March 18, 2026 *Submitted Electronically*

Co-Chair Backer, Co-Chair Bierman and members of the House Health Finance and Policy Committee,

As 340B covered entities and members of the Minnesota 340B Coalition, **we are writing in strong support of HF3609 (Zeleznikar/Koegel)** which secures and defends existing protections for the 340B Drug Pricing Program at contract pharmacies in Minnesota.

The 340B program has worked for thirty-four years because the framework was clear: manufacturers provided discounted drugs, and safety-net providers invest those savings to ensure the state's rural and underserved communities have access to high-quality comprehensive health care. That framework hasn't changed. What has changed is unilateral manufacturer restrictions on contract pharmacies that undermine it — and with it, access to primary and specialty care, cancer care, infusion services, and behavioral health close to home. Minnesota's 340B covered entities use 340B savings exactly as Congress intended. Policies that restrict or undermine that framework jeopardize patient access – especially in rural Minnesota. It's that simple.

The 340B Drug Pricing Program was enacted by Congress in 1992 and provides a way for safety-net providers to purchase discounted drugs from participating pharmaceutical companies. To participate in 340B, covered entities like community health centers, sexually transmitted infection clinics, and hospitals must serve a disproportionate share of low-income patients or patients living in isolated rural communities. The program allows providers to offer more comprehensive services by stretching scarce resources as far as possible to give patients access to the healthcare services they need, services that government payers and commercial insurers can't or won't cover.

For decades, the Health Resources and Services Administration (HRSA) maintained a longstanding policy that permitted 340B covered entities to engage with their choice of contract pharmacies to dispense 340B drugs on their behalf to their patients. These contract pharmacy arrangements are critical for covered entities, particularly those in rural and underserved areas where in-house retail pharmacy is not feasible, to ensure patients have access to their medications.

Beginning in 2020, drug manufacturers began unilaterally imposing restrictions on 340B discounts at contract pharmacies, undermining the intent of the program and denying Minnesota's safety-net providers millions of dollars in drug savings. These restrictions have forced covered entities to absorb significant financial losses and, in many cases, to scale back the very services the 340B program was designed to support.

In response to these manufacturer-imposed restrictions, states across the country have taken action to protect 340B contract pharmacy arrangements. In 2021, Arkansas became the first state to enact a law prohibiting drug manufacturers from limiting 340B discounts at contract pharmacies. After several legal challenges brought by the Pharmaceutical Research and Manufacturers of America (PhRMA) and individual manufacturers, courts have upheld the Arkansas law. Today, over 20 states have passed similar laws to protect 340B discounts at contract pharmacies, and courts across the country have consistently upheld these state protections.

Minnesota enacted its own 340B contract pharmacy protection law in 2024 (Minn. Stat. § 62J.96). However, unlike other states, Minnesota's law is not being enforced. As a result, many drug

manufacturers are simply ignoring Minnesota's state law and continuing to impose contract pharmacy restrictions with impunity.

The disparity in treatment is striking. For example, certain drug manufacturers enforce a policy that prohibits 340B hospital covered entities from using contract pharmacies, but exempts covered entities in Arkansas, Maryland, Mississippi, Colorado, Maine, Missouri, North Dakota, Rhode Island, South Dakota, Vermont, and Nebraska, all states that are actively enforcing their 340B contract pharmacy laws. Because Minnesota is not enforcing its law, those manufacturers do not list Minnesota as an exempt state. Drug manufacturers are flagrantly violating Minnesota state law and treating Minnesota differently than other states with similar laws.

Compounding this problem, Minnesota's current law includes a sunset date of July 1, 2027. The existence of this sunset provision further emboldens manufacturers to ignore the law, as they believe the requirement will eventually go away without the need for compliance.

Additionally, the imminent financial destabilization caused by HR 1 on safety-net providers is undisputed. Allowing pharmaceutical manufacturers to ignore the law will further degrade the 340B program and only add to the destabilization of our safety-net providers.

HF3609 (Zeleznikar/Koegel) will make permanent the protections the Minnesota Legislature enacted in 2024 and provide the Attorney General with clear authority to enforce the law when manufacturers do not comply. Minnesota's 340B covered entities and the patients they serve deserve the same certainty and protection that exist in other states with similar laws.

We urge the committee to support HF3609 (Zeleznikar/Koegel). This bill provides clarity, stability, and accountability — and ensures Minnesota patients are treated no differently than patients in other states with comparable protections. At a time when safety-net providers face mounting financial pressures, maintaining predictable and enforceable 340B protection is essential to sustaining life-saving care in communities across our state.

Advocates for Reproductive Education (WeARE)
Aliveness Project
Allina Health
Aspirus Lake View
Aspirus St. Luke's
Astera Health
Avera Granite Falls Health Center
Avera Marshall Regional Medical Center
Avera Tyler Hospital
CCM Health
CentraCare
Children's Minnesota
City of Minneapolis
Essentia Health
Fairview Health Services
Grand Itasca Clinic & Hospital
HealthPartners
Hennepin Healthcare System
Indian Health Board of Minneapolis
Johnson Memorial Health Services
Lakewood Health System
Madison Healthcare Services
Minnesota Community Care
Minnesota Hospital Association
Neighborhood HealtlhSource
North Memorial Health
NorthPoint Health & Wellness Center
Olmsted Medical Center
Open Door Health Center
Pipestone County Medical Center
RiverView Health
Rural AIDS Action Network (RAAN)
Sanford Health
Sanford Health Bemidji
Sleepy Eye Medical Center
The Minnesota Association of Community Health Centers
Welia Health

Date: March 17th, 2026

To: Representative Zeleznikar & House Health Finance & Policy Committee members

From: The Minnesota Society of Health-System Pharmacists

Re: HF3609/ SF3769, the 340B Drug Pricing Program Protections Act revisions

Representative Zeleznikar & House Health Finance & Policy Committee members,

We are writing in **strong support of HF3609 (Zeleznikar) and SF 3769 (Klein)** which secures and defends existing protections for the 340B Drug Pricing Program in Minnesota. The 340B program has worked for thirty-four years because the framework was clear: manufacturers provided discounted drugs, and safety-net providers invest those savings to ensure the state's rural and underserved communities have access to high-quality comprehensive health care. That framework hasn't changed.

What has changed is manufacturer restrictions on contract pharmacies that undermine access to the program for patients — and with it, access to primary and specialty care, cancer care, infusion services, and behavioral health close to home. Minnesota's 340B covered entities use 340B savings exactly as Congress intended. Policies that restrict or undermine that framework jeopardize patient access – especially in rural Minnesota.

The 340B Drug Pricing Program was enacted by Congress in 1992 and provides a way for safety-net providers to purchase discounted drugs from participating pharmaceutical companies. To participate in 340B, covered entities like community health centers, sexually transmitted infection clinics, and hospitals must serve a disproportionate share of low-income patients or patients living in isolated rural communities. The program allows providers to offer more comprehensive services by stretching scarce resources as far as possible to give patients access to the healthcare services they need, services that government payers and commercial insurers can't or won't cover.

For decades, the Health Resources and Services Administration (HRSA) maintained a longstanding policy that permitted 340B covered entities to engage with their choice of contract pharmacies to dispense 340B drugs on their behalf to their patients. These contract pharmacy arrangements are critical for covered entities, particularly those in rural and underserved areas where in-house retail pharmacy is not feasible, to ensure patients have access to their medications.

Beginning in 2020, drug manufacturers began unilaterally imposing restrictions on 340B discounts at contract pharmacies, undermining the intent of the program and denying Minnesota's safety-net providers millions of dollars in drug savings. These restrictions have forced covered entities to absorb

significant financial losses and, in many cases, to scale back the very services the 340B program was designed to support.

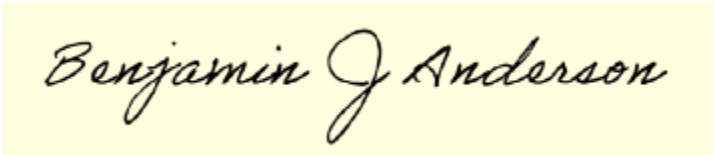
In response to these manufacturer-imposed restrictions, states across the country have taken action to protect 340B contract pharmacy arrangements. In 2021, Arkansas became the first state to enact a law prohibiting drug manufacturers from limiting 340B discounts at contract pharmacies. After several legal challenges brought by the Pharmaceutical Research and Manufacturers of America (PhRMA) and individual manufacturers, courts have upheld the Arkansas law. Today, over 20 states have passed similar laws to protect 340B discounts at contract pharmacies, and courts across the country have consistently upheld these state protections.

