Senate Fiscal Agency
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BILL ANALYSIS

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Senate Bills 94 and 95 (as passed by the Senate)
Sponsor: Senator Sam Singh (S.B. 94)
Senator Jonathan Lindsey (S.B. 95)
Committee: Oversight

Date Completed: 5-30-25

RATIONALE

The Federal 340B Drug Pricing Program requires manufacturers that participate in Medicaid to sell certain drugs at reduced prices. According to testimony before the Senate Committee on Oversight, by purchasing drugs at reduced prices the State's 87 participating hospitals can then allocate their savings to other areas such as patient transportation and community-based care; but reportedly fewer pharmacies can contract with hospitals, leading to a decrease in the Program's benefits. Some believe that prohibiting drug manufacturers or wholesalers from limiting access to 340B Program entities would enable the Program to continue helping Medicaid users. Additionally, some believe it necessary to increase transparency in hospital operations to ensure proper use of the Program and to address rising healthcare costs.

CONTENT

Senate Bill 94 would amend the Public Health Code to do the following:

- **Prohibit a drug manufacturer, wholesaler, or wholesale distributor-broker from limiting a 340B Program entity's access to drugs covered under the Federal 340B Program.**
- **Beginning July 1, 2026, require each 340B entity to annually submit a report concerning the entity's licensing information and compliance with the 340B program to the Department of Licensing and Regulatory Affairs (LARA).**
- **Beginning July 1, 2026, require each drug manufacturer to annually report certain information on prescription drugs that exceeded $40 for the cost of one course of treatment and that had a cost increase of over 15% in the last year.**

Senate Bill 95 would enact the "Hospital Price Transparency Act" to prohibit hospitals from attempting to collect debts when not in compliance with specified price transparency laws.

The bills are tie-barred.

Senate Bill 94

340B Program Coverage

The Federal 340B Drug Pricing Program requires manufacturers that participate in Medicaid to sell certain drugs at reduced prices. Under the bill, "340B drug" would mean a covered outpatient drug eligible for reduced pricing under the Federal 340B Drug Pricing Program. "340B entity" would mean an entity authorized by the Federal 340B Drug Pricing Program as provided in Federal law, such as a federally qualified health center.

The bill would prohibit a manufacturer, wholesaler, or wholesale distributor-broker from doing any of the following:

-- Denying, restricting, prohibiting, conditioning, discriminating against, or otherwise limiting the acquisition of a 340B drug by a 340B entity.
-- Denying, restricting, prohibiting, conditioning, discriminating against, or otherwise limiting the acquisition of a 340B drug by, or the delivery of a 340B drug to, a pharmacy that was under contract with or otherwise authorized by a 340B entity to receive a 340B drug on behalf of the 340B entity.
-- Designating a person to act on behalf of the manufacturer, wholesaler, or wholesale distributor-broker to engage in the prohibited conduct above.

The bill would allow a manufacturer, wholesaler, or wholesale distributor-broker to engage in the conduct prohibited under the bill if otherwise authorized by State or Federal law.

Reporting Requirements

Beginning July 1, 2026, and each following July 1, a 340B entity would have to submit a report to LARA and to the House and Senate Fiscal Agencies that included all the following in a form and manner required by LARA:

-- The name of the 340B entity submitting the report.
-- A copy of the entity's annual 340B program recertification.
-- A copy of the entity's community health needs assessment if the assessment were required under Federal Law.
-- An affidavit affirming that the entity complied with certain Federal law that prohibits duplicate discounts for a 340B price and a Medicaid drug rebate.
-- An affidavit affirming that the entity complied with 340B Program audits.
-- A description of any adverse 340B Program audits within the preceding 12 months.
-- A description of the impact of the 340B Program on the patients and community served by the entity.

