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Coalition of State Rheumatology Organizations

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July 30, 2026

Massachusetts House of Representatives
State House
Boston, MA 02108

Concerns re: Amendment 63 to S3141 – Federal 340B Drug Pricing Program

Speaker Mariano, Chair Michlewitz, Chair Lawn, and Ranking Minority Member Smola:

The Coalition of State Rheumatology Organizations (CSRO) would like to express **concerns regarding Amendment 63 to S3141**. This amendment would allow for greater expansion of the 340B program in Massachusetts without greater accountability and transparency. 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.

Amendment 63 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

Amendment 63 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 Massachusetts, 22% 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 Amendment 63 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 Amendment 63 could lead to greater healthcare consolidation throughout the state, jeopardizing the viability of Massachusetts-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 Massachusetts, we request that you **do not adopt Amendment 63 to S3141.** We thank you for your consideration and are happy to further detail our comments upon request.

Respectfully,

Aaron Broadwell, MD, FACR
President
Board of Directors

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