Minnesota enacted its own 340B protection law in 2024 (Minn. Stat. § 62J.96). However, unlike other states, Minnesota's law is not being enforced. As a result, many drug manufacturers are simply ignoring Minnesota's state law and continuing to impose contract pharmacy restrictions with impunity. The disparity in treatment is striking. For example, certain drug manufacturers enforce a policy that prohibits 340B hospital covered entities from using contract pharmacies, but exempts covered entities in Arkansas, Maryland, Mississippi, Colorado, Maine, Missouri, North Dakota, Rhode Island, South Dakota, Vermont, and Nebraska, all states that are actively enforcing their 340B protection laws. Because Minnesota is not enforcing its law, those manufacturers do not list Minnesota as an exempt state.

Compounding this problem, Minnesota's current law includes a sunset date of July 1, 2027. The existence of this sunset provision further emboldens manufacturers to ignore the law, as they believe the requirement will eventually go away without the need for compliance. Additionally, the imminent financial destabilization caused by HR 1 on safety-net providers is undisputed. Allowing pharmaceutical manufacturers to ignore the law will further degrade the 340B program and only add to the destabilization of our safety-net providers.

SF 3769 (Klein) will make permanent the protections the Minnesota Legislature enacted in 2024 and provide the Attorney General with clear authority to enforce the law when manufacturers do not comply. Minnesota's 340B covered entities and the patients they serve deserve the same certainty and protection that exist in other states with similar laws.
We urge the committee to support HF3609 (Zeleznikar) and SF 3769 (Klein). This bill provides clarity, stability, and accountability — and ensures Minnesota patients are treated no differently than patients in other states with comparable protections. At a time when safety-net providers face mounting financial pressures, maintaining predictable and enforceable 340B protection is essential to sustaining life-saving care in communities across our state.

Sincerely,



Benjamin J Anderson, PharmD, MPH, FASHP, FMSHP
President, Minnesota Society of Health-System Pharmacists
Rochester, MN

Minnesota Hospital Association

161 Rondo Ave, St. 1010
St. Paul, MN 55103

March 18, 2026

Submitted Electronically

Chair Backer, Chair Bierman, and Members of the House Health Finance and Policy Committee,

We are writing to you today on behalf of the Minnesota Hospital Association (MHA) regarding the Minnesota Department of Health's 2025 report on the Federal 340B Drug Pricing Program (340B). The report offers a mistakenly limited glimpse into a critical safety net program that is quite literally keeping the lights on and doors open at 100 Minnesota hospitals at a time of unprecedented financial challenges.

MDH's final 340B report lacks critical context on the purpose and impact of 340B and its 34-year status as an essential safety net support program. By adopting the pharmaceutical industry-preferred definitions and metrics, the report presents an incomplete and misleading view of a program that exists solely to protect health care access for Minnesota's most vulnerable patients.

MDH Report Continues to Leave Out Necessary Context on 340B. While the MDH report provides another look at 340B, it both mischaracterizes and misses critical context about the program's role in sustaining essential health care services across the state – and Minnesota's health care safety net hangs in the balance.

Administered Drugs Now Included. The report does acknowledge that the year over year growth in drug savings is primarily due to inclusion of administered drugs. These are mostly injectable or infusion drugs, used to treat cancer patients or patients with blood, neurological, or autoimmune conditions. Hospitals provide live-saving care for high acuity and complex patients, making their financial impact from 340B incomparable to other covered entities – which use 340B in the exact same way as hospitals, just with different services and medications needed to care for patients.

"Buy low and sell high." MDH claims that hospitals buy outpatient drugs at a low price and then sell them at a higher price to generate profit. This underscores the state agencies' categorical misunderstanding of the federal program. Hospitals use 340B to purchase outpatient drugs at the federally determined 340B discount price, then dispense or administer them to patients, and then pursue the pre-negotiated commercial or government set reimbursement rates. This is all normal patient care delivery determined by federal law.

Revenue vs. Savings. MDH's report claims that 340B generated over a billion dollars in revenue in Minnesota. This simply is not true and represents a well-rehearsed talking point of big pharma. Rather, 340B provided hundreds of millions in savings to safety net providers on outpatient medications, without which many critical services would face reduction or elimination.

Drug Prices Missing. MDH's report does not include any information key to understanding 340B within the total market for drug purchasing and the astronomical list prices set by drug manufacturers. List prices for drugs are second only to defense contractors and represent the fastest growing cost for delivering patient care. Drug prices far exceed inflation, exceed reimbursement levels, and directly impact 340B prices and the resulting savings.

Minnesota Hospital Association

161 Rondo Ave, St. 1010
St. Paul, MN 55103

"Middlemen" Miscue. The report erroneously makes the case that due to administrative costs, 340B is diverting resources to intermediaries and not to patient services and access. This is an attack on 340B used by the pharmaceutical industry and relies on the notion that if 340B were taken away there would be no administrative costs associated with delivering drugs to patients. On the contrary, there are real and unavoidable administrative costs associated with all aspects of health care delivery.

Program Structure and Funding. MDH's report presents a lot of information on 340B without including information on the basic funding mechanism, leading readers to believe that 340B costs the health care system over a billion dollars with nothing to show for it. Unlike many health care programs, 340B operates without direct government funding. As Congress intended, this vital pillar of support does not rely on spending additional taxpayer dollars, but instead, it draws from the substantial profits of pharmaceutical companies - profits that continue to break records year after year while hospitals and other safety net providers struggle to maintain basic services for their patients and communities.

For perspective, without the 340B program, program savings would flow instead to pharmaceutical manufacturers - the same companies who reported $102 billion in profits in 2024. Yet these same companies continue to attack the program and by default safety net providers and their patients. And even with 340B support, 30% of Minnesota hospitals are operating at a financial loss, contributing to ongoing risks of service line closures.

The Bottom Line. Support from 340B is more vital than ever as Minnesota hospitals and other critical safety net providers struggle with inadequate reimbursements from public programs, which typically pay less chronically below the actual cost of care. With more than half of Minnesota hospital patients now covered by public programs (Medicare and Medical Assistance), and more than a third of Minnesota births are covered by Medical Assistance, the 340B program helps offset the staggering $2.6 billion in uncompensated care provided by Minnesota hospitals.

To conclude, 340B is an established and successful federal program that Minnesotans and their safety net providers have relied on for 34 years to support access to comprehensive health care services. MDH's report offers more insight on the program but must not be seriously balanced with additional context and understanding to adequately appreciate 340B and its vital role across Minnesota and the nation in sustaining access to patient care.

Sincerely,

Michelle Benson
Senior Director of State Government Relations
mbenson@mnhospitals.org

Danny Ackert
Director of State Government Relations
dackert@mnhospitals.org

Evaluating the Role of 340B in Managing Healthcare Costs for Taft-Hartley Plans

PILMA
Pharmaceutical Industry Labor-Management Association

The Pharmaceutical Industry Labor-Management Association (PILMA) engaged 3 Axis Advisors, an independent consulting firm specializing in prescription drug data analytics, to estimate the impact of 340B on Taft-Hartley plan expenses for prescription drugs.

KEY FINDINGS

The 340B program increased drug spending of Taft-Hartley plans by

4.7%

per claim.

Extrapolating these findings to all 5.2 million Americans covered by Taft-Hartley plans (source: Milliman), one can estimate the 340B program is driving up costs in Taft-Hartley health plans by

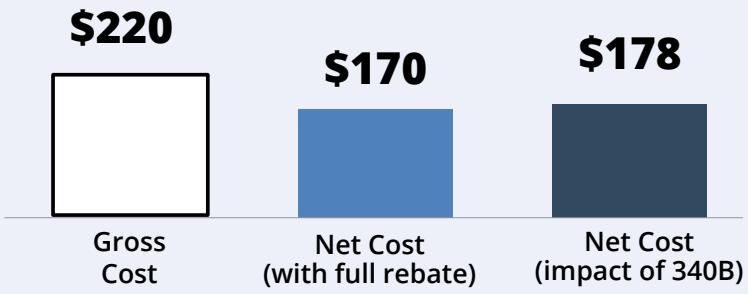
$416M per year.

As 340B continues to grow at

24%

year over year, the model predicts additional losses of rebates over time, putting additional upward pressure on plans' net drug expenditures.

AVERAGE COST PER Rx CLAIM



**In US Dollars, 2023*

The analysis relied on financial modeling based on publicly available 340B program data and proprietary data from 44 private plan sponsors representing **$993 million** in gross drug expenditures over roughly **450,000** prescription drug claims in 2023.

Evaluating the Role of 340B in Managing Healthcare Costs for Taft-Hartley Plans

340B is a federal program that allows eligible providers ("covered entities") to purchase prescription drugs at a discount. Most covered entities do not fully pass their 340B discounts on to patients or payers. Instead, they may request reimbursement based on undiscounted prices.

For non-340B claims, payers negotiate rebates from manufacturers to reduce claims costs. Negotiated rebates vary by product and payer type, averaging **approximately 25% but reaching as high as 80%** in some cases. Plan sponsors ascribe high importance to these rebates in managing overall health plan costs.