Also, beginning July 1, 2026, and each following July 1, a manufacturer would have to submit a report to LARA and the House and Senate Fiscal Agencies on any prescription drug that exceeded $40 for the cost of one course of treatment and that had more than a 15% increase in its wholesale acquisition cost during the preceding 12 months. The report would have to be in a form and manner required by LARA and would have to include all the following:

-- The name of the manufacturer submitting the report.
-- The name of the prescription drug included in the report.
-- Whether the prescription drug had a brand name or generic name, whether the drug was a biological drug product or interchangeable biological drug product, and any variation of the name of the drug.
-- The wholesale acquisition cost of the drug and the schedule of wholesale acquisition cost increases for the preceding five years.
-- The year the prescription drug was introduced to the market.
-- The wholesale acquisition cost of the prescription drug at the time the drug was introduced to the market.
-- The cost of producing one course of treatment of the drug, including whether or when the drug needed compounding immediately before dispensing.
-- The expiration date of the patent for the prescription drug.
-- Each form of the drug dispensed, including by oral pill, tablet, capsule, suppository, liquid, tincture, topical cream or ointment, or topical patch or other wearable, or by intravenous, port, peripherally inserted central catheter, or other method.

The bill would require LARA to post the reports described above on its publicly accessible website.

Senate Bill 95

Definitions

"Collection action" would mean any of the following actions taken with respect to a debt for items and services that were purchased from, or provided to a patient by, a hospital on a date during which the hospital was not in material compliance with hospital price transparency laws:

-- An attempt to collect a debt from a patient or patient guarantor by referring the debt, directly or indirectly, to a debt collector, a collection agency, or another third party retained by or on behalf of the hospital.
-- Suing the patient or patient guarantor or enforcing an arbitration or mediation clause in any hospital documents, including contracts, agreements, statements, or bills.
-- Directly or indirectly having a report made to a consumer reporting agency.

"Collection agency" would mean a person that does any of the following:

-- Engages in a business, the principal purpose of which is the collection of debts.
-- Regularly collects or attempts to collect, directly or indirectly, debts owed or due or asserted to be owed or due to another.
-- Takes assignment of debts for collection purposes.
-- Directly or indirectly solicits for the collection of debts owed or due or asserted to be owed or due to another.

The term would not include any of the following:

-- An officer or employee of a creditor while, in the name of the creditor, the officer or employee was collecting debts for the creditor.
-- A person while acting as a collection agency for another person, both of whom were related by common ownership or affiliated by corporate control, if the person acting as a collection agency did so only for creditors to whom it was so related or affiliated and if the principal business of the person were not the collection of debts.
-- An officer or employee of the U.S. or any state to the extent that collecting or attempting to collect a debt was in the performance of the officer's or employee's official duties.
-- A person while serving or attempting to serve legal process on another person in connection with the judicial enforcement of a debt.
-- A person licensed to provide debt management services under the Debt Management Act.
-- A person whose principal business was the making of loans or the servicing of debt not in default and that acted as a loan correspondent, seller and servicer for the owner, or holder of a debt that was secured by a deed of trust on real property, regardless of whether the debt was also secured by an interest in personal property.

A person that was collecting or attempting to collect a debt owed or due or asserted to be owed or due to another person would be considered a "collection agency" to the extent that any of the following applied:

-- The activity was incidental to a bona fide fiduciary obligation or a bona fide escrow arrangement.
-- The activity concerned a debt that was extended by the person attempting to collect the debt.

-- The activity concerned a debt that was not in default at the time it was obtained by the person attempting to collect the debt.
-- The activity concerned a debt obtained by the person attempting to collect the debt as a secured party in a commercial credit transaction involving the creditor.

A licensee under any of the following acts would not be considered a collection agency:

-- The Horse Racing Law.
-- The Lottery Act.
-- The Bingo Act.
-- The Michigan Gaming Control and Revenue Act.
-- The Lawful Sports Betting Act.
-- The Fantasy Contests Consumer Protection Act.
-- The Lawful Internet Gaming Act.

The term also would include a person that, in the process of collecting the person's own debts, used another name that would indicate that a third person was collecting or attempting to collect the debts.

"Consumer reporting agency" would mean a person that, for monetary fees or dues or on a cooperative nonprofit basis, regularly engages, in whole or in part, in the practice of assembling or evaluating consumer credit information or other information on consumers for the purpose of furnishing consumer reports to third parties.

