Testimony on HB 2385

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Thank you for the opportunity to share my views on this bill. I do not represent any interest party, but I have a clinician and economist interest in the 340B program, which I have been studying for several years.

As I understand it, HB 2385 creates a civil penalty for drug manufacturers that interfere directly or indirectly with certain entities acquiring 340B drugs, delivering 340B drugs to certain healthcare providers, or dispensing 340B drugs. Unfortunately, this legislation will prohibit transparency for a program desperately requiring transparency.

Let me first share some specific data regarding the state of Oregon.

The following data is regarding 340B hospitals and contract pharmacies that operate within the state of Oregon. The following data is available on the Pioneer Institute Website - https://pioneerinstitute.org/340babuse/. The data was gathered through HRSA, RAND Institute, a think tank similar to the Pioneer Institute, and the U.S. Census Bureau.

In Oregon, 8 out of the top 10 340B contract pharmacies with the most contracts are for-profit chain drug stores, for-profit pharmacies owned by for-profit Pharmacy Benefit Managers (PBMs), or pharmacies affiliated with health plans.

Almost half of the contract pharmacies affiliated with the top 340B hospital in Oregon are out-of-state.

Oregon Health Sciences University: 2024 (44%), 2025 (45%) – pharmacies as far as Texas, Florida, and Hawaii

Location of pharmacies IN state: Only 51% are in Low-Income legislative house districts

Charity care provided by 340B hospitals in Oregon has dropped year over year:

2021 U.S. (2.18%) Oregon (1.97%) OHSU (1.4%)

2022 U.S. (2.15%) Oregon (1.86%) OHSU (1.52%)

In Oregon, most of the charity care is provided to insured patients rather than uninsured patients, which is very unusual and does not follow the pattern nationally or in neighboring states of CA, WA, or NV, where more charity care is provided to uninsured patients.

But let's discuss the contract pharmacy provision in front of the committee; this legislation will essentially expand the program by discouraging transparency for a government program that will soon eclipse Medicare's drug program. As the Minnesota Legislative report points out, almost 16% of revenue gained by the 340B hospitals is funneled to contract pharmacies and vendors. This was confirmed by the newly released report from Senate HELP committee. Millions of dollars that should go towards patient care are instead enriching the coffers of big for-profit entities. This legislation can be correctly characterized as corporate welfare that drives revenue toward profitable companies.

With passage of this law

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."

Finally, by supporting this law, the state of Oregon is abdicating the revenue gained from the Medicaid-eligible patients to the hospitals in Oregon. The federal government makes states choose between a Medicaid discount or 340B pricing for covered entities. As was stated in the hearing, you don't get dual discounts.

I understand that the 340B program is vital to some hospitals and clinics, and state legislators may want to support their efforts. However, I suggest that providing corporate welfare to for-profit pharmacy chains and PBMs may not be the best policy option.

Let me suggest a couple of other policy options for state legislators to consider, with one option providing useful information to policymakers and another supporting patients treated at 340B facilities.

Implement Transparency Requirements: Follow Minnesota's example and require all 340B hospitals and contract pharmacies to publicly report the revenue gained through the 340B program and how much is spent on direct patient care. This ensures that policymakers can monitor whether patient benefits align with program intent.

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.

Charity Care Requirements: Collect what percent of 340B revenue goes back to the community in the form of charity care.

Define charity care: Provide a minimum percentage of revenue to be dedicated to charity care of all participating organizations, including contract pharmacies

I want to thank the committee for the opportunity to submit my views.