For 340B claims, negotiated rebates generally are unavailable to plan sponsors To prevent duplication of discounts already provided on 340B prescriptions, rebate contracts preclude payment of negotiated rebates on 340B claims.

This study found that, in the absence of 340B, negotiated rebates would reduce plan sponsors' average cost per claim from $220 to $170. If 15% of claims are for 340B prescriptions, however, some of those savings will erode due to lost rebates. The revised **average cost per claim increases to $178 from $170 – a 4.7% increase.**

In recent years, the 340B program has **grown by double digits to eclipse $66.3 billion in 2023 – a 24% year-over-year increase**. As the percentage of claims filled with 340B increases, the availability of negotiated rebates declines, making future 340B program growth a topic of concern for Taft-Hartley plans.

CONCLUSION

Congress must enact strong federal reforms to ensure the 340B program supports patient care without shifting costs onto multi-employer health plans.

Pending legislation would tighten rules on outpatient versus inpatient pricing, limit certain administrative costs, increase transparency, and add new requirements for 340B hospitals.

PILMA
Pharmaceutical Industry Labor-Management Association

The Minnesota Star Tribune

MARCH 11, 2026

Readers Write

Independent pharmacies can't hang on

Two recent articles, "Fairview goes all in on robotic pharmacy" (March 8) and "Hospitals received $1B selling discounted drugs at full price" (March 3), have prompted me to write this letter to explain why Minnesota is having a pharmacy "problem."

For years independent pharmacies across the country have been excluded from the specialty drug market due to insurance clauses that force consumers to use exclusive mail order pharmacies. These specialty drugs, in many cases, are "special" only because the exclusive pharmacies make huge amounts of money. If the pharmacy is owned by a hospital system, that amount increases exponentially if the hospital system is a 340B entity where they buy drugs at pennies on the dollar compared to independent pharmacies. When 340B began it was supposed to lower the cost of medications for the consumer. Today, it is a $1 billion enterprise (in Minnesota alone) that is pushing pharmacies out of business in order to keep the 340B profits for hospital systems. Oh, and it increases medication prices for everyone, by the way.

The programs mentioned above are just two reasons why Minnesota has lost almost 60% of its independent pharmacies in the last 10 years. Many of these stores were the only ones in their towns, counties and ZIP codes, which has forced consumers to travel long distances (or rely on suboptimal mail order pharmacies and the associated shipping issues) to get life-sustaining medications.

Minnesota must do better. We deserve better.

Jay Norberg, Pipestone, Minn.

The writer is a registered pharmacist and owner of A and S Drugs.

March 18, 2026

To members of the Minnesota House Health Finance and Policy Committee

Dear Representatives,

We are writing to share our concerns regarding recently introduced legislation, SF 3769/HF 3609, which would repeal the sunset of 340B mandate legislation. As representatives that work with underserved and minority communities, we are very concerned that the 340B program has become a profit generator for corporate hospital systems and their contract pharmacies, with scant evidence to suggest it is providing benefits to the underserved populations it was created to serve.

340B is a federal program created in 1992 to help safety-net clinics provide care to low-income and uninsured patients by providing discounted prescriptions that clinics could then charge full price for, using the "spread" between these prices to pay for care. Today, corporate hospital systems and for-profit pharmacies have co-opted the program to generate huge profits. Studies have found that 340B hospitals tend to expand into more affluent and less diverse areas to ensure maximum profit from the "spread." According to the Pioneer Institute, 53 percent of 340B contract pharmacies in Minnesota are located in affluent neighborhoods.

As the 340B program has continued to grow beyond its intended patient population, investigations have tried to shed light on how hospitals are using the program. The 2025 report from the Minnesota Department of Health looking at hospital 340B revenue has raised many questions, especially about contract pharmacies and third-party administrators which received $165 million from 340B hospitals in 2024. The report also found that just 23 large hospitals made 80 percent of the statewide net 340B revenue. Meanwhile federally qualified health clinics, tribal clinics, and others made less than 1 percent of the total statewide revenue. These numbers call into question how much benefit Minnesota's safety-net providers are seeing from 340B and in turn the low-income and minority patient populations they serve.

In addition to hospitals and contract pharmacies expanding into affluent areas, there is also a real lack of transparency regarding how 340B revenue is used. While the original intent of the program was to help safety-net clinics and FQHCs pay for the care they provided, Minnesota 340B hospitals provide less charity care than the national average. In 2025 Abbot Northwestern told the Minneapolis City Council that 340B revenue had been used for a native pollinator garden, EV charging stations, LEED certification and a solar roof. These expenses and the decline in charity care suggest that 340B revenue is not being used to benefit patient care.

340B is a federal program, and one that needs significant reforms to ensure it benefits the vulnerable patients it was intended to serve, the very patients we work with every day.

We hope you will take our concerns into consideration and reconsider any support for SF 3769 or HF 3609.

Sincerely,

Advocates for Compassionate Therapy NOW
Ai Arthritis
Biomarker Collaborative
Community Access National Network (CANN)
Community Liver Alliance
Cystic Fibrosis United
Exon 20 Group
International Cancer Advocacy Network
Lupus and Allied Diseases Association, Inc.
MET Crusaders
National Infusion Center Association
PD-L1 Amplifieds
SLC6A1 Connect

CSRO
Coalition of State Rheumatology Organizations

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Website: www.csro.info

March 17, 2026

Health Finance and Policy Committee
Minnesota House of Representatives
Capitol 120
75 Rev. Dr. Martin Luther King, Jr. Blvd.
Saint Paul, MN 55155

Concerns re: HF 3609 – Federal 340B Drug Pricing Program

Members of the Health Finance and Policy Committee:

The Coalition of State Rheumatology Organizations (CSRO) would like to express concerns regarding HF 3609, which would address aspects of the federal 340B drug pricing program. CSRO serves the practicing rheumatologist and is comprised of over 40 state and regional professional rheumatology societies nationwide whose mission is to advocate for excellence in the field of rheumatology, ensuring access to the highest quality of care for the management of rheumatologic and musculoskeletal disease.

Rheumatologic diseases, such as rheumatoid arthritis, psoriatic arthritis and lupus, are systemic and incurable, but innovations in medicine over the last several decades have enabled rheumatologists to better manage these conditions. With access to the right treatment early in the disease, patients can generally delay or even avoid damage to their bones and joints, as well as reduce reliance on pain medications and other ancillary services, thus improving their quality of life.

HF 3609 would allow for significant growth in the 340B drug pricing program and fails to incorporate guardrails that ensure patient access to discounted medications. Section 340B of the federal Public Health Service Act, known as the 340B drug pricing program, was created to provide discounted outpatient medications for disproportionate share hospitals (DSH) and federally qualified clinics that treat low-income and uninsured patients. However, over the past three decades, the program has grown greatly, demonstrating weaknesses in its implementation and execution.

Contract Pharmacy Expansion

HF 3609 would enable greater expansion of contract pharmacies within the 340B program, without any oversight to ensure that underserved patients actually receive discounted medications from the contract pharmacies associated with DSHs. According to a 2018 U.S. Government Accountability Office (GAO) report, the number of pharmacies that contract with 340B entities has increased "more than fifteen-fold" since the 2010 guidance that allows for an unlimited number of contracts. Initially these contract pharmacies were primarily located in the same communities as the covered entity. However, GAO reported that contract pharmacies are located between 0-5,000 miles away from their associated covered entity.[i] In fact, in Minnesota, 20% of 340B pharmacies supposedly serving poor patients are located outside of the state.[ii]

More than half of all U.S. pharmacy locations act as a contract pharmacy for a covered entity participating in the 340B program.[iii] CVS Health, Walgreens, Cigna (via Express Scripts), UnitedHealth (via OptumRx), and Walmart – all publicly traded, vertically integrated subsidiaries of pharmacy benefit managers (PBMs) – account for 75% of all

contract pharmacy relationships with 340B covered entities.[iv] These pharmacies are all top Fortune 30[v] companies, profiting off of underserved patients through their 340B business arrangements. Clearly, access to contract pharmacies is *not* what is limiting patient access to 340B medications, and provisions within HF 3609 would only allow large PBMs to continue to profit from these broken aspects of the system.

Healthcare Consolidation

The Health Resources and Services Administration (HRSA) allows 340B covered entities to register their off-campus outpatient facilities, or child sites, under their 340B designation. Covered entities, such as hospitals and their off-campus facilities, have a competitive advantage as they can purchase drugs at a 20-50% discount through their 340B status. Covered entities acquire drugs at the 340B price, while imposing markups on the reimbursement they submit to commercial health plans.

According to a study in the New England Journal of Medicine, after accounting for drug, patient, and geographic factors, price markups at 340B eligible hospitals were 6.59 times as high as those in independent physician practices. In this study, 340B eligible hospitals earned $650.24 more per drug unit than independent physician practices. This may also have the unintended consequence of exacerbating government healthcare spending.

