CYRUS JAVADI, DDS
STATE REPRESENTATIVE
DISTRICT 32

HOUSE OF REPRESENTATIVES

April 21, 2025

Chair Bowman, Vice Chairs Drazan and Pham, and Members of the Committee,

My name is Representative Cyrus Javadi, and I represent House District 32—the north coast of Oregon.

I'm here today in support of House Bill 3409. It's a step toward preserving access, especially in rural areas like mine, where a contract pharmacy might be the only pharmacy within miles.

This bill fits into the larger conversation surrounding the federal 340B program. And I want to start with this: I don't think there's a villain in this story. Manufacturers are trying to comply with federal requirements and manage risk. PBMs are navigating complex rebate structures. Covered entities are doing everything they can to serve patients with shrinking margins. Everyone is reacting to a federal program that was built with the best of intentions—but without a very good instruction manual.

Now, there's been a lot said about what 340B is or isn't. So let me be crystal clear: when Congress created the program in 1992, the express purpose wasn't to create direct patient discounts—it was to help safety-net providers stretch their dollars. It was a way to offset the reduced payments they were receiving from government payors like Medicaid and Medicare, which often reimburse well below the cost of delivering care.

In many ways, 340B has worked. But it's also become administratively burdensome. Today, many covered entities are being told they have to mark 340B claims at the point of sale—in real time. That might sound simple, until you realize that one missed modifier or misflagged claim isn't just a clerical error—it can trigger an audit, a lost rebate, or even program violations.

HB 3409 offers a more workable approach. It gives providers the option to use a third-party clearinghouse to validate and report 340B claims after the fact—accurately, securely, and without forcing community pharmacies to become data clearing centers. It's voluntary. It creates no new mandates. But it gives healthcare providers a cleaner, less risky path to compliance.

But HB 3409 also does something else that's critically important—and easy to miss if you're just scanning the bill: **it ensures fair treatment for 340B pharmacies.**

It says PBMs and insurers **can't pay pharmacies less** just because the drug was purchased under 340B.
It says they **can't exclude those pharmacies from their networks** just because they work with covered entities.
And it says they **can't impose clawbacks or post-sale fees** that only apply to 340B transactions.

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Because when we allow that kind of discrimination, we create a chilling effect—and we push pharmacies and providers out of the very arrangements that make 340B viable.

This bill also works hand-in-hand with HB 2385, which this committee already advanced and which we passed earlier this session. That bill made clear that if a covered entity in Oregon is lawfully working with a contract pharmacy, that pharmacy should not be restricted from receiving and dispensing 340B medications. That wasn't about pointing fingers—it was about ensuring that our health system stays functional for the people it's meant to serve.

Both bills are aimed at the same goal: making sure that the people we serve—patients in rural areas, low-income families, those with chronic conditions—aren't the ones who pay the price when administrative complexity overwhelms clinical care.

And on the legal front—we're not walking alone here. The Eighth Circuit recently upheld a similar law out of Arkansas, affirming that states do have a role in protecting access and ensuring that contract pharmacy arrangements aren't arbitrarily limited.

So no, this isn't about blame. It's about balance. It's about giving providers and pharmacies the tools they need to comply with the program without burning out or backing out. It's about keeping 340B functional—because when it's working, patients get more care, and more providers stay in business.

Original Intent of 340B (1992)

When Congress created the 340B Drug Pricing Program in **Section 602 of the Veterans Health Care Act of 1992**, the **stated intent was not to create direct discounts or rebates for patients**. Instead, the goal was to **support safety-net providers**—particularly those serving large numbers of low-income and uninsured patients—by allowing them to **stretch federal resources** further.

The core idea was this:

"**To enable covered entities to stretch scarce federal resources as far as possible, reaching more eligible patients and providing more comprehensive services.**"
—House Report and HRSA guidance, 1992–1996

Why It Was Created:

1. **Medicaid Drug Rebates (1990)** significantly reduced drug manufacturers' net revenues when they sold to state Medicaid programs.\

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2. As a result, manufacturers began **raising prices** in the commercial market and limiting discounts to other providers, including safety-net hospitals and clinics.
3. The **1992 340B program was a congressional trade-off**: If drug makers wanted access to Medicaid and Medicare Part B markets, they had to offer **discounted prices** to eligible safety-net providers (called "covered entities").

So:

- 340B **was designed to support providers**, not to create a patient-level subsidy or cap out-of-pocket costs.
- Providers could **use the savings however they saw fit**—whether to expand services, fund uncompensated care, or in some cases, keep their doors open.

Important to Note:

- **Patients do not get an automatic discount** at the pharmacy counter.
- Covered entities **own the drugs**, and they may charge patients standard rates, offer sliding scales, or use 340B savings to subsidize other areas of care.
- There is **no federal requirement** to pass savings directly to patients—though some entities do so voluntarily.

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