

September 22, 2026

The Honorable Paul Utke
President
The Honorable Tom Oliverson, M.D.
Chair, Joint State-Federal Relations & International Insurance Issues Committee
National Council of Insurance Legislators
616 Fifth Ave., Suite 106
Belmar, N.J. 07719

Re: Strengthening Transparency in the 340B Drug Pricing Program Model Act

Dear Sen. Utke, Rep. Oliverson and Members of NCOIL:

On behalf of our more than 2,000 member hospitals and health systems that participate in the 340B Drug Pricing Program, the American Hospital Association (AHA) appreciates the opportunity to comment on the National Council of Insurance Legislators' (NCOIL's) model legislation on the 340B program. We recognize NCOIL's interest in 340B is part of your broader work to promote accountability and transparency within the healthcare system. The AHA and 340B hospitals share those goals and are committed to being responsible stewards of the 340B program.

While we appreciate the intent behind the model legislation, we are concerned that the proposal will not achieve its intended aims but instead add substantial administrative burden on the healthcare system — burden that translates into added costs at a time when many states are looking for ways to improve healthcare affordability. We encourage members of NCOIL not to move forward with this proposal.

The 340B program is a lifeline for vulnerable communities across the country. Congress designed the program to ensure that high and rising drug prices would not impede the efforts of providers serving these communities to ensure access to comprehensive, high-quality care. Unfortunately, the challenges of managing high drug prices have only grown more acute, making the 340B program more critical than ever.

This draft model legislation will further strain providers' ability to meet their obligations under the program. Specifically, the excess burden of additional reporting will add



considerable costs for 340B entities, diverting funds that otherwise could be spent on patient care, and it does so while failing to capture vital information about the full scope of the program, such as pharmaceutical company pricing decisions and their role in directly driving growth of the program. Moreover, the draft model legislation does not include any meaningful information that would be necessary to fully understand the impact of the program, such as information on patient care, access to services, or community benefit supported through 340B savings. Finally, the draft appears to be premised on misconceptions about the operation of the 340B program and overlooks the extensive oversight and accountability mechanisms that already exist under federal law. We provide additional details on these concerns below.

The Model Legislation's Requirements Would Result In Misleading Data. The model legislation would create an administrative framework unlikely to produce reliable or meaningful information. Unlike a dedicated funding stream, the 340B program works by lowering a hospital's cost structure, and thus the savings are embedded within the broader operations of the hospital or health system, enabling these facilities to provide care across multiple service lines and patient populations. Moreover, each 340B hospital uses these cost savings in different ways to address the unique needs of the entire population it serves. Attempting to attribute specific expenses, services or outcomes directly to individual 340B discounts risks generating arbitrary and inconsistent reporting that may mislead policymakers rather than inform them. For example, data on charity care or other community benefits often reflects the combined effect of numerous funding sources and operational decisions rather than any single mechanism. Requiring hospitals to isolate and assign these activities specifically to the 340B program would necessitate subjective assumptions and complex cost-allocation methodologies that vary widely across providers. As a result, the reported data would likely be inconsistent, difficult to compare across institutions, and of limited value for evaluating how the 340B program supports patient access to care and community health needs.

Pharmaceutical Company Transparency Is Not Addressed Here or Elsewhere. We also are concerned that the proposal focuses exclusively on hospitals while failing to examine other factors affecting prescription drug affordability and patient access. **The most significant driver of prescription drug spending remains the continually rising prices of pharmaceuticals.** Any discussion of 340B program transparency should include manufacturers, pharmacy benefit managers (PBMs), insurers and other entities that play a significant role in determining drug costs and the scope of the 340B program. NCOIL's prior model legislation on transparency for pharmaceutical manufacturers and PBMs does not address the role of these stakeholders within the 340B program. Requiring extensive reporting from 340B safety-net hospitals without similar transparency expectations for other stakeholders creates an incomplete and potentially distorted picture of the 340B program.

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The Added Reporting Costs Would Ultimately Be Borne by Patients. Additionally, the proposal could force 340B hospitals to divert resources away from patient care by imposing costly compliance obligations on hospitals already facing extraordinary financial pressures. Many hospitals, particularly rural hospitals, critical access hospitals and other safety-net providers, continue to face workforce shortages, inflationary pressures and inadequate reimbursement from public programs. New state reporting mandates would require investments in personnel, technology and compliance infrastructure, reducing resources available for direct patient services and community health programs.

The AHA believes that any 340B transparency initiative should recognize the existing federal oversight structure, acknowledge the broad range of ways hospitals legitimately use 340B savings to support patient care, and ensure that reporting requirements yield information that is accurate, useful and meaningful for policymakers and the public. We believe this model legislation does not meet these goals and therefore urge you not to move forward with this proposal.

The AHA and 340B hospitals remain committed to working with NCOIL on this important issue and sharing the vital role the 340B program plays in supporting access to care in communities across the country.

Sincerely,

/s/

Molly Smith
Group Vice President, Public Policy

CC: Will Melofchik, Chief Executive Officer, NCOIL