5 May 2025

Chair Patterson, Vice Chair Hayden, and members of the committee,

As an ordained minister, my calling is to serve both within and outside the ecclesiastical structure, uplifting the inherent worth of all people, advocating for peace and justice, and working to abolish poverty and end suffering. It is in this spirit that I write to express my strong support for **HB 2385A**.

I also come to you as an Oregonian with over 13 years of experience working in pharmacy, spanning large chain retail pharmacies, independent community pharmacies, and non-profit pharmacies. Currently, I serve at a Federally Qualified Health Center (FQHC) in their 340B Program, working to ensure our compliance with the 340B statute, HRSA regulations, and the self-imposed restrictions by drug manufacturers for this covered entity's clinics and in-house and contract pharmacies.

The **340B Program**, established in 1992, was designed to help covered entities stretch limited federal resources to reach more eligible patients and provide more comprehensive care. The savings achieved from purchasing 340B medications at reduced costs allow these entities to serve vulnerable populations and improve access to vital healthcare services.

Since 1996, HRSA guidelines have allowed covered entities to contract with pharmacies to serve their patients. In 2010, further guidance expanded this to include multiple contract pharmacies, even when in-house pharmacies exist.[1] However, in 2020, drug manufacturers began imposing severe restrictions on covered entities and contract pharmacies. These restrictions vary but often limit covered entities to a single contract pharmacy—or none at all—if they already operate an in-house pharmacy. Some manufacturers also restrict the geographical location of contract pharmacies.

HB 2385A, if passed, will restore and protect the ability of covered entities to contract with pharmacies where their patients already receive services, including retail, mail order, central-fill, and specialty pharmacies. Many insurance plans require patients to use specific pharmacies—often large chains and their mail-order, central-fill, and specialty pharmacies. All these pharmacies provide pharmacy services to Oregonians that are patients of covered entities including those living in pharmacy deserts.

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[1] U.S. Department of Health and Human Services, **The Notice Regarding 340B Drug Pricing Program — Contract Pharmacy Services**, 75 Fed. Reg. 10579 (Mar. 5, 2010), https://www.govinfo.gov/content/pkg/FR-2010-03-05/pdf/2010-4755.pdf

These manufacturer-imposed restrictions undermine the ability of safety net providers to maximize the care they can offer to our most vulnerable populations. The significant reduction in savings, as highlighted by many FQHCs in their testimony, means reduced revenue that would otherwise support care for those in need. Additionally, to comply with these ever-changing restrictions, covered entities must divert additional time and resources—time and resources that could be better spent serving patients.

It is important to understand that the **340B program** is not a discount program for patients, but a mechanism that allows covered entities to purchase outpatient medications at a reduced cost, using the savings to expand services and reach more people. This includes things like mobile medical services, additional medical and support services, free or reduced-cost medications, supporting in-house pharmacy services, or covering patient copays when allowed by their pharmacy benefit manager (PBM) contracts. These services help increase the health of Oregonians and decrease the overall costs of medical care for vulnerable Oregonians.

Passing **HB 2385A** would restore crucial funding to safety net providers and ensure that we continue to care for our most vulnerable populations. By passing this bill, Oregon would join states like Arkansas, which have already taken action to protect these programs and prevent pharmaceutical manufacturers from imposing harmful restrictions.

Some have raised concerns about program accountability. However, HRSA requires covered entities to undergo annual audits by independent entities and maintain detailed records for review.[2] At the FQHC where I work, I conduct internal audits monthly to ensure compliance at our clinics, in-house pharmacies, and contract pharmacies.

While the **340B program** is not without its challenges, limiting the number of pharmacies a safety net provider can work with is not the solution. Instead, we should focus on expanding access to care and ensuring that covered entities can maximize their resources to serve those in need.

I urge you to support **HB 2385A** to protect and strengthen this vital program that supports our safety net providers and the vulnerable Oregonians they serve.

Sincerely,
Rev. Lyle Anderson II, M.Div, COPT

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[2] U.S. Department of Health and Human Services, **340B Drug Pricing Program - Contract Pharmacy Implementation**, Health Resources and Services Administration, https://www.hrsa.gov/opa/implementation-contract.