed contract pharmacy legislation is estimated to increase health care costs by **$118 million** due to additional foregone rebates.[i]
- Employers already bear an estimated **$241 million** in additional costs annually as a result of the program.[ii]

A state manufacturer mandate would further entrench contract pharmacy arrangements, which are not defined in federal statute or regulation, expanding a model that has not been shown to improve patient access or affordability. For these and the following reasons, PhRMA and MassBio respectfully oppose the inclusion of any such provisions in the House budget.

The 340B program has become a hidden tax on employers and their workers.

Congress created the 340B program in 1992 to help vulnerable and uninsured patients directly access prescription medicines at safety-net facilities. However, over more than three decades since its creation, the 340B program has expanded in ways that have increasingly benefited large, tax-exempt hospital systems, for-profit pharmacies, and other middlemen, leaving behind the patients that the program is meant to serve and raising concerns about the sustainability of the program for true safety-net entities that provide much needed care to vulnerable communities. **According to the Health Resources and Services Administration ("HRSA"), discounted 340B purchases increased from $66.3 billion in 2023 to $81.4 billion in 2024, reflecting 23% growth in a single year.[iii]**

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 7 times as much as independent physician offices for the sale of medicines administered to commercially insured patients.[iv]
- 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.[v]

The current design of the program directly increases costs for employers by an estimated 4.2%, or $5.2 billion,[vi] due to foregone rebates from manufacturers (which reduce the price of medicine), and indirectly increases employer costs by incentivizing provider consolidation and use of higher cost medicines.[vii] **Employers in Massachusetts pay an estimated $241 million more in health care costs due to foregone rebates as a result of the 340B program.[viii] This leads to a $12.1 million reduction in state and local tax revenue.[ix]**

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.[x] 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.[xi,xii]

The 340B program has fiscal implications for state employees and ultimately taxpayers. Manufacturer mandates increase that fiscal impact.

Evidence from other states demonstrates the potential impact:

- The North Carolina State Treasurer found that North Carolina 340B hospitals charged state employees average markups of 5.4 times the hospitals' discounted 340B acquisition cost for outpatient infused cancer medicines, resulting in billing the North Carolina State Health Plan for Teachers and State Employees a price markup on cancer medicines that was 84.8% higher than North Carolina hospitals outside of the 340B program.[xiii]
- Findings from the Congressional Budget Office's (CBO's), *Growth in the 340B Drug Pricing Program*, reinforce state reports. The CBO report found that the 340B program mainly affects the federal budget by encouraging behaviors that tend to increase federal spending because they lead to higher prices or an increased use of drugs and other health care services. Clinicians prescribe more drugs, as well as higher-priced drugs. Medicaid,

Medicare, and private insurance lose access to rebates for 340B drugs. Participating facilities expand the services they provide. And finally, more hospitals and off-site clinics integrate.[xiv]

Proposed contract pharmacy legislation in Massachusetts is estimated to increase health care costs for employers and state and local governments by $118 million due to additional foregone rebates.[xv]

340B is also causing states to lose out on potential Medicaid prescription drug rebate dollars, which ultimately costs taxpayers.

Managed care is now the dominant delivery system in Medicaid, with managed care organizations (MCOs) covering 75% of Medicaid enrollees.[xvi] In Massachusetts, approximately 40% of Medicaid beneficiaries are enrolled in managed care according to KFF.[xvii] The federal 340B statute prohibits the same prescription from being subject to a 340B discount and a Medicaid rebate. While fee-for-service (FFS) Medicaid is required to pay for drugs at the acquisition cost (thereby benefiting states that are reimbursing 340B drugs at the 340B ceiling price), this requirement does not extend to MCOs.[xviii] Medicaid pays MCOs on a capitated basis and in many cases the 340B entities retain the value of the 340B discount and may be reimbursed by the MCO at an amount far above the 340B discounted price. This then drives up MCO capitated rates and state Medicaid spending, with one estimate finding that state Medicaid programs could be forgoing an estimated $4 billion in rebates[xix] each year for prescriptions covered through Medicaid MCOs.

New research also shows that contract pharmacy mandates increase the cost of a state's Medicaid program. **Because contract pharmacies are allowed to participate in Massachusetts' Medicaid managed care program, the cost of a contract pharmacy mandate could result in increased costs to the program of $46.88 million.[xx]** This cost reflects the potential Medicaid rebates that would be paid to the state had the drugs not been billed as 340B.

