National Alliance of Healthcare Purchaser Coalitions
Driving Health, Equity and Value

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March 11, 2025
Re: HB 2385, Relating to restrictions on 340B covered entities; prescribing an effective date.

Dear Members of the Oregon State Legislature,

Thank you for the opportunity to submit testimony on behalf of the National Alliance of Healthcare Purchaser Coalitions (National Alliance) regarding HB 2385 and the proposed reforms to the 340B Drug Pricing Program. This testimony is intended for inclusion in the official record of the hearing on HB 2385.

The National Alliance is a distinctive nonprofit organization led by healthcare purchasers, exerting both national and regional influence. We represent more than 40 regional and local employer/purchaser coalitions. Collectively, these groups provide healthcare coverage to over 40 million Americans, influencing over $400 billion in annual healthcare expenditures in the commercial market.

As an advocate for employers and purchasers across the country, we at the National Alliance believe in the critical mission of the 340B Drug Pricing Program to increase access to more affordable medications for low-income patients and communities. We strongly support Congress' original intent when it established the program in 1992 and recognize its importance today for the numerous health centers and core safety-net hospitals that serve as responsible stewards of program funds. These institutions use these resources to expand care and services, not just in specific states like Oregon, but across the nation, benefiting a broad spectrum of Americans in need.

The 340B program, thanks to minimal guardrails and a low threshold for program qualification that has not changed in over 30 years, has gone well past that intent. Today, 340B operates as a government-sanctioned arbitrage scheme, rather than the support for patients it was intended to be, and many corporate health systems exploit this loophole. As a representative for employers, purchasers, we are worried that 340B and its distortive effects on the market are driving up costs for business leaders and working families across the state. We urge the legislature today to carefully consider 340B's impact on employers and working families before advancing any reforms, and to avoid codifying elements of the program that may have far-reaching negative effects for working families.

Background

At its core, 340B allows health systems that qualify for the program to "buy low and sell high" on prescription medicines. They can purchase drugs at a steep discount, mark them up as much as eight times, and charge working families and their health plans full list prices – pocketing the proceeds with no requirements that they are used to benefit low-income or uninsured patients.

Originally, this applied to fewer than 100 core safety net hospitals and smaller, specialized clinics serving specific vulnerable populations like those with HIV/AIDS and hemophilia. However, over the past three decades, the program has grown exponentially. This is partially a result of policy changes, such as the federal government's whole-cloth creation of a rule in 2010, without Congressional agreement, to allow hospitals to work with an unlimited number of external pharmacies.

It also reflects shifts in the nation's healthcare landscape more broadly, such as the expansion of Medicaid in states like Oregon. Since 2010, Medicaid has expanded dramatically, but the threshold for hospitals to qualify for 340B hasn't changed – even though that threshold is based in part on the number of Medicaid patients they serve.

Over time, hospital systems, including those in Oregon, have recognized the boost that 340B can provide to their bottom lines and capitalized on it. From its humble origins in 1992, the program has grown to become the second-largest federal drug program today, surpassed only by Medicare Part D. 340B purchases at the discounted price were nearly $54 billion in 2022 alone[1] – and the discounts ranged from 30-50% off wholesale or "list" prices, and sometimes can be low as one penny.[2]

In Oregon, substantial participation is evident with 50 hospitals involved in the 340B program[3], with health systems like Oregon Science Center as chief beneficiary accounting for 176 contracts, 44% with out-of-state pharmacies.[4]

340B contributes to cost increases for employers and working families

At its current size, employers in Oregon and across the country worry that 340B is in many cases falling short of its original mission. In fact, a growing body of evidence shows that it is contributing to the rising cost of healthcare that continues to cripple Oregon businesses and working families. Despite claims by its advocates that it is "free," it increases healthcare costs for employers and their workers due to lost drug rebates.[5] New research has estimated the financial impact of the 340B program on each state.[6]

The Cost of the 340B Program

The 340B Drug Pricing Program is currently imposing a significant financial impact on Oregon, costing employers and workers approximately $131 million annually. This figure is projected to rise to $166 million if Oregon enacts legislation mandating the inclusion of contract pharmacies in the program.[7] Additionally, the cost of the 340B program per beneficiary for state and local government employers in Oregon is approximately 6% higher than that for commercial employers. This is noteworthy considering Oregon's 340B activity is above the national average at 19% 340B utilization and 22.3 340B facilities per 100k pop, indicating a robust engagement with the program across the state.

