HEARTLAND IMPACT

Testimony Before the Ohio House Insurance Committee on HB 276

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Chairman Lampton, Members of the Committee:

Thank you for the opportunity to provide testimony on HB 276, legislation that codifies and expands the federal 340B drug pricing program in Ohio. While the program was created with seemingly good intentions more than 30 years ago, its expansion has produced harmful market distortions, created inefficiencies that have ballooned throughout the health-care system, discouraged innovation, weakened transparency, and actually raised drug prices for patients. Any effort to grow the program further – particularly through state action – risks entrenching these problems rather than solving them.

Origins and Intent of 340B

Congress created the 340B drug pricing program in 1992 with the narrow intent of helping a defined set of safety-net providers – those serving large numbers of uninsured or low-income patients – cope with the rising cost of prescription drugs. Under the program, drug manufacturers are required to provide steeply discounted prices to these covered entities as a condition of participation in Medicaid.

At the outset, the program applied to a relatively small universe of facilities. Its purpose was not to restructure the drug market, but to ensure that safety-net hospitals and clinics could stretch limited federal resources further. In theory, it was a temporary, targeted intervention designed to support vulnerable populations.

Over time, however, the scope of eligible providers ballooned. Entire hospital systems, cancer centers, and even large metropolitan hospitals with limited charity-care obligations have become beneficiaries. With the addition of contract pharmacies – numbering in the tens of thousands – the program's reach today bears little resemblance to what Congress envisioned in 1992.

Mission Creep and Abuse

The original justification for 340B – helping safety-net providers serve vulnerable populations – has been lost. Studies have shown that many 340B hospitals provide little uncompensated care relative to their program revenues. In some cases, hospitals with high profit margins and minimal charity-care obligations are among the largest beneficiaries.

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The proliferation of contract pharmacies has also magnified abuse. A single covered entity may contract with hundreds of retail pharmacies, creating vast networks for capturing 340B discounts far removed from the patients the program was meant to serve.

This mission creep erodes the moral foundation of the program. It is not helping patients directly; it is enriching institutions. From an economic standpoint, it represents the worst of both worlds: government distortion combined with private capture of benefits and the consequent expansion of inefficiencies all across the system.

In this way, 340B's incentive to prescribe more-expensive medications and use those profits for other things pushes up drug costs and overall health care costs well beyond what they would otherwise be, and thus reduces access to care, especially for the most vulnerable segments of the population.

Market Distortions and Consolidation

From an economic perspective, the most serious problem with 340B is the way it distorts normal competitive dynamics. Hospitals and health systems are incentivized to expand their footprint, not necessarily to improve care, but to capture more 340B revenue.

A hospital that acquires an outpatient clinic, for instance, can immediately classify that clinic as 340B-eligible, giving it access to discounted drug purchases. The clinic's patients may be commercially insured and not part of any vulnerable population, yet the institution reaps the benefits of government-mandated price controls.

This arbitrage opportunity has accelerated consolidation in health care, as hospitals buy up physician practices and community clinics. Independent providers – who are often more efficient and accessible to patients – struggle to compete when their larger rivals are subsidized by 340B margins. In a free market, efficiency, quality, and consumer choice should determine winners and losers. The 340B program overrides those signals with artificial incentives.

Lack of Transparency and Accountability

Transparency is a hallmark of competitive markets. Prices, costs, and outcomes must be visible so that consumers and policymakers can make rational choices. The 340B program instead cloaks its financial flows in secrecy.

Hospitals and covered entities are not required to show how they use 340B revenue, whether they pass savings on to patients, or whether the funds actually benefit low-income populations. Numerous federal watchdog reports – from the Government Accountability Office and the Office of Inspector General – have highlighted the lack of accountability. The failure to hold providers accountable tempts them to bend the rules to benefit their bottom lines, which is exactly what has happened.

In practical terms, this means that hospitals can purchase a drug at a heavily discounted 340B price, bill an insurer or government program at the standard reimbursement rate, and pocket the

spread as profit. Patients see no reduction in their out-of-pocket costs. Instead of lowering prices, 340B creates a hidden cross-subsidy that enriches institutions while obscuring true costs.

This opacity undermines consumer trust, erodes competition, and entrenches inefficiency. No genuine free market could function under such conditions.

Perverse Incentives and Misaligned Rewards

The 340B framework produces perverse incentives that undermine rational decision-making in health care.