"Debt" would mean an obligation or alleged obligation of a consumer to pay money arising out of a transaction, regardless of whether the obligation has been reduced to judgment. The term would not include a debt for business, investment, commercial, or agricultural purposes or a debt incurred by a person engaged in business.

"Debt collector" would mean any person employed or engaged by a collection agency to perform the collection of debts owed or due or asserted to be owed or due to another person.

"Hospital" would mean, consistent with 45 Code of Federal Regulations 180.20 (Hospital Price Transparency), a hospital licensed under the Public Health Code.

"Hospital price transparency laws" would mean 42 U.S. Code 300gg-18(e) (Public Health and Welfare) and regulations adopted by the U.S. Department of Health and Human Services implementing 42 U.S. Code 300gg-18(e).

Adherence to Hospital Price Transparency Laws

After the bill's effective date, a hospital that was not in material compliance with hospital price transparency laws on the date that items and services were purchased from or provided to a patient could not initiate or pursue a collection action against the patient or patient guarantor for a debt owed for the items and services. The bill would apply to critical access hospitals licensed and certified by LARA under Federal rules six months after its effective date.

If a patient had evidence that a hospital was not in material compliance with hospital price transparency laws on a date after the bill's effective date and that items and services were purchased by or provided to the patient on that date, and if the hospital took a collection action against the patient or patient guarantor regarding the items and services, the patient or patient guarantor could file a civil action to determine if the hospital were materially out of compliance with hospital price transparency laws in effect on the date of service and if the

noncompliance were related to the items and services. The hospital could not take collective action against the patient or patient guarantor while the civil action was pending.

If the judge or a jury in a civil action under the bill, considering compliance standards issued by the Centers for Medicare and Medicaid Services, determined that a hospital was materially out of compliance with hospital price transparency laws, the hospital would have to do all the following:

-- Refund the payer any amount of the debt the payer had paid and pay a penalty to the patient or patient guarantor an amount equal to the total amount of the debt.
-- Dismiss or move to dismiss with prejudice any court action based on the debt and pay any attorney fees and costs incurred by the patient or patient guarantor relating to the action.
-- Remove or have removed from the patient's or patient guarantor's credit record any report made to a consumer reporting agency relating to the debt.

The Act would not prohibit a hospital from billing a patient, patient guarantor, or third-party payer, including a health insurer, for items and services provided to the patient. The Act would not require a hospital to refund any payment made to the hospital for items and services provided to the patient, if no collection action were taken in violation of the Act.

Proposed MCL 333.17757c (S.B. 94)

PREVIOUS LEGISLATION

(This section does not provide a comprehensive account of previous legislative efforts on this subject matter.)

Senate Bills 94 and 95 are reintroductions of Senate Bills 1197 and 952, respectively, of the 2023-2024 Legislative Session. Each bill passed the Senate and was referred to the House Committee on Government Operations but received no further action.

ARGUMENTS

(Please note: The arguments contained in this analysis originate from sources outside the Senate Fiscal Agency. The Senate Fiscal Agency neither supports nor opposes legislation.)

Supporting Argument

A loss in revenue from limiting contract pharmacy relationships is preventing hospitals from funding needed programs that aid patients. According to testimony before the Senate Committee on Oversight, contract losses due to pharmacy restrictions for one hospital system were $41.0 million in 2024. Hospitals may use those lost funds to reduce the price of pharmaceutical drugs, cover copays for cancer care, provide free transportation for patients, and fund community health workers and care management coordinators. Without the revenue gained by unlimited contract pharmacy relationships, these beneficial community services will continue being cut. To preserve access to these beneficial services, the bill should be passed.

Supporting Argument

Senate Bill 95 would increase price transparency in healthcare. Increased price transparency is necessary because Americans and Michigan residents have experienced declining health outcomes for decades despite paying more for healthcare. According to testimony, the average life expectancy in the United States has gone down six years compared to other Organization for Economic Cooperation and Development nations over the last 50 years, while US health expenditures as a share of gross domestic product have seen a 500% increase when compared to the same countries. Testimony further indicates that only a small fraction of 340B-covered entities fully comply with 340B standards. Entities benefitting from the 340B program should comply with healthcare transparency requirements to reduce negative health outcomes.