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[1] https://www.drugchannels.net/2023/09/exclusive-340b-program-reached-54.html
[2] https://www.gao.gov/assets/gao-11-836.pdf
[3] https://olis.oregonlegislature.gov/liz/2024R1/Downloads/PublicTestimonyDocument/113170
[4] https://340breform.org/340b-hospitals/oregon/
[5] https://www.iqvia.com/locations/united-states/library/white-papers/the-cost-of-the-340b-program-part-1-self-insured-employers
[6] https://www.iqvia.com/locations/united-states/library/white-papers/the-cost-of-the-340b-program-to-states
[7] https://www.iqvia.com/-/media/iqvia/pdfs/us/white-paper/2025/iqvia-cost-of-340b-to-states-whitepaper-2025.pdf

Prescription drug mark-ups

At its most basic level, 340B is structured as an arbitrage system in which participants can buy prescription drugs at a steep discount, mark them up significantly, and charge commercial insurance plans the full price. These mark-ups are well documented across the country. Most notably, North Carolina's State Treasurer recently found that 340B hospitals in the state had billed the state employee health plan an average markup of 5.4 times their acquisition cost for oncology drugs.[8] While 340B is often referenced as a "costless" program to taxpayers, these mark-ups represent profits for corporate healthcare systems, on the backs of higher prices paid by working families with employer-sponsored insurance.

Impact on consolidation

340B provides strong incentives for consolidation, as hospitals are able to acquire previously independent outpatient physician offices and classify them as 340B "child sites." In doing so, they can boost profits by maximizing the spread they receive from their mark-ups through the expansion of their 340B reach to more commercially insured patients.

In recent years, Oregon has seen a significant trend of healthcare consolidation, characterized by mergers and acquisitions that have raised concerns over increasing healthcare costs and access to services. This consolidation trend, reflecting national patterns, has been particularly impactful in rural areas, often leading to higher healthcare prices and a reduction in service diversity due to the dwindling number of independent providers.[9,10] The evidence overwhelmingly shows that consolidation increases costs for patients and does not improve care;[11] It is therefore troubling for employers that 340B is a contributor to this phenomenon.

In response to increased consolidation, the Oregon legislature passed House Bill 2362, establishing the Health Care Market Oversight program under the Oregon Health Authority to ensure healthcare transactions support state goals of equity, lower costs, and improved access.[12] Given the importance that Oregon legislators place on addressing consolidation, focusing on the implications of the 340B Drug Pricing Program should also be a priority as the association between 340B and vertical consolidation in hematology-oncology, in particular,[13] is well-documented, particularly due to the fact that high-cost drugs for these disease states yield significant 340B margins for hospitals. This is especially true for outpatient "child sites" located

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[8] https://www.nctreasurer.com/news/press-releases/2024/05/08/state-treasurer-folwell-releases-report-finding-north-carolina-340b-hospitals-overcharged-state
[9] https://www.oregon.gov/oha/HPA/HP/HCMOPageDocs/HCMO-One-pager.pdf
[10] https://compassionandchoices.org/news/new-white-paper-on-healthcare-consolidation-in-oregon-reveals-trend-likely-to-accelerate-jeopardizing-access-to-care/
[11] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6170097/
[12] https://www.oregonlegislature.gov/housedemocrats/Documents/PRESS%20RELEASE%20House%20Passes%20Bill%20to%20Ensure%20Equitable%20and%20Affordable%20Access%20to%20Healthcare.pdf
[13] https://www.nejm.org/doi/full/10.1056/NEJMsa1706475#:~:text=Hospital%20eligibility%20for%20the%20340B,and%200.1%20(or%2033%25)

in wealthy areas with well-insured patients, which is often the case.[14] Research indicates that 340B hospitals markup medicines at significantly higher rates than independent physician offices.[15]

Hospital systems can also game the program by classifying facilities in wealthy areas as "child sites" of their hospitals that serve low-income patients. While the Bon Secours system in Richmond, VA, is the most notorious example,[16] this practice is widespread in Oregon as well. This practice gives 340B hospitals both a competitive advantage and a vested interest in securing as many facilities as possible to expand their 340B reach through horizontal consolidation.

Opportunities for chain pharmacy and PBM profit

340B also encourages for-profit chain pharmacies and PBMs to profit from the program. Currently, corporate health systems are able to create unlimited networks of external chain pharmacies they can use to profit from 340B. The exponential growth of these networks since 2010 – which have zero basis in statute – is a major factor in the program's rapid expansion.