There is little evidence to suggest that vulnerable patients benefit from the 340B program or that patients have benefited from contract pharmacy growth.

Since 2010, the number of contracts with pharmacies to dispense 340B medicines has grown by more than 12,000%, and between 2013 and 2024, over 200,000 contract pharmacy agreements were established.[xxi] Adding to the concern these pharmacies are not improving access to medicines, studies find contract pharmacy growth from 2011 to 2019 was concentrated in affluent and predominantly white communities, leaving more at-risk communities behind.[xxii] Additional studies have found that 65% of the roughly 3,000 hospitals that participate in the 340B program are not located in medically underserved areas.[xxiii] In 2025, in Massachusetts, only 39% of in-state 340B contract pharmacy locations were in ZIP codes with an average household income lower than the state median [$113,900]**.**

Research has also found that more than 77% of 340B hospitals provide less charity care than the national average for all hospitals, and these hospitals often spend less on charity care and community investment than the estimated value of their tax breaks as nonprofits.[xxiv] **In 2024, 94% of 340B hospitals in Massachusetts were below the national average for charity care levels (2.5%).**

A lack of transparency and oversight has led to abuse of the 340B program.

Since 2015, HRSA has only targeted approximately 200 covered entities for audit annually. There were over 60,000 covered entities in 2024. The share of total covered entities audited shrank to roughly 0.3% in 2022.[xxv] Episodes of noncompliance by covered entities dropped following HRSA's adoption of more lax standards in 2019; alarmingly, the rate of adverse findings reached a new peak of 70% in 2022. Since 2019, 253 covered entities have had adverse findings, with 53% having more than one adverse finding. Approximately 26% of adverse findings were either duplicate discount or diversion violations.[xxvi]

Since 2015 there have been 68 reaudits, with 68% found to continue to be non-compliant.[xxvii] 12 states in 2023 did not have a single covered entity audited. In Massachusetts, HRSA audited only 1 covered entity in 2025.[xxviii]

Manufacturer mandates will line the pockets of PBMs, pharmacy chains, and 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.[xxix] Big-box retailers such as Walgreens—which was recently acquired by a private equity firm[xxx] that could now benefit from the 340B program, CVS Health, and Walmart are major participants in the 340B program through contract pharmacy arrangements. Because of vertical integration in the supply chain, PBMs now own the vast majority of pharmacies, meaning PBMs also profit from contract pharmacy arrangements. In fact:

- The five largest for-profit pharmacy chains comprise 60% of 340B contract pharmacies, but only 35% of all pharmacies nationwide.[xxxi]
- 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.[xxxii]

In April 2025, Senate Health, Education, Labor, and Pensions (HELP) Committee Chairman Bill Cassidy (R-LA) published a groundbreaking report titled "Congress Must Act to Bring Needed Reforms to the 340B Drug Pricing Program." The result of a multi-year investigation that relies on information received by nine entities, Chairman Cassidy's findings underscore the need for transparency and additional oversight to ensure patients benefit and concludes that several legislative reforms are necessary.[xxxiii]

According to the report, each of the two investigated hospitals (Bon Secours Mercy Health and Cleveland Clinic) saved hundreds of millions of dollars from 340B and stated that the 340B program was not designed to provide direct savings to patients. Further, contract pharmacies and third-party administrators (TPAs) charge complex fees to covered entities that generally increase each year. Wellpartner (a CVS subsidiary) made more than $1.6 billion in 340B revenue over five years (2019 to 2023) from its 340B TPA fees.[xxxiv]

A 2025 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 of at least $1.34 billion on medicines they acquired for $1.53 billion for the 2024 calendar year.**[xxxv] MDH believes this is an underestimate of the true size of the 340B program in Minnesota due to challenges in capturing office-administered drugs.[xxxvi]
- Once again, the state's largest 340B hospitals benefitted most from the 340B program. Just 13% of reporting entities generated 90% of the statewide net 340B revenue in 2024.[xxxvii]

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.

Conclusion

At a time when the Legislature is making difficult budget decisions, proposals that increase costs for the Commonwealth, employers, and taxpayers without clear evidence of patient benefit should be approached with caution. A manufacturer mandate would codify and expand the very dynamics that are driving higher costs within the current program.

For the reasons outlined above, PhRMA and MassBio respectfully urge the House Committee on Ways and Means not to include a 340B manufacturer mandate in the House budget.

Sincerely,

Kevin J. Bourque
Regional Vice President, State Advocacy
PhRMA

Kendalle Burlin O'Connell
CEO & President
MassBio

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