The additional revenue these covered entities can pocket provides them with a cash flow advantage that physician practices and outpatient clinics will never be able to actualize. These child site clinics compete with independent community practice rheumatologists and oncologists, who prescribe many of the expensive medications available to 340B DSH, and eventually run them out of business. This uneven playing field may make rheumatology practices more susceptible to hospital acquisitions. In fact, between 2016-2022, large 340B hospitals were responsible for approximately 80% of hospital acquisitions.[vi]

This consolidation was also recognized in a 2022 Congressional Budget Office report, which states the 340B program could encourage large healthcare systems that prescribe expensive 340B eligible medications to acquire physician practices, such as rheumatology and oncology. These acquisitions threaten the viability of rheumatology practices across the United States. We are concerned that HF 3609 could lead to greater healthcare consolidation throughout the state, jeopardizing the viability of Minnesota-based rheumatology practices and leading to increased costs for patients and the healthcare system in general.

Weaknesses in 340B Implementation

In recent years, rheumatologists have seen the effects of the weaknesses within the 340B program as Medicaid patients have been turned away from 340B DSH clinics for their regular treatments. Medicaid patients with chronic conditions are certainly "underserved" and do not always benefit from the discounted medications made available through the 340B program. This clearly falls outside of the original mission of the 340B program. This is just one of the weaknesses in the 340B system, particularly with large DSH systems, that reveal a failure to consistently serve patients in need, in spite of large profits that come from contract pharmacies and child site clinics.

CSRO believes that the 340B drug pricing program was created with a noble mission – to ensure that underserved, low-income and uninsured patients receive the medications they need at little to no cost. However, expanding access through unrestricted contract pharmacy access is not the solution and offers no assurances of benefit to the intended patients. Instead, to ensure the program's success, the mission should be realigned to prioritize the patient and establish greater transparency and accountability. For more information on CSRO's position, please visit https://csro.info/UserFiles/file/CSRO-340B-Statement-2024.pdf.

On behalf of practicing rheumatologists throughout Minnesota, we request that you **do not advance** HF 3609. We thank you for your consideration and are happy to further detail our comments to the Committee upon request.

Respectfully,

Aaron Broadwell, MD, FACR
President
Board of Directors

Madelaine A. Feldman, MD, FACR
VP, Advocacy & Government Affairs
Board of Directors

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[i] U.S. Government Accountability Office. "Drug Discount Program: Federal Oversight of Compliance at 340B Contract Pharmacies Needs Improvement." June 2018.
[ii] Pioneer Institute. "340B State One Page Fact Sheets." 2025.
[iii] Drug Channels. "EXCLUSIVE: For 2023, Five For-Profit Retailers and PBMs Dominate an Evolving 340B Contract Pharmacy Market." July 2023.
[iv] ibid
[v] Fortune. "Fortune 500." 2024.
[vi] Avalere. "Characteristics of Hospitals Undergoing Mergers and Acquisitions." February 2023.

STATEMENT

PhRMA
RESEARCH • PROGRESS • HOPE

In Opposition to Minnesota HF 3609
Repeal of Sunset Provision for 340B Manufacturer Mandate
March 2026

Position: The Pharmaceutical Research and Manufacturers of America ("PhRMA") respectfully opposes Minnesota HF 3609. HF 3609 repeals the July 1, 2027 sunset provision for legislation passed by the Minnesota Legislature in 2024, HF 4757,[1] that requires biopharmaceutical manufacturers to provide 340B-priced drugs to all pharmacies that contract with 340B covered entities ("the mandate"). Repeal of the sunset provision would further entrench HF 4757, a law that violates both the U.S. and Minnesota Constitutions and is preempted by federal law, and continue to increase the cost of medicines for Minnesota taxpayers, employers, and patients.

The 340B program is a comprehensive federal program that is governed exclusively by federal law.

As detailed in PhRMA's complaint challenging HF 4757,[2] HF 4757 is preempted under the Supremacy Clause of the U.S. Constitution because the mandate directly contravenes Supreme Court precedent and creates new requirements that are not in or conflict with the federal 340B statute. HF 4757 also violates the U.S. Constitution's prohibition on state extraterritorial regulation and the Minnesota Constitution's prohibition on laws "embrac[ing] more than one subject" which must be "expressed in its title."[3] It is unclear why the Minnesota Legislature would propose via HF 3609 to repeal the sunset provision in HF 4757 when the constitutionality of HF 4757 is being litigated.[4]

Manufacturer mandates like the one in HF 4757 exacerbate the fiscal impact of the federal 340B program on the state, employers, and ultimately, taxpayers.

The 340B program is a financial profit generator for tax-exempt hospitals. The newly released 2025 Minnesota 340B Covered Entity Report ("Covered Entity Report") found that 340B tax-exempt hospitals and grantees in Minnesota collected $3.04 billion in reimbursement on 340B prescriptions that cost them a total of $1.53 billion to acquire. The Minnesota Department of Health (MDH) estimates this is at least $1.34 billion in net 340B revenue.[5]

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[1] Laws of Minn. 2024, ch. 121, art. 4, sec. 3 (codified at Minn. Stat. § 62J.96).
[2] *Pharm. Rsch. and Manufs. of Am. v. State*, No. 62-CV-24-5744 (Ramsey Cnty. Dist. Ct. 2024).
[3] Minn. Const. art. IV, sec. 17; *Ass'n for Accessible Meds. v. Ellison*, 140 F.4th 957 (8th Cir. 2025) (affirming preliminary injunction of a Minnesota law that barred manufacturers from "impos[ing], or caus[ing] to be imposed, an excessive price increase, whether directly or through a wholesale distributor, pharmacy, or similar intermediary, on the sale of any generic or off-patent drug sold, dispensed, or delivered to any consumer in the state").
[4] *Pharm. Rsch. and Manufs. of Am. v. State*, No. 62-CV-24-5744 (Ramsey Cnty. Dist. Ct. 2024), *aff'd*, No. A25-0805 (Minn. Ct. App. Feb. 17, 2026) (Mar. 19, 2026, deadline to petition for discretionary review).
[5] Minnesota Department of Public Health, "340B Covered Entity Report," Feb. 27, 2026. https://www.health.state.mn.us/data/340b/docs/2025report.pdf

While the 340B program financially benefits tax-exempt hospitals, it raises costs for the health care system in general. For example, MDH estimates $261 million in net 340B revenue in 2024 was generated from prescriptions written for patients in Minnesota Health Care Programs, including Medical Assistance/Medicaid and MinnesotaCare, and $479 million was generated from prescriptions written for Medicare patients[6] — costs borne by public budgets and ultimately taxpayers. 340B also causes states like Minnesota to lose out on potential Medicaid prescription drug rebate dollars, which ultimately costs taxpayers. The federal 340B statute prohibits the same prescription from being subject to a 340B discount and a Medicaid rebate.

MDH also estimates $608 million in net 340B revenue in 2024 was generated from the commercial market[7], where costs are often passed on to employers and workers through higher premiums[8]. Use of 340B-priced drugs also displaces manufacturer rebates that would otherwise be available to health plan sponsors, raising costs for everyone.

Numerous studies show that the 340B program drives up costs for employers and the government in other ways too, like by incentivizing the use of more and higher-cost medicines,[9] shifting care to more expensive settings, and driving provider consolidation.[10] By extending 340B pricing beyond that contemplated by Congress, manufacturer mandates worsen this problem.

The Covered Entity Report also sheds light on the massive profits 340B hospitals retain from the 340B program.

HF 4757 allows large hospital systems to increase their profits without ensuring that vulnerable or low-income patients can access medicines at reduced 340B prices. According to the Covered Entity Report, the state's largest 340B hospitals benefitted most from the 340B program, accounting for 12% of reporting entities but representing 80%—more than $1 billion—of net 340B revenue. The largest single 340B beneficiary was M Health Fairview University of Minnesota Health Center, which earned $335 million in net 340B revenue. By comparison, M Health Fairview earned more money than all of the state's 73 critical access hospitals, 2 sole community health hospitals, 2 children's hospitals, 1 rural referral center, and all grantees combined.[11]

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[6] *Id*.
[7] *Id*.
[8] Masia N, Ph.D., Motyka J, PharmD, Westrich K, Campbell J, PhD. "The 340B Drug Purchasing Program and Commercial Insurance Premiums," Health Capital Group, May 2025. https://www.npcnow.org/sites/default/files/2025-05/340B%20and%20Employer%20Costs%20White%20Paper.pdf
[9] Hunter M Et. Al., "Analysis of 2020 Commercial Outpatient Drug Spend at 340B Participating Hospitals." Milliman, 2020. https://edge.sitecorecloud.io/millimaninc5660-milliman6442-prod27d5-0001/media/Milliman/PDFs/2022-Articles/9-13-22_PhRMA-340B-commercial-analysis.pdf
[10] Horn D, "The incentive to treat: Physician agency and the expansion of the 340B drug pricing program," 101 J. Health Econ., 2025. https://doi.org/10.1016/j.jhealeco.2025.102971
[11] Minnesota Department of Public Health, "340B Covered Entity Report," Feb. 27, 2026. https://www.health.state.mn.us/data/340b/docs/2025report.pdf

<u>There is no requirement that a contract pharmacy pass along the reduced price of a medicine to a patient, and analysis shows chain pharmacies and pharmacy benefit manager (PBM) middlemen are profiting off 340B</u>.

