November 1, 2023

The Honorable Mike Johnson
The Speaker of the House of Representatives
United States Capitol
Washington, DC 20515

Dear Speaker Johnson,

As you assume the mantle of leadership of the House, we wanted to bring to your attention the unique opportunity you have to work in a bipartisan manner with Minority Leader Hakeem Jeffries and follow the lead of a group of six U.S. Senators John Thune (R-S.D.), Debbie Stabenow (D-Mich.), Shelley Moore Capito (R-W.Va.), Tammy Baldwin (D-Wis.), Jerry Moran (R-Kan.), and Ben Cardin (D-Md.), who formed a bipartisan working group to ensure the 340B program can continue to achieve its original intent of supporting entities serving eligible patients.

Earlier this month, Senate HELP Committee Chairman Bernie Sanders (D-Vt.) released a report in which the senator called into question many of the practices we see today in the non-profit hospital industry. Related to their future tax-exempt status, the report observes that non-profit hospitals could play a significant role in delivering necessary care to Americans while also satisfying their charity care obligations. Instead, we often learn that some of these hospitals are not directing these discounts to their patients.

The 340B program began in the early 1990s when Congress wanted to require pharmaceutical manufacturers to donate low or no-cost prescription drugs to charitable hospitals as a condition of benefiting from government programs. These hospitals, overwhelmingly located in underserved urban and rural communities with patients of all races and ethnicities, were, in turn, expected to use these discount-price medicines to serve patients who otherwise could not afford these drugs.

For a while, the program worked as intended. The average discount on a 340B drug is nearly 60%, and for many drugs, it's much more than that. But a few bad actors have put profits over people over time, exacerbating health inequities.

The definition of a "charitable hospital" was never well-defined in law, and today, 57% of all hospitals participate in the drug discount program. They are happy to accept the cheaper medicines, but where do they end up? Out of the nearly 13,000 hospitals and community pharmacies participating in the 340B program today, six in ten are in middle-class and affluent areas, not the poorer zip codes the program is meant to serve.

How is this possible? How has a program Congress created to get PhRMA to provide affordable drugs to charitable hospitals become an area of concern? The answer is that a well-intended program does not have the proper federal oversight or community-based organizations in collaboration. There are few requirements for hospitals to use the cost savings from 340B to help underserved patients, and there are not enough community-based organizations partnering with the hospitals to help let patients know they are eligible for these drugs.

In addition, stand-alone hospitals are now the exception compared to the rule of a broad hospital network with facilities in diverse income areas. A hospital or clinic that qualifies for the discounted drugs in this program might be one of dozens of healthcare centers in a network conglomerate. As a result, drug price reductions are eagerly gobbled up, and the drugs are fed into the larger system. In short, medicines intended for vulnerable urban and rural areas are sometimes re-routed and sold at full price to insured patients in more affluent areas. That's the definition of health inequity.

This problem is not a mere theoretical concern. Last year, the New York Times broke a story that Bon Secours, a hospital network in the Richmond, VA area, was accepting 340B discount drugs at Richmond Community Hospital, not telling local patients they were eligible for these free-to-inexpensive medicines, and selling the drugs for full price to patients in more affluent hospitals in their network. This led Richmond mayor Levar Stoney to send a letter to Bon Secours, charging them with using "loopholes [to increase] profit margins for the hospital system while they have reduced services in one of our predominantly Black communities."

Notably, Mayor Stoney also called on the Biden Administration to increase oversight of the 340B program: "I request for your administration to urgently investigate the effectiveness and unintended consequences of 340B--not only regarding Bon Secours in the City of Richmond but in other localities across the country."

Stories like this exist in communities across the country–Bon Secours was unlucky enough to get caught with their hand in the cookie jar by the New York Times and to be called out by Mayor Stoney. But the fact is the hospital lobbyists have cowed Congressional and Administration oversight officials from both political parties for decades. Every Congressman has a hospital in their district, ready to send lobbyists in to urge a hands-off approach to the 340B program.

The many problems in the 340B program have attracted the attention of prominent civil rights leaders. The Southern Christian Leadership Global Policy Initiative I founded recently sent a letter to a bipartisan group of senators urging greater 340B Congressional oversight. We also hosted a webinar with Congressman Jonathan Jackson (D-Ill.) and Virginia Delegate Kathy Tran, a leader in pursuing the Bon Secours scandal locally. This builds off of attention to the issue first brought by the Rev. Al Sharpton and an Op-ed recently published by Ben Chavis.

The executive branch runs the 340B program out of the Health Resources and Services Administration, a Department of Health and Human Services branch. HRSA, as it's known, determines what entities the program covers, and they have been very generous over the years. According to the Government Accountability Office, the number of hospitals and clinics HRSA has approved has increased from fewer than 10,000 in 2010 to nearly 13,000 today–an increase of 30 percent in a little over a decade.

And while HRSA is supposed to collect information and conduct audits on 340B covered entities, they simply don't have the human resources to do so. The small number of questions they raise are answered and accepted because no real oversight is possible. There are only staff resources to facilitate drug discounts to hospitals.

What's urgently needed is a combination of Congressional hearings and a more inquisitorial HRSA. Until that happens, low-income patients across America will be the excuse giant hospital chains use to get drugs on the cheap and sell them at full price to more affluent patients. Take away the shell game, and it's reduced to what it is: stealing from the poor.

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