Opposing Argument

The 340B Drug Pricing Program does not receive adequate oversight to align the program with its intended purpose, connecting poor and medically vulnerable patients with prescription drugs at a reduced price. Further relying on the Program to improve prescription drug affordability would widen the gap between its intended purpose and its practical result. For example, testimony before the Senate Committee on Oversight indicates that hospitals, private equity firms, and large chain pharmacies generally profit off of the 340B Program without translating those cost-savings into lower prices for patients. A study published in the New England Journal of Medicine concluded that hospitals eligible for 340B discounts marked up prices for 340B-eligible drugs by 659% when compared to independent physician practices; this markup was higher than the control group of hospitals ineligible for 340B discounts at 434% when compared to independent physician practices.[1] Additionally, this study found that hospitals eligible for 340B discounts retained 64.3% of insurer drug expenditures while hospitals ineligible for 340B discounts retained 44.8% and independent physician practices retained 19.1%.[2] There is also evidence to conclude that hospitals eligible for 340B discounts are less charitable than hospitals ineligible for 340B discounts. The top quintile of 340B hospitals based on operating margins earn $9.92 in profit for every dollar they spend on charity care compared to $7.51 for the top quintile of non-340B hospitals.[3] Hospitals eligible for 340B discounts, on average, impose larger price markups, retain a larger share of insurer spending, and spend less on charitable care than hospitals ineligible for 340B discounts and independent physician practices.

Testimony also indicates that the additional revenue received by 340B-eligible hospitals allows them to maintain a cash flow advantage over physician practices and outpatient clinics. According to testimony, this has led to 340B-eligible outpatient clinics connected to larger, parent hospitals outcompeting smaller, independent clinics, eventually forcing them to consolidate. The cash flow advantage gained by 340B eligible hospitals also has a direct effect on hospital consolidation. Between 2016 to 2022, large hospitals eligible for 340B discounts were responsible for 81.6% of hospital acquisitions while hospitals ineligible for 340B discounts comprised 71.2% of hospitals that were purchased.[4]

Finally, 75% of all contract pharmacy relationships with 340B covered entities are through five large chain pharmacies: CVS Health, Walgreens, Cigna (via Express Scripts), United Health (via OptumRx), and Walmart. In 2023, these contract pharmacy operators made nearly $3.0 billion in profit from these contracts.[5] This consolidated coverage may affect service to those who the Program is supposed to support. From 2006 to 2019, the percentage of 340B-eligible pharmacies in America's lowest income neighborhoods declined by 5.6% while the percentage of the same pharmacies increased in America's highest income neighborhoods by 5%.[6] The 340B Program's intentions are not being met, and the bill's continuing to rely upon its provisions without improving its oversight could continue to worsen the gap between intentions and results.

Legislative Analyst: Eleni Lionas

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[1] Robinson, J., PhD, et al., "Hospital Prices for Physician-Administered Drugs for Patients with Private Insurance", *The New England Journal of Medicine*, January 2024.
[2] *Id*.
[3] Masia, Neal, PhD, "Comparing the Financial Health and Charitable Care of 340B and Non-340B Hospitals", *Health Capital Group*, 2023.
[4] Sullivan, M., et al., "Characteristics of Hospitals Undergoing Mergers and Acquisitions", Avalere Health, February 2023.
[5] *Id*.
[6] Lin, John, "Assessment of US Pharmacies Contracted With Health Care Institutions Under the 340B Drug Pricing Program by Neighborhood Socioeconomic Characteristics", *JAMA Network*, June 2022.

FISCAL IMPACT

The bills would have no fiscal impact on State or local government.

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This analysis was prepared by nonpartisan Senate staff for use by the Senate in its deliberations and does not constitute an official statement of legislative intent.