According to available information, contract pharmacies retained 9% of the $64 billion in 340B profits generated in 2023—for a total of $5.76 billion.[12] What's more, findings from Senate Health, Education, Labor, and Pensions Committee's years-long investigation into the 340B program show that large chain contract pharmacies, like Walgreens and CVS, require covered entities to use — and pay fees to — their respective third-party administrator (TPA) subsidiaries. Wellpartner, the TPA subsidiary of CVS, pocketed $1.6 billion in 340B safety net funds from 2019 to 2023.[13]

The state's Covered Entity Report provides evidence of the 340B profits reaped by chain pharmacies and third-party administrators (TPAs) like PBMs in Minnesota. The Covered Entity Report notes that payments to contract pharmacies and TPAs were roughly $1137 million in 2024, representing approximately $10 of every $100 of gross 340B revenue generated paid to external parties. Contract pharmacy fees accounted for approximately 70% of hospital costs and 42% or less of grantee costs.[14]

The Legislature should have the opportunity to understand the full costs of the 340B program and HF 4757 to stakeholders, including through Minnesota's revised 340B Covered Entity Report[15] and the legality of HF 4757 before expanding the mandate in HF 4757 indefinitely. The Legislature should be guided by a clear understanding of the program's effects in order to protect Minnesotans from the cost of a manufacturer mandate.

PhRMA respectfully opposes HF 3609 and appreciates your consideration prior to advancing it.

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The Pharmaceutical Research and Manufacturers of America (PhRMA) represents the country's leading innovative biopharmaceutical research companies, which are 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. PhRMA member companies have invested more than $850 billion in the search for new treatments and cures over the last decade, and they support nearly five million jobs in the United States.

[12] 340B Industry Roundtable, "For-Profit Pharmacy Participation in the 340B Program: 2025 Update," Jan. 2025. https://roundtable.thinkmosaic.com/links/for_profit_phcy_340b_2025_update

[13] "Congress Must Act to Bring Needed Reforms to the 340B Drug Pricing Program," Senate Committee on Health Education Labor & Pensions, Majority Staff Report, April 2025. https://www.help.senate.gov/imo/media/doc/final_340b_majority_staff_reportpdf.pdf

[14] Minnesota Department of Public Health, "340B Covered Entity Report," Feb. 27, 2026. https://www.health.state.mn.us/data/340b/docs/2025report.pdf

[15] *See* Laws of Minn. 2024, ch. 127, art. 59, sec. 2 (codified at Minn. Stat. § 62J.461).

Bristol Myers Squibb™

March 18th, 2026

VIA ELECTRONIC SUBMISSION

House Health Finance and Policy Committee
Rep. Jeff Backer
Rep. Robert Bierman

Re: Opposition to SF 3769

Dear Chair Backer and Co-Chair Bierman and Members of the House Health Finance Committee,

I appreciate the opportunity to express Bristol Myers Squibb's (BMS) strong opposition to HF 3609, a bill that, contrary to its description, does nothing to protect Minnesota's health care safety net or patient access to prescription medicines, and instead maximizes existing efforts to significantly expand a federal program intended to ensure care for vulnerable patients.

BMS is a global biopharmaceutical company whose mission is to discover, develop, and deliver innovative medicines that help patients prevail over serious diseases. In Minnesota, we have 138 employees working throughout the state, supporting some of the most advanced therapies in medicine today.

HF 3609 would continue to incentivize the dramatic expansion of the federal 340B program in Minnesota, requiring manufacturers to provide federal 340B discounts through an unlimited system of contract pharmacies, at a time when the program is already larger, less transparent, and more disconnected from patient benefit than ever before.

In 2025, BMS paid more than $135 million in 340B discounts in Minnesota alone, an increase of more than 18% when compared to 2024, without commensurate growth in the 340B covered entity or patient population to justify such a significant impact. 98% of those discounts were extended to hospitals while a mere 2% those discounts were extended to grantees. This is a stark reminder of how today's 340B program has evolved into a revenue generating platform for major health systems, rather than a program with transparency, accountability, or with direct benefit for vulnerable patients.

Minnesota is not an outlier; this state's experience reflects what is happening nationally. Across the country, 340B has exploded in size through program abuse. Discounted drug purchases reached more than $81 billion [1],¤ making 340B, once a limited program narrowly designed to support vulnerable patients, now the second largest drug program after

[1] HRSA. "2024 340B Covered Entity Purchases." December 2025.

Medicare Part D. Contract pharmacy arrangements have increased by 4,000% since 2010,▫ and nearly three quarters of such arrangements are now tied to large chain and PBM-owned pharmacies, reflecting the use of these arrangements for profit.

The newly released 340B transparency report from the Minnesota Department of Health highlights the unprecedented scale and growth of 340B in our state.[2] Minnesota covered entities generated at least $1.34 billion in net 340B revenue in 2024.[3] Of that number, less than 1% of total statewide revenue went to grantees (grantees include federally qualified health centers, tribal clinics which significantly undercut the narrative that 340B primarily benefits small safety net providers.[4]

Despite that extraordinary growth, evidence of covered entities helping vulnerable patients afford their medicines is increasingly hard to find in the data because that promise is not being fulfilled. In Minnesota, charity care at 340B hospitals averages just 1.9% of operating costs, and more than two thirds of hospitals fall below the national average. From 2014 to 2022, hospital assets increased by 25% while charity care declined.

The system that HF 3609 would expand is already sprawling and misaligned going far beyond what is critical and abandoning the communities 340B was meant to serve. Minnesota has 4,523 contract pharmacies, including 1,275 with pharmacies located outside the state.[5] Of the 521 in-state contract pharmacy locations, only 38% are located in zip codes with average household income below the state median, and just 34% are located in rural areas, even though 61% of Minnesota zip codes are considered rural.[6] HF 3609 may be framed as protecting access for vulnerable patients and rural communities, but the geography and the data tell a very different story.

HF 3609 would lock this system into law, a flawed structure that does not require hospitals or contract pharmacies to pass 340B savings directly to patients and has shown vulnerability to diversion and compliance failures. Since 2015, federal audits in Minnesota have returned adverse findings in more than half of cases reviewed.[7] The cost of that failure is passed on to Minnesota families and taxpayers. Employers in Minnesota already pay an estimated $158 million more each year in health care costs due to foregone rebates, resulting in $12.3 million reduction in state and local tax revenue.[8] Extending this model would further compound those costs.

Instead of passing flawed legislation, we should embrace the unique opportunity to continue to lead in patient innovation through policy. Minnesota was the first state in the nation to enact a 340B transparency law under the leadership of Chair Wicklund. Seven additional

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[2] Minnesota Department of Health. (2025). *Minnesota 340B report 2025*. Minnesota Department of Health. https://www.health.state.mn.us/data/340b/docs/2025report.pdf.
[3] Id.
[4] Id.
[5] Pharmaceutical Research and Manufacturers of America (PhRMA). *"A Closer Look at 340B in Your Community – Washington State Profile."* 2025.
[6] Id.
[7] Id.
[8] Id.

states have enacted similar transparency laws including Washington, Ohio, Vermont, Maine, Rhode Island, Idaho and Indiana. Policymakers across the country are acting because the 340B program has grown into a sprawling, opaque financial scheme that lacks accountability.

340B is already the second largest drug program in the country. The question is whether growth is improving patient access, or simply fueling a system that no longer serves them. All available evidence shows a program that is growing rapidly, generating enormous revenue for large institutions, and yet delivering little measurable benefit to the vulnerable patients it was intended to benefit. HF 3609 would expand that system, not fix it.

We respectfully urge you to oppose HF 3609.

