Testimony on HB 2385

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Thank you for the opportunity to provide my views on HB 2385. I do not represent any interest group but have spent several years studying the economic and clinical implications of the 340B Drug Pricing Program. As I understand it, HB 2385 would prohibit drug manufacturers from requiring utilization review data from contract pharmacies participating in the 340B program. Unfortunately, this bill would hinder transparency in a program plagued by opacity.

Data Insights: The State of Oregon's 340B Landscape

The following data highlights the current state of Oregon's 340B program, gathered from the Pioneer Institute, HRSA, RAND Institute, and the U.S. Census Bureau (source). This data underscores the financial dynamics of the program and the potential for misuse.

- **8 of Oregon's top 10 contract pharmacies** participating in 340B are **for-profit chain drug stores, pharmacies owned by Pharmacy Benefit Managers (PBMs), or pharmacies affiliated with health plans.** This structural dynamic suggests that the bill would disproportionately benefit large, for-profit corporations rather than community pharmacies.
- Of Oregon's 421 unique contract pharmacies, only **56 are independent pharmacies** (13%). The 56 independent pharmacies account for just **12% of the total 340B contracts** in the state (184 of 1,520 contracts). Nationally, independent pharmacies represent **35% of the pharmacy market** (National Community Pharmacy Association).
- Moreover, **45% of the contract pharmacies affiliated with the largest 340B hospital in Oregon (Oregon Health Sciences University) are out-of-state**, extending as far as **Texas, Florida, and Hawaii.** This indicates that revenue generated by the 340B program is often diverted outside the local economy.

- **Only 51% of in-state contract pharmacies** affiliated with 340B hospitals are located in **low-income legislative districts**, diminishing the program's intended impact.

FTC interim report in 2024 found that vertically integrated Pharmacy Benefit Managers (PBMs) are significantly contributing to the decline of independent pharmacies. PBMs and chain drug stores affiliated with PBMs favor their own pharmacies, making it difficult for independent pharmacies to compete and potentially forcing them out of business.

This is the same pattern observed in the decline of community oncology practices. The 340B program creates a widening revenue disparity between non-eligible and eligible hospitals and affiliated oncology practices in the profits they are able to gain through the program. This revenue disparity is one of the primary causes of hospitals' acquisition of community oncology practices.

Declining Charity Care Despite Growing 340B Revenue

Data from the **RAND Institute** demonstrates that charity care provided by 340B hospitals in Oregon is decreasing despite the growing scale of the program:

- **National charity care in 2022:** 2.15%
- **Oregon statewide charity care:** 1.86%
- **Oregon Health Sciences University (OHSU):** 1.52%
- **Pioneer Memorial Hospital:** 5.19%

This trend is alarming, as the 340B program was originally intended to expand care for underserved populations. Instead, hospitals appear to capitalize on the program without reinvesting proportionally in charity care.

Outsized Revenue from Contract Pharmacies

The Minnesota Legislative Report revealed that **16% of total revenue** received by 340B hospitals flows directly to contract pharmacies and third-party vendors, far removed from patient care. One troubling data point from Minnesota - oxycodone was identified as the most frequently filled prescription drug where 340B discounts were applied.

The Urgent Need for Transparency

The 340B program requires more transparency, not less. In fact, through transparency, pharmacies, and institutions that do right by patients will be rewarded. The prohibition of biopharmaceutical companies from determining whether a drug was dispensed for an

eligible 340B patient through contract pharmacies creates an environment for further opacity and potential for abuse.

Further, federal law explicitly prohibits "duplicate discounts," where manufacturers must give both a steep 340B discount to hospitals and substantial rebates to State Medicaid programs for the same dispensed drug for the same patient. That's why biopharmaceutical companies need the information to ensure compliance with federal law. The General Accountability Office (GAO) has already voiced that the potential for noncompliance is a reality.

It is also essential to note that HRSA requires enforcement of compliance related to program eligibility, duplicate discounts, and diversion. Explicitly focusing on diversion, HRSA states that diversion occurs when a 340B drug is dispensed or administered to an ineligible patient who does not meet HRSA's definition of a "340B patient."

Policy Recommendations

Given the evidence, it is clear that **HB 2385 would diminish transparency and enable continued corporate profiteering** from a program designed to benefit vulnerable patients. Instead, I recommend the following:

1. **Implement Transparency Requirements**: Follow Minnesota's example and require all 340B hospitals and contract pharmacies to publicly report revenue gained through 340B and how much is spent on direct patient care. This ensures policymakers can monitor if patient benefit aligns with program intent.
2. **Prohibit Corporate Enrichment**: Restrict 340B contracts for PBM-owned pharmacies, including retail chain drug stores or pharmacies affiliated with health plans. This will ensure that you do not advocate for corporate welfare that drives revenue toward profitable for-profit companies.

Closing Statement

The 340B program holds the potential to provide substantial community benefit, but only if administered with transparency and accountability. Allowing for-profit corporations to extract vast sums of revenue under the protection of the 340B program without oversight fundamentally contradicts the program's mission. I urge the committee to reject HB 2385 and instead advance policies that protect Oregon patients, small independent pharmacies, and vulnerable communities.

Thank you for considering my testimony.