

## Modernizing the 340B program will create better health outcomes:

- **REP. TIM MURPHY (R-PA):** “The integrity of the 340B program must be protected. HRSA must be able to conduct oversight in a way that allows it to uncover fraud and non-compliance.”  
— Comments at Energy and Commerce Hearing, July 2017
- **REP. GREG WALDEN (R-OR):** “HRSA’s annual audits reveal a high level of noncompliance with program requirements by covered entities, including the potential for duplicate discounts and diversion of 340B drugs to ineligible patients.”  
— Comments at Energy and Commerce Hearing, July 2017
- **ERIN BLISS, ASSISTANT INSPECTOR GENERAL FOR EVALUATION AND INSPECTIONS AT HHS OFFICE OF INSPECTOR GENERAL:** “Despite the 340B program’s goal of increasing access and providing more comprehensive care, neither the 340B statute nor HRSA guidance speaks to how 340B providers must use savings from the program — nor do they stipulate that the discounted 340B price must be passed on to uninsured patients.”  
— Comments at Energy and Commerce Hearing, July 2017
- **REP. MICHAEL BURGESS (R-TX):** “The program has challenges, and audits by the HRSA have found high levels of non-compliance among 340B covered entities, raising questions as to who is currently overseeing the program, and who should provide that oversight going forward... this is a multifaceted problem, the way forward isn’t entirely clear... so I’m grateful we’re having the hearing today and look forward for an opportunity to examine the 340B landscape going forward.”  
— Comments at Energy and Commerce Hearing, July 2017
- **REP. FRANK PALLONE (D-NJ):** “GAO and OIG have identified weaknesses in the oversight of the program which can have negative consequences for both the participating providers and drug manufacturers. HRSA should appropriately improve program integrity while protecting the mission of the 340B Program and be given the necessary resources to oversee the program.”  
— Comments at Energy and Commerce Hearing, July 2017
- **REP. CHRIS COLLINS (R-NY):** “It is wrong if a hospital fills in gaps in revenue by taking inappropriate discounts.”  
— Comments at AIR340B Summit, May 17, 2016

## The rapid expansion of contract pharmacies stands in contrast to the intent of the 340B program:

- **ECONOMIST ADAM FEIN:** “These 340B contract pharmacy shenanigans need to stop. Based on the OIG report, uninsured and indigent patients aren’t benefiting from 340B drug discounts. Hospitals should stop hiding behind vague language about ‘stretching scarce federal resources’ and come clean about who really gains from 340B contract pharmacies.”  
— “New OIG Report Confirms Our Worst Fears About 340B Contract Pharmacy Abuses,” Drug Channels, February 14, 2014
- **STUART WRIGHT**, Deputy Inspector General for Evaluation and Inspections, HHS: “The use of contract pharmacies has increased rapidly over the past few years. Since 2010, the percentage of all covered entities that use contract pharmacies has risen from 10 percent to 22 percent. Moreover, the number of unique pharmacies serving as 340B contract pharmacies has grown by 770 percent, and the total number of contract pharmacy arrangements has grown by 1,245 percent.”  
— Comments in Memorandum Report, February 4, 2014

## There is a growing lack of transparency and accountability among 340B hospitals:

- **REP. CHRIS COLLINS (R-NY):** “It is wrong if a hospital fills in gaps in revenue by taking inappropriate discounts.”  
— Comments at AIR340B Summit, May 17, 2016
- **ANN MAXWELL**, Assistant Inspector General for Evaluation and Inspections, HHS: “More transparency is needed in both 340B ceiling prices and Medicaid claims for 340B-purchased drugs. OIG’s work on the 340B program has consistently found that a lack of transparency in both 340B ceiling prices and Medicaid claims for 340B-purchased drugs has negatively affected 340B providers, State Medicaid programs, and drug manufacturers.”  
— Testimony to Congress, March 24, 2015
- **DEBORAH A. DRAPER**, GAO: “We believe the guidance needs to be clear as to who participates [in 340B.]”  
— Comments at House Energy and Commerce Committee Hearing, March 24, 2015
- **KATHLEEN SEBELIUS**, former Secretary of Health and Human Services: “[The 340B program has] expanded beyond its bounds.”  
— Testimony at Senate Finance Committee Hearing, April 10, 2014

## The trajectory of the 340B program leads to higher costs and often hinders patients' access to care:

- **DR. PETER BACH, MEMORIAL SLOAN KETTERING:** "The 340B program was designed to help facilities that take care of impoverished patients and patients with limited means with low-cost drugs. And the program has shifted from that objective to one that is being used by many hospitals where a small fraction of their patients are poor in the hospital and then they are able to obtain drugs for outpatients who aren't necessarily poor."  
— Interview with *American Journal of Managed Care*, November 21, 2016
- **ECONOMISTS RENA CONTI AND MEREDITH ROSENTHAL:** "Lawmakers could lower the price of prescription drugs by reforming the federal 340B Drug Pricing Program. [...]The scope of the 340B program is currently so vast for drugs that are commonly infused or injected into patients by physicians that their prices are probably driven up for all consumers."  
— *New England Journal of Medicine*, February 25, 2016
- **U.S. GOVERNMENT ACCOUNTABILITY OFFICE:** "[T]here is a financial incentive at hospitals participating in the 340B program to prescribe more drugs or more expensive drugs to Medicare beneficiaries. Unnecessary spending has negative implications, not just for the Medicare program, but for Medicare beneficiaries as well, who would be financially liable for larger copayments as a result of receiving more drugs or more expensive drugs."  
— U.S. GAO Report, "Medicare Part B Drugs: Action Needed to Reduce Financial Incentives to Prescribe 340B Drugs at Participating Hospitals," July 5, 2015
- **PROFESSOR STEPHEN PARENTE, UNIVERSITY OF MINNESOTA MEDICAL INDUSTRY LEADERSHIP INSTITUTE:** "[In its current form], the 340B program arbitrarily lines hospital and pharmacy bottom lines, without improving patient care or physician access. It makes it difficult for local, smaller entities, particularly physicians with their own practices, to compete, since they cannot qualify for the 340B program on their own... this policy will ultimately end up increasing health care costs for everyone..."  
— Working paper, "Unprecedented Growth, Questionable Policy: The 340B Drug Program," Winter 2014
- **ECONOMIST RENA CONTI, UNIVERSITY OF CHICAGO:** "[A]s currently structured ... the financial benefits of the 340B discounts are accruing almost entirely to hospitals, clinics, and physicians; and patients' out-of-pocket costs and total cost of care are being increased."  
— "Cost Consequences of the 340B Program," *JAMA*, May 15, 2013