Sincerely,

/s/

Genevieve Plumadore
Director, State & Local Government Affairs
U.S. Policy & Government Affairs

March 16, 2026

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Representative Jeff Backer
Co-Chair, Health Finance and Policy Committee
2nd Floor Centennial Office Building
St. Paul, MN 55155

Representative Robert Bierman
Co-Chair, Health Finance and Policy Committee
5th Floor Centennial Office Building
St. Paul, MN 55155

Dear Co-Chair Backer and Co-Chair Bierman:

Eli Lilly and Company (Lilly) opposes HF 3609 which would unlawfully alter the federal 340B program by requiring that pharmaceutical manufacturers extend federal 340B discounts to for-profit contract pharmacies. HF 3609 would expand 340B by intruding into an exclusively federal program, making it patently unconstitutional. In fact, Oklahoma and West Virginia have been enjoined by federal courts from implementing similar proposals. Adding to this issue, studies have shown that 340B expansion results in higher costs for states, patients, taxpayers, and employers–while simultaneously enriching large hospitals and for-profit pharmacies. Minnesota's recently released 2025 Covered Entity Report shows that 340B entities profited a staggering $1.34 billion in 2024 alone- while patients received no direct benefits.[1] For these reasons, we request that you oppose HF 3609. Lilly remains committed to 340B reform to ensure the program works to help underserved patients with affordable access to needed medicines. We stand willing to work with stakeholders to bring transparency and accountability to 340B—but this reform needs to be undertaken comprehensively at the federal level.

1. State proposals to modify the federal 340B program are unconstitutional.

HF 3609 would expand the ability of for-profit pharmacies and large hospital systems to use the 340B program to generate profit at the expense of patients. Doing so raises significant legal concerns, both under the United States Constitution and in light of several court rulings. In particular, rulings in the D.C. Circuit Court and the Third Circuit Court have affirmed that pharmaceutical manufacturers can impose restrictions on contract pharmacies under the federal 340B law.[2] The United States Department of Justice (DOJ) has also reaffirmed that 340B is an exclusively federal program and state laws imposing additional requirements are unconstitutional, stating

[1] Minnesota Department of Health. 340B Covered Entity Report. https://www.health.state.mn.us/data/340b/docs/2025report.pdf

[2] *Novartis v. Johnson*, 102 F.4th 452, (D.C. Cir. 2024); *Sanofi Aventis U.S. LLC v. U.S. Dep't of Health & Human Servs.,* 58 F.4th 696 (3d Cir. 2023*).*

unequivocally that "Congress left no role for States in determining manufacturers' 340B obligations."[3]

In addition, federal district court judges ruled that Oklahoma and West Virginia's contract pharmacy laws are unconstitutional and officials cannot enforce the laws while legal challenges play out.[4] Minnesota proposed HF 3609 attempts to impose similar restrictions on manufacturers and is inconsistent with the rulings in Oklahoma, West Virginia, and the Third Circuit[5], as well as the DOJ's position, even if some other courts have upheld other states' laws.

2. The 340B Program increases costs for state and local governments

The rapid expansion of 340B has a significant impact on the people of Minnesota. Recent data shows conclusively that 340B increases costs for the Medicaid program, state employers and taxpayers. A 2025 CBO report concluded "the 340B program encourages behaviors—including the prescription of more and higher-priced drugs, the expansion of services, and the integration of hospitals and off-site clinics"—which all result in higher costs for the state.[6]

The federal 340B law prevents Medicaid from collecting rebates on prescriptions filled at the 340B price. This means that as more tax-exempt hospitals exploit the 340B program as a profit center, Medicaid rebate losses also rise. This is a hidden tax on patients, taxpayers, and employers. For example, a recent study found that the program is **costing Minnesota employers and workers $157 million annually**, $22M of which is associated with the state's government health plans.[7] This number is expected to *increase* to roughly $190M annually if HF 3609 passes. Another study built on this analysis found that the 340B program is costing Minnesota $12.3 million annually in lost tax revenue, driven by increased expenses for health plans which decreased taxable income for affected employers and workers.[8] Minnesota's own 340B Covered Entity Report shows that Covered Entities generated more than $250 million of net revenue off of Minnesota Health Care Programs, including Medicaid.[9]

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[3] Brief for the United States as Amicus Curiae in Support of Appellant, *Pharmaceutical Research and Manufacturers of America v. Neronha*, No. 26-1039 (1st Cir. Feb. 25, 2026); Brief for the United States as Amicus Curiae in Support of Appellants, *AbbVie, Inc. v. Weiser*, No. 25-1439 (10th Cir. Feb. 25, 2026).

[4] *AbbVie v. Drummond*, 2025 U.S. Dist. LEXIS 215004 (W.D. Okla. Oct. 31, 2025); *Pharm. Rsch. & Mfrs. Of Am. v. Morrisey*, 760 F.Supp. 3d 439 (S.D.W.V. 2024); *see also Sanofi Aventis U.S. LLC v. U.S. Dep't of Health & Human Servs.*, 58 F.4th 696 (3d Cir. 2023) (holding that the government cannot require manufacturers to "[deliver] discounted drugs to an unlimited number of contract pharmacies," and that "drug makers' policies [with respect to contract pharmacies] are lawful); *Novartis v. Johnson*, 102 F.4th 452, (D.C. Cir. 2024) (rejecting "HRSA's position that section 340B prohibits drug manufacturers from imposing any conditions on the distribution of discounted drugs to covered entities").

[5] *Sanofi Aventis U.S. LLC v. U.S. Dep't of Health & Human Servs.,* 58 F.4th 696 *(3d Cir. 2023).*

[6] CBO. Growth in the 340B Drug Pricing Program. https://www.cbo.gov/publication/60661

[7] https://www.iqvia.com/locations/united-states/library/white-papers/the-cost-of-the-340b-program-to-states

[8] https://www.magnoliamarketaccess.com/wp-content/uploads/340B-Tax-Impact-Analysis_2025.01.23.pdf

[9] Minnesota Department of Health. 340B Covered Entity Report. https://www.health.state.mn.us/data/340b/docs/2025report.pdf

One state concluded that "[t]oo many hospitals have converted the 340B drug discount program into a profit center at the expense of state employees, cancer patients, and taxpayers."[10] For example, North Carolina found that 340B hospitals charged higher rates – billing 84.8% higher prices on average than non-340B hospitals. And studies revealed that the growth in 340B provider participation drove an increase in Medicaid spending of $1100 per patient,[11] and over $32 billion per year.[12]

3. **Despite exponential growth in the size of the 340B program,[13] patients have seen no direct benefits in access or affordability. In fact, patients' costs may go up—with no improvement to access.**

Many studies demonstrate that participation in the 340B program does not result in additional patient benefit – at the pharmacy counter or otherwise. For example, the North Carolina State Treasurer's Office found that North Carolina 340B hospitals charged cancer patients – on average – 5.4 times more than what the hospitals paid to acquire the oncology medicines. This is consistent with our experience. 340B hospitals can purchase many of our insulins for pennies per milliliter (mL), but contract pharmacies frequently charge patients significantly more. For example, one pharmacy we interviewed charged an uninsured patient over $500 for insulin that the pharmacy purchased for 15 cents – a markup of over 330,000%.

Additionally, expansion of the 340B program has not coincided with improvements in patient access to needed medicines. A recently published analysis critically concluded that there was "no evidence that 340B contract pharmacies increase drug availability in a meaningful way or that manufacturer policies reduced patient access."[14] Instead, this analysis found that despite a significant increase in the number of contract pharmacies over the past four years (more than 25%), there has been no meaningful increase in patient access to medicines.

Although proponents of state 340B contract pharmacy bills argue that 340B profits are used to help patients in other ways, data show this is misleading – 340B hospitals do not spend more on charity care than non-340B hospitals. For example, the North Carolina Treasurer's Office concluded that the vast majority of 340B hospitals did not provide enough charity care to equal the estimated value of their tax

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[10] https://www.shpnc.org/documents/overcharged-state-employees-cancer-drugs-and-340b-drug-price-program/download?attachment.
[11] Jung, J., Xu, W.Y. and Kalidindi, Y. (2018), Impact of the 340B Drug Pricing Program on Cancer Care Site and Spending in Medicare. Health Serv Res, 53: 3528-3548. https://doi.org/10.1111/1475-6773.12823.
[12] Masia, N. The 340B Drug Purchasing Program and Per Enrollee Medicaid Costs. https://www.healthcapitalgroup.com/340b-and-total-medicaid
[13] In 2023, the number of hospitals participating in the 340B program has grown from 45 to more than 2,600. The number of contract pharmacy arrangements has grown over 9,500% from 2,300 to 220,000. In 2024 discounted purchases have reached a record $81.4 billion. See: https://www.gao.gov/products/gao-23-106095; https://www.drugchannels.net/2025/12/340b-hit-81-billion-in-2024-23-why-cms.html; https://www.drugchannels.net/2024/10/hospitals-are-relying-more-on-pbms-to.html
[14] IQVIA. Do 340B Contract Pharmacies Really "Increase Access" for 340B Patients? https://www.iqvia.com/-/media/iqvia/pdfs/us/white-paper/2025/iqvia-340b-contract-pharmacies-white-paper-2025.pdf

exemptions and were among those that reported the **lowest investments in charity care** from 2011 to 2021.[15] Another study found that "at least 56% of 340B profits do not go to patients in any form."[16] And another found that 340B hospitals make up all 10 of the non-profit hospitals found to provide the least amount of community benefit relative to the value of their tax breaks.[17]

4. **Large hospitals and for-profit pharmacies are benefiting from the expansion of the 340B program through contract pharmacy arrangements – at the expense of smaller hospitals and payers.**

Minnesota published the first of its kind report that highlights how large hospital systems and their contract pharmacies are using the 340B program to increase their profits. The Minnesota Department of Health determined that large 340B hospitals benefited the most from the program, accounting for only 13% of all entities but comprising 80% (approximately $1 billion) of state 340B revenue.[18] Additionally, the report found that one out of every ten dollars in 340B revenue went to for-profit contract pharmacies or other vendors, underscoring the significant share of financial benefits captured by these entities. In fact, certain small grantees **reported losing money** on 340B purchases as a result of payments to contract pharmacies and other vendors.