- Drug Utilization: Hospitals are encouraged to prescribe more expensive branded drugs over lower-cost alternatives, because the profit margin on the discounted purchase is larger.
- Geographic Inequities: Urban hospitals with large patient volumes can capture enormous 340B revenues, while rural hospitals – often the true safety-net providers – are left struggling.
- Misallocation of Resources: Revenue derived from 340B is often used to finance hospital expansion projects, executive compensation, or competitive acquisitions, rather than subsidizing patient care.

These are classic examples of moral hazard and rent-seeking behavior: institutions exploit government rules for gain without producing corresponding social value.

Barriers to Innovation

Perhaps the most concerning long-term effect of 340B expansion is its chilling effect on pharmaceutical innovation.

The American life sciences sector is the global leader in developing new treatments, particularly in areas like oncology, rare diseases, and precision medicine. This innovation is driven by enormous private-sector investment. Investors take risks because there is a reasonable expectation of return.

When government mandates force manufacturers to provide steep discounts divorced from patient benefit, the economics of drug development change. Companies face reduced revenue streams that are not linked to actual market competition but to arbitrary eligibility criteria.

This risk is most acute for small and mid-sized biotech firms, which often operate on thin margins and depend on predictable revenue from a limited product line. Discouraging investment in these firms could slow the pipeline of breakthrough therapies, harming patients in the long run.

A free market rewards innovation by allowing innovators to recoup their costs through voluntary exchange. The 340B program undermines this mechanism, substituting government compulsion for market reward.

Circumventing the Hyde Amendment and Funding Controversial Services

Another critical concern is that the 340B program enables an end-run around federal restrictions such as the Hyde Amendment, which bars the use of federal funds for abortion services. Because 340B discounts create a stream of institutional revenue untethered to patient benefit, hospitals and clinics can apply those profits however they see fit. Nothing prevents a covered entity from using 340B-derived revenues to subsidize abortion services or related infrastructure, even though such activities could not lawfully be funded with direct federal dollars.

Similarly, 340B revenues can be used to underwrite gender-affirming interventions, including hormonal treatments and procedures, which are among the most hotly contested issues in medicine and public policy today. By allowing hospitals to pocket margins from drug arbitrage without any transparency, the program effectively provides a financial subsidy for these services outside the reach of federal appropriations oversight.

This is a fundamental accountability problem. Congress has repeatedly drawn clear lines about what taxpayer dollars may and may not support. Yet 340B blurs those lines by creating a hidden revenue stream that circumvents democratic checks on spending. In practice, this makes 340B not just a market distortion, but also a policy distortion – undermining decisions that elected officials have already made regarding sensitive and controversial medical practices.

Better Alternatives

If the ultimate goal is to reduce drug costs and expand access, there are far more effective, market-oriented solutions than expanding 340B. Policymakers should consider:

- Price Transparency: Require clear disclosure of drug prices, rebates, and markups so that patients and insurers can make informed choices.
- Encouraging Competition: Streamline approval processes for generics and biosimilars to increase supply and lower prices through competition.
- Reducing Regulatory Barriers: Eliminate policies that protect entrenched players and discourage entry by new manufacturers.
- Targeted Support: If subsidies are necessary, tie them directly to patients rather than institutions, ensuring that assistance is transparent and accountable.
- Data Transparency: prohibiting data requests beyond federal minimums makes it difficult for officials and manufacturers to track where 340B dollars go and hinders innovation and efforts to target scarce resources.
- Avoid cost-shifting: forcing manufacturers to expand 340B access ensures costs are shifted downstream into higher list prices, reduced R&D, and increased insurance premiums for both large and small businesses.

These approaches empower consumers, foster innovation, and maintain market discipline. Expanding 340B does none of these.

Conclusion

The 340B drug pricing program began as a modest, targeted intervention to help safety-net providers. Over three decades, it has morphed into a sprawling, opaque system that distorts markets, discourages innovation, misaligns incentives, disturbs pricing mechanisms across the system, and enables questionable practices. Hospitals and institutions, not patients, are the primary beneficiaries.

Expanding the program at the state level would double down on these failures. It would further entrench opacity, encourage consolidation, subsidize controversial services outside the bounds of federal law, and reduce the incentives that drive innovation in medicine.

A commitment to proven market-discipline principles – transparency, competition, and accountability – demands that policymakers resist the temptation to expand 340B and instead pursue reforms that empower patients directly. The best path forward is not to enlarge a broken program but to restore market discipline to the health care sector.

Thank you for your time and attention.