There is no requirement that these pharmacies be located in low-income communities or that they provide medicines to patients at affordable prices. In fact, research has found they are expanding in increasingly wealthier, predominantly white, and better-insured areas. This enables health systems to further augment the number of prescriptions they can purchase at 340B discounts, which they can then mark up and bill employers and families at full commercial prices.[17]

Oregon is no exception to this rule, with only 26% of contract pharmacies located in medically underserved areas. Additionally, Oregon 340B hospitals have over 750 contracts with pharmacies outside the state, including 44% of Oregon Health Sciences Center's contract pharmacies which are located in Florida.[18,19] Clearly, such locations are being used to drive extra revenue to healthcare systems rather than improve access for low-income Oregonians. House Bill 2716, introduced in 2023, sought to regulate practices by insurers and PBMs and prohibit discriminatory practices by pharmacy benefit managers and insurance plans against 340B pharmacies, including reimbursing a 340B pharmacy less for prescription drugs compared with non-340B pharmacies.[20] Legislation like this could help curb some of these egregious practices and promote better access to healthcare for vulnerable populations.

Incentives for prescribing higher-cost medicines

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[14] https://avalere.com/insights/340b-hospital-child-sites-and-contract-pharmacy-demographics
[15] https://jamanetwork.com/journals/jama-health-forum/fullarticle/2807907
[16] https://www.nytimes.com/2022/09/24/health/bon-secours-mercy-health-profit-poor-neighborhood.html
[17] https://jamanetwork.com/journals/jama-health-forum/fullarticle/2807907
[18] https://olis.oregonlegislature.gov/liz/2024R1/Downloads/PublicTestimonyDocument/113170
[19] https://pioneerinstitute.org/wp-content/uploads/Oregon-2024.pdf
[20] https://340breport.com/oregon-bill-targets-pbm-policies-that-discriminate-against-340b-pharmacies/

Finally, 340B has been shown to drive providers to prescribe higher-priced drugs. Healthcare systems can make a larger 'spread' from more expensive, brand name drugs than the lower-cost, equally effective biosimilar. A study published in *Health Affairs* found that 340B program eligibility was associated with a 22.9 percentage point reduction in biosimilar adoption between 2017 and 2019.[21] Another analysis found that between 25% and 56% of corporate health systems only list prices for the innovator product, and very few offer all available biosimilars.[22]

All of these distortive effects raise costs for employers and their employees, without any requirements that 340B funds benefit low-income communities. In fact, Oregon hospital's spending on charity care — free or discounted services for low-income patients — declined by 17.3% from its peak in 2020, and overall community benefit spending also saw a reduction of 8.7% from the previous year, despite a state law expanding eligibility in 2023.[23,24]

The Impact of HB 2385

Employers and lawmakers in Oregon have made great strides to introduce more transparency in the healthcare system in order to help bring down costs. HB 2385 would represent a step backward. It would exacerbate 340B's upward pressure on costs for working families without doing anything to promote access or affordability for low-income patients.

First, the bill effectively serves as a "gag rule," a practice that the state has sought to prohibit in the past by allowing pharmacists to communicate openly and honestly about drug prices. This legislation would similarly prevent employers and the government from identifying what drugs were purchased at 340B discounts and how much corporate health systems mark them up – hampering our ability to eliminate this waste in the system and harm to our bottom line.

The bill would also lock in one of 340B's most well-documented flaws: contract pharmacy. Unlimited networks of pharmacies in wealthy, well-insured, and often far-flung regions of the state have been a key factor in the program's expansion over the past decade-plus. They have helped hospitals maximize the number of 340B prescriptions they can process through commercial insurance and, thus, their profit on the sale of discounted drugs that are not being shared with working families or the employer purchasers who provide their healthcare.

HB 2385 would simply enshrine this status quo in law, perpetuating the continued unchecked expansion of the program's underlying arbitrage system, exacerbating its distortive effects on consolidation and prescribing patterns, and preventing efforts to introduce transparency into this opaque program. All in all, it would raise costs for employers and working families while benefiting the corporate health systems and their chain pharmacy and PBM partners.

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[21] https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2022.00812
[22] https://communityoncology.org/hospital-340b-drug-profits-report-feb-2021/
[23] https://www.oregonlive.com/health/2025/02/nonprofit-oregon-hospitals-spent-less-on-charity-care-community-benefits-in-2023.html
[24] https://www.thelundreport.org/content/oregon-hospitals-report-less-spending-community-benefit-programs

Conclusion

As rising healthcare premiums and insurance costs continue to increase our overall operational expenses and impact the benefits coverage we can offer our employees, we cannot support legislation that would irresponsibly increase expenses without ensuring the program works for Oregon's vulnerable communities.

Employers urge the Committee to oppose HB 2385 and instead look to more comprehensive reforms that promote transparency and accountability in 340B, provide affordability protections for patients, and limit 340B's inflationary effects on healthcare spending for working families.

Sincerely,

Shawn Gremminger
President and CEO
National Alliance of Healthcare Purchaser Coalitions