Given HF 3609 does not advance patient drug affordability goals, increases costs for Minnesota State taxpayers, and raises serious constitutional preemption concerns, we respectfully request that you oppose HF 3609.

Sincerely,

William S. Reid
Vice President
State Government Affairs
Eli Lilly and Company

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[15] Overcharged: State Employees, Cancer Drug and the 340B Drug Pricing Program. https://www.shpnc.org/documents/overcharged-state-employees-cancer-drugs-and-340b-drug-price-program/download?attachment

[16] N. Masia and F. Kuwonza, Health Capital Group, Measuring the 340B Drug Purchasing Program's Impact on Charitable Care and Operating Profits for Covered Entities, 2022.

[17] Lown Institute 2022 Hospitals Index, https://lownhospitalsindex.org/2022-fair-share-spending/. *See also* New England Journal of Medicine, "Consequences of the 340B Drug Pricing Program." (2018). Consequences of the 340B Drug Pricing Program | NEJM (finding that although 340B hospitals purchase drugs at steep discounts the "[f]inancial gains for [340B] hospitals have not been associated with clear evidence of expanded care or lower mortality among low-income patients.").

[18] Minnesota Department of Health. 340B Covered Entity Report. https://www.health.state.mn.us/data/340b/docs/2025report.pdf

March 18, 2026

VIA ELECTRONIC MAIL
Minnesota House Health Committee
658 Cedar Street
Saint Paul, Minnesota 55155

Re: Testimony in Opposition House File 3609, Legislation Removing the 2027 Sunset on Minnesota's 340B Contract Pharmacy Law

Dear Chairs Backer and Bierman, Vice-Chairs Nadeau and Reyer and members of the House Health Finance and Policy Committee,

My name is Emily Gibellina, and I serve as the Director of State Government Affairs at AbbVie. AbbVie is a global biopharmaceutical company headquartered in Illinois with over 55,000 employees worldwide, including more than 100 employees in Minnesota. Thank you for the opportunity to testify today in opposition to House File 3609.

AbbVie's Experience with the 340B Program

First, I would like to address the narrative that without Minnesota's 340B contract pharmacy law, covered entities are losing millions of dollars. Last year alone, AbbVie provided more than $233 million in 340B drug discounts to Minnesota covered entities. In 2022, our 340B discounts in Minnesota totaled $103 million – this represents a 126% increase in 340B discounts in just 3 years. This $233 million represents just one manufacturer, AbbVie, in a single year, and does not account for all the other manufacturers providing 340B discounts in the state.

Further, we see a discrepancy in the use of the program between large hospital systems and smaller grantees like FQHCs. AbbVie currently pays the bulk of our discounts, $229.8M, or 98.5% to hospitals. Within those covered entities, two large hospitals alone make 55% of our discounts. All Minnesota grantees, make up just a fraction of discounts paid last year-just 1.5%.

This program is a financial windfall for large hospitals systems and for-profit middlemen, like the PBM owned large national pharmacy chains with no requirement that those savings are passed through to the most vulnerable patients.

Financial Incentives Distort Prescribing – The Humira Story

As health care cost growth continues to be a concern for policymakers, it is important for this committee to note that 340B hospitals prescribe 23% fewer biosimilars compared to non-340B hospitals[1], underscoring a significant difference in prescribing patterns between the two groups.

Let's take AbbVie's drug, Humira, for example. Humira went off patent in 2023 allowing for the introduction of biosimilar competition in the market. Today there are now 10 biosimilars on the market, with some being offered at discounts exceeding 85% of the cost of branded HUMIRA. As a result, in non-340B hospitals and clinics, we have seen a significant decrease in Humira brand sales across the country.

As such, you would expect that we would see a similar pattern in 340B covered entities, however with 340B eligible hospitals and clinics in Minnesota, our Humira sales have continued to grow.

For example, one Minnesota hospital's 340B Humira purchases increased from $18 million in 2022 to $50 million in 2025. Another Minnesota hospital's 340B Humira purchases rose from $3.6 million in 2022 to $17 million in 2025—an increase of more than fivefold—even as more biosimilars became available on the market during this period.

Why is this? The 340B hospitals and clinics make more money on Humira than the biosimilars, creating a financial incentive for them to continue to prescribe the more expensive branded drug. As the recent MN transparency report notes, the significant opportunity to generate net 340B revenue from administered drugs and specialty drugs suggests that 340B could be influencing additional areas—such as prescribing patterns, which may affect overall health care spending.

In addition, we believe 340B sales in that report might be severely underreported by covered entities. The report stated in 2024 340B gross revenue from Humira totaled $26.2M. However, our data shows gross revenue of approximately $98M in Minnesota for the same reporting year. There is clearly a need for consistent reporting standards to ensure that we are getting the full picture of the impact of the 340B program on Minnesotans.

Federal Preemption

Before I close, I want to emphasize that, because the 340B program is a federal program governed by federal law, we do not believe it is lawful for individual states to legislate in this area. On February 25, 2026, the United States Department of Justice filed amicus curiae briefs in two separate federal Circuit Courts of Appeals, supporting legal challenges to state 340B contract pharmacy laws in Rhode Island (First Circuit) and Colorado (Tenth Circuit). Both of these state laws closely resemble Minnesota's 340B law. The Executive Branch's decision to submit these amicus curiae briefs sends a clear signal that federal authorities view state efforts in this area as potentially conflicting with the federal 340B framework. Accordingly, the Department of Justice's active support for federal preemption should be a critical consideration

[1] https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2022.00812

for Minnesota with respect to its current 340B law and reinforces the need not to advance legislation to remove the law's sunset provision.

When this law was passed in 2024, the Minnesota legislature wisely put a sunset provision in to allow time to gather information. Over the course of the last two years, as that information has been gathered, we have seen the unsustainable growth of program. AbbVie's own numbers tell a similar story. It is clear that removing the sunset provision from Minnesota's 340B contract pharmacy mandate perpetuates the continued, unsustainable growth of the 340B program.

Thank you for the opportunity to provide this feedback. Please feel free to contact me at emily.gibellina@abbvie.com with any questions.

Sincerely,

Emily Gibellina
Director of State Government Affairs
On behalf of AbbVie Inc.

TO: House Health Finance & Policy Committee
FROM: Community Action for Responsible Hospitals
DATE: Tuesday, March 17, 2026
SUBJECT: Protect Patients & Taxpayers, Don't Open the Door to Abuse – OPPOSE HF 3609

Our organization, representing the interests of workers, patient advocates, healthcare providers, and community groups, urges you to oppose 340B abuse legislation, House File 3609. This bill would allow the expansion of the program to continue indefinitely – beyond the July 2027 expiration date. This unchecked growth in the program would allow big hospitals and their corporate partners to expand their access to 340B savings without requiring critical safeguards to ensure those savings reach patients as intended.

The abuse of the 340B program is not an isolated issue – it's a clear symptom of a broader trend: the corporatization of our healthcare system, where profit comes before patients. This concern is particularly urgent in Minnesota, where public programs are already facing intense scrutiny due to significant waste, fraud, and abuse. Permanently expanding a program with known accountability gaps invites further misuse of public resources and undermines trust in our healthcare system.

Under 340B, hospitals capture steep discounts with the intent that they use the savings to make medications accessible and affordable for low-income and uninsured patients – and reinvest in improving care for the communities they serve. There is extensive evidence, however, that the 340B mission is not being fulfilled in Minnesota, despite collecting significant revenues through the program.

A new report by the Minnesota Department of Health (MDH) found that:

- Minnesota hospitals and clinics generated at least $1.34 billion in net 340B profits in CY 2024, and MDH notes the true total is likely higher.
- 72.4% of 340B profits were concentrated in urban areas, including Minneapolis, St. Paul, Duluth, and nearby suburbs, rather than rural Minnesota as often claimed.
- Taxpayers funded 54.9% of 340B profits through programs such as MinnesotaCare, Medicaid, Medicare, and other public coverage.
- The remaining profits came from higher drug prices paid by commercial insurers, increasing costs for employers and privately insured patients.

