

**In Opposition to Ohio HB 276
340B Mandate
October 14, 2025**

Position: The Pharmaceutical Research and Manufacturers of America (“PhRMA”) respectfully opposes Ohio House Bill 276 (HB 276). HB 276 prohibits a biopharmaceutical manufacturer from denying, prohibiting, restricting, discriminating against or “otherwise [limiting] the acquisition of a 340B drug by or delivery of a 340B drug to a 340B grantee.” 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, 340B covered entities, 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.

Allowing federally qualified health centers-only (FQHCs) to access an unlimited number of contract pharmacies will not address patient access or help low-income and vulnerable patients better afford their prescriptions.

While FQHCs are required to offer health care services at a sliding fee scale, these services do not include drugs. Like all 340B covered entities, FQHCs are not required to provide prescription drugs at reduced 340B prices to patients. FQHCs, like for-profit hospitals, generate revenue from 340B-priced drugs.

State legislation similar to HB 276 is being challenged in courts.

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 several 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 manufacturers to provide 340B-priced drugs to an unlimited number of contract pharmacies or to offer 340B-priced drugs to covered entities without limitations on the use 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 HB 276 that 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. *Pharm. Rsch. & Mfrs. of Am. v. Morrissey*, 760 F. Supp. 3d 439, 453-60 (S.D. W. Va. 2024).

There is little evidence to suggest that patients have benefited from contract pharmacy growth.

Since 2010, the number of contracts with pharmacies has grown by more than 8,000%, with roughly 33,000 pharmacies participating in the program today. Because the program has no transparency or guardrails on how hospitals and clinics use 340B profits, the money often is not going to help low-income and uninsured patients access medicines. An analysis of contract pharmacy claims for brand medicines only found evidence that patients were directly receiving a discount for 1.4% of prescriptions eligible for 340B.ⁱ

The 340B 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 covered entities. 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.^{ii,iii}

HB 276 will further exacerbate 340B-created market distortions that increase health care spending for people with commercial insurance, which raises costs for state governments and taxpayers.

The 340B program has often been touted as cost-free to taxpayers. However, research from IQVIA found that the 340B program increases drug costs for self-insured employers and their workers by 4.2% due to lost manufacturer rebates when a 340B drug is dispensed.^{iv} These higher costs impact state budgets through both higher spending for state employees’ health care and forgone tax revenue due to higher premiums for state residents. Based on a recent

analysis by IQVIA, the 340B program increased state and local governments' health care costs by \$1.9 billion (4.2%) in 2022 alone.^v

Additional analysis from Magnolia Market Access found that the 340B program caused a combined \$7.8 billion increase in healthcare costs for self-insured and fully insured employers and workers in 2021, leading to \$1.8 billion in lost federal and state tax revenue.^{vi} This includes \$2 million in lost state tax revenue for Ohio in 2021.^{vii}

HB 276 will line the pockets of pharmacy benefit managers (PBMs) and pharmacy chains

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.^{viii} Big-box retailers such as Walgreens, 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 they also make a profit from contract pharmacy arrangements. In fact, the five largest for-profit pharmacy chains comprise 60 percent of 340B contract pharmacies, but only 35 percent of all pharmacies nationwide.^{ix} 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.^x The program reached \$66.3 billion in 2023, a 23% growth increase from the previous year.^{xi}

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 and prepare a report with findings for the legislature and public. The first Minnesota 340B report was released in November 2024 and provides further evidence that for-profit middlemen are profiting from the 340B program. Specifically, the report found that payments to contract pharmacies and third-party administrators (TPAs) were over \$120 million, representing approximately \$16 of every \$100 of gross 340B revenue generated paid to external parties.^{xiii} In fact, 10% of safety-net federal grantees reported a negative net 340B revenue due to payments made to middlemen.^{xiv} The top 10% of critical access hospitals and disease-specific grantees with the highest external operational costs lost at least half their gross 340B revenue to TPAs and contract pharmacies.^{xv}

PhRMA respectfully opposes the provisions outlined above and appreciates your consideration prior to advancing HB 276.

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 IQVIA. "Are Discounts in the 340B Drug Discount Program Being Shared with Patients at Contract Pharmacies." Oct. 10, 2022. Access: <https://www.iqvia.com/locations/united-states/library/fact-sheets/are-discounts-in-the-340b-drug-discount-program-being-shared-with-patients-at-contract-pharmacies>.

ⁱⁱ 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>

ⁱⁱⁱ 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>

^{iv} IQVIA. The Cost of the 340B Program Part 1: Self-Insured Employers. March 12, 2024. <https://www.iqvia.com/-/media/iqvia/pdfs/us/white-paper/iqvia-cost-of-340b-part-1-white-paper-2024.pdf>

^v Based on analysis of: IQVIA. The Cost of the 340B Program Part 1: Self-Insured Employers. March 12, 2024. <https://www.iqvia.com/-/media/iqvia/pdfs/us/white-paper/iqvia-cost-of-340b-part-1-white-paper-2024.pdf>; National Health Expenditure Accounts. Table 05-6. Available at: <https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/historical>; Census Bureau. Annual Survey of Public Employment & Payroll Datasets and Tables. 2022. <https://www.census.gov/data/datasets/2022/econ/apes/2022.html>; Agency for Healthcare Research and Quality. Medical Expenditure Panel Survey Insurance Component. 2022. Table V.C.1. https://meps.ahrq.gov/data_stats/summ_tables/insr/state/series_5/2022/ic22_va_e.pdf?_gl=1*zvyno6*_ga*MTE1NjMyOTI3OS4xNzEyMDg2OTUz*_ga_45NDTD15CJ*MTcxMjg1OTM1NC43LjAuMTcxMjg1OTM1NC42MC4wLjA; 2022 Milliman Medical Index. May 25, 2022. <https://www.milliman.com/en/insight/2022-milliman-medical-index>

^{vi} Magnolia Market Access. How the 340B Program Impacts Federal and State Tax Liability. 2025.

<https://www.magnoliamarketaccess.com/insight/how-the-340b-program-impacts-federal-state-tax-liability/>

^{vii} *Ibid.*

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

^{ix} Government Accountability Office, "*Drug Discount Program: Federal Oversight of Compliance at 340B Contract Pharmacies Needs Improvement*," GAO-18-480, June 2018.

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

^{xi} 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>

^{xii} 2023 Minnesota Statutes, Section 62J.312

^{xiii} Minnesota Department of Public Health, "340B Covered Entity Report," Nov. 25, 2024.

<https://www.health.state.mn.us/data/340b/docs/2024report.pdf>

^{xiv} *Ibid.*

^{xv} *Ibid.*