Codifying the expansion would lock in this abusive financial structure permanently without legislative oversight and accountability.

National research found similar statistics including our study of disproportionate share hospitals (DSHs) – highlighted in a *Wall Street Journal* editorial – that while DSH revenues skyrocketed after joining the 340B program, there was no evidence of corresponding benefits to patients. The editorial also states that the 340B program incentivizes physicians to prescribe higher-cost medications, driving up prices for Medicare and private insurers, and calls for immediate federal reforms to the program.

In addition, a Congressional Budget Office report revealed that the 340B program is driving up federal and state Medicaid costs, adding strain to an already burdened system.

By removing the sunset provision, the 340B expansion bill would become permanent, further opening the door to weaker accountability and greater abuse funded by patients and taxpayers – all in the name of chasing profits. We strongly urge you to reject HF 3609 and work to uphold Minnesota's vital healthcare system for patients who rely on it.

Thank you for your consideration of this critical matter.

February 25, 2026

Senator Erin Murphy
95 University Ave W
Minnesota Senate Building, Room 3113
St. Paul, MN 55115

Representative Lisa Demuth
Centennial Office Building, 2nd Floor
St. Paul, MN 55115

Dear Majority Leader Murphy and Speaker Demuth:

On behalf of the Pharmaceutical Industry Labor-Management Association (PILMA), a labor-management partnership representing unions and biopharmaceutical companies, we write regarding SF3769/HF3609 and proposed changes affecting Minnesota's oversight of the federal 340B Drug Pricing Program.

While the original intent of the 340B program was to support safety-net providers serving vulnerable patients, the program has expanded significantly with limited transparency or accountability. Evidence shows that expansion of 340B has contributed to higher costs in employer-sponsored coverage, including union Taft-Hartley plans, which have experienced an estimated $1 billion in additional costs due to program distortions.

When large hospital systems and contract pharmacies generate revenue through 340B without clear requirements that savings be passed directly to patients, the burden shifts to working families and the employers who fund their coverage.

We respectfully urge reconsideration of SF3769/HF3609. Further expanding 340B at the state level, while the program continues to grow without meaningful federal oversight or transparency, risks unintended consequences for working men and women across Minnesota. PILMA believes that 340B is a federal program and should be addressed through clear, consistent federal regulation rather than a patchwork of state-level policies.

Thank you for your attention to this important issue.

Sincerely,

AJ Stokes, Executive Director
Pharmaceutical Industry Labor-Management Association (PILMA)

To: **Rep. Jeff Backer, Health Finance & Policy Committee Members**

From: **Kent Kaiser, Ph.D., Domestic Policy Caucus**

Date: **March 18, 2026**

Re: **H.F. 3609**

Thank you, Mr. Chairman, and committee members for allowing us to submit testimony in opposition to House File 3609.

On behalf of the Domestic Policy Caucus, I want to express our strong opposition to the expansion of 340B, the federal law on prescription drugs, which H.F. 3609, would create in Minnesota.

Current 340B legislation has a sunset clause extending to the middle of 2027. There is no need to act on 340B in Minnesota before next year.

Proposing H.F. 3609 at this time is premature. As you know, the Minnesota Department of Health is mandated to provide a report on the 340B program in the state each year. The November 2024 340B report, the first of its kind, provided transparency into the program, revealing high revenue concentrations among large hospitals, which is what the Journal of the American Medical Association has reported is the case across America.

In fact, the Minnesota report found that 13% of hospitals generated 80% of the $630 million+ in net 340B revenue, which represents potential abuse or certainly misuse of the program's intent.

The newest report has only recently been issued to shed more light on potential abuse and fraud in the 340B program in the state, and yet here you are, jumping into making the program permanent in its current form.

At a time when Minnesota is mired in a regime of fraud and abuse, it is not appropriate to push forward with another massive program that lacks transparency and reeks of abuse. If you move forward with H.F. 3609, then you are voting to be part of the problem.

In other states, officials are onto the scandalous way that 340B has been administered. The North Carolina State Treasurer found that 340B hospitals overcharged state employees for cancer drugs and reaped thousands of dollars in profits per claim, enriching themselves at taxpayers' expense rather that serving vulnerable communities like they were supposed to.[1]

The New York Times recently reported on a cancer patient from Santa Fe, New Mexico, whose insurance provider was charged $22,700 for a cancer medicine that cost her hospital only $2,700 through the 340B program. The Times reported that **340B hospital markups**

[1] https://www.nctreasurer.gov/news/press-releases/2024/05/08/state-treasurer-folwell-releases-report-finding-north-carolina-340b-hospitals-overcharged-state

drive billions in profit for hospitals and middlemen in this regime with no guardrails or oversight.

Beyond straight up fraud and abuse, we have other concerns, as well, and we believe you should, too.

H.F. 3609 would create an economic environment in which incentives would be put in place to encourage even more consolidation of healthcare systems, to put healthcare farther out of reach of rural Minnesotans, and to imperil the ability of underserved Minnesotans to receive the medications they need, all while lining the pockets of big healthcare systems and giant chain pharmacies. Meanwhile, it would do nothing to reduce healthcare costs, which is what everyone really wants.

We are very much concerned that an expansion of 340B would hand over even more economic power to massive, national chain pharmacies that have driven so many local, mom-and-pop pharmacies out of business over the past several years.

As you know, pharmacies are essential to the communities they serve. But in Minnesota and throughout America, rural independent drugstores are struggling.

In a 2022 policy brief,[2] the Rural Policy Research Institute reported this troubling fact: The number of independently owned retail pharmacies declined by 16 percent in the United States between 2003 and 2021. According to NPR,[3] that has contributed to the appearance of what are called "pharmacy deserts"—areas where residents must drive more than 15 minutes to a drugstore.

GoodRx has produced a map[4] of the nation's pharmacy deserts showing that hundreds of thousands of rural and suburban Minnesotans have inadequate access to a drug store—in fact, only Ramsey County has no pharmacy desert, and in more than two dozen Minnesota counties, 100% of the residents live more than 15 minutes from the three closest pharmacies. This includes Traverse, Grant, Pope, Meeker, Rock, Lincoln, Renville, and Lake Counties.

According to the Minneapolis Star Tribune,[5] over the last decade, Minnesota has lost more independent drug stores than any other state. H.F. 3609 would exacerbate the problem. In 2023 alone,[6] 24 pharmacies closed in Minnesota, according to the Minnesota Pharmacists Association: 6 were part of national chains, 1 was in the Thrifty White regional chain, and 17 were independents. So, at the end of 2023, there were only 126 independent pharmacies left in the state.[7]

Disparities in access to care and health outcomes for rural, underserved, and minority populations have long been significant issues. Any policy that could further restrict the

[2] https://rupri.public-health.uiowa.edu/publications/policybriefs/2022/Independent%20Pharmacy%20Closures.pdf
[3] https://www.kmuw.org/the-range/2024-02-02/independent-pharmacies-struggle-to-stay-open
[4] https://www.goodrx.com/healthcare-access/research/healthcare-deserts-80-percent-of-country-lacks-adequate-healthcare-access
[5] https://www.startribune.com/minnesota-is-losing-independent-pharmacies-victims-scale-and-efficiency-drugstore-consolidation-pbms/600324746/
[6] https://www.startribune.com/minnesota-is-losing-independent-pharmacies-victims-scale-and-efficiency-drugstore-consolidation-pbms/600324746/
[7] https://www.startribune.com/minnesota-is-losing-independent-pharmacies-victims-scale-and-efficiency-drugstore-consolidation-pbms/600324746/

availability of medicines to these populations—or force them to travel farther to obtain them—needs to take the issue of health equity into consideration.

340B was meant to help low-income people afford their medicines.

Think about this: The 340B program has been in place for over 30 years. So, just ask your constituents if they think they are enjoying more affordable medicines today than they did 25 or 30 years ago, or do they think that financial benefits meant to help them pay for their prescriptions, their copays, and the coinsurance are being funneled into something else. Ask your constituents if they have easier access to a drugstore, closer to home, or if they have to drive farther to get to a drugstore now than they did 25 years ago. Ask your constituents if the care and service they receive from their drugstore is more personal today than it was 25 or 30 years ago, or if the pharmacy seems more impersonal and corporate. If you receive generally negative answers to these questions—as I'm sure you will—then you know that the 340B program needs reform before it is cemented into operating like it currently does.

The sunset provision in the current law is an opportunity. Just like sunsets in nature give you the opportunity to reflect on the day and look forward to a better day tomorrow, a sunset provision like the one in the current law regarding 340B gives you the opportunity to look reflect on how the law has worked and where it needs reform and to make changes before the sunset comes in the summer of 2027 so that 340B serves Minnesotans in the best way possible.

In the meantime, please oppose H.F. 3609.