COMMUNITY ACCESS NATIONAL NETWORK

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May 8, 2025

Oregon State Legislature
Senate Committee on Health Care
900 Court St. NE,
Salem Oregon 97301
Via electronic mail

RE: HB 2385 - OPPOSE

Dear Honorable Chairwoman Patterson, Vice Chair Hayden, Members of the Oregon Senate Committee on Health Care, and your well respected staff,

Today, we respectfully write in **OPPOSITION** to **HB 2385**, which as written seeks to expand 340B contract pharmacy arrangements in Oregon without adequate oversight and accountability to ensure the program appropriately serves patients, particularly those living with HIV and other chronic health conditions.

The Community Access National Network (CANN) is a 501(c)(3) national nonprofit organization focusing on public policy issues relating to HIV/AIDS and viral hepatitis. CANN's mission is to define, promote, and improve access to healthcare services and support for people living with HIV/AIDS and/or viral hepatitis through advocacy, education, and networking.

While CANN is primarily focused on policy matters affecting access to care for people living with and affected by HIV, we stand in firm support of all people living with chronic and rare diseases and recognize the very reality of those living with multiple health conditions and the necessity of timely, personalized care for every one of those health conditions. The 340B Drug Pricing Program is of profound importance to our community.

HB 2385 undermines the well-recognized need for reform to align 340B with its original intent because the bill seeks an avenue to expand 340B contract pharmacy arrangements without limitation – particularly, limitations necessary to ensure proper transparency, accountability and ensure patients benefit from reduced acquisition costs.

Abuse is rampant in the 340B Drug Pricing Program, as has been outlined in a recent report from Chairman Bill Cassidy of the Senate Health, Education, Labor and Pensions Committee (HELP) which requested a comprehensive understanding of where the dollars generated by this program flow and how such revenue benefits patients. The information gathering included letters requesting information and data from hospital covered entities, health centers, large for-profit chain pharmacies, and pharmaceutical manufacturers.

There is ever growing evidence that manufacturer mandates add unnecessary burden to already strained state budgets due to loss of rebates to state Medicaid, Medicare, and employer plans as outlined by the North Carolina treasurer's report, and in the case of Tennessee, adding $7,452,700 to state expenditures as outlined by the fiscal note on the state's manufacturer mandate bills HB 1242 & SB 1414, while Texas's fiscal note estimates that unlimited contract pharmacy agreements will make the state's HIV program insolvent by 2027.

IRA and 340B Discount Duplication Concerns - Unclear Definition of "Restriction"

Of the issues outlined within the report is the failure for provider specific de-duplication of discounts between 340B and the Inflation reduction Act's drug price negotiation program (MFP). The Centers for Medicare and Medicaid has absolved itself of any responsibility of oversight and prevention of prohibited duplicate discounts. The report rightly highlights CMS' failure by quoting the agency directly: "[CMS]...expects providers to submit accurate claims and *utilize correct modifiers*.

Furthermore, in a May 2nd, 2025 litigation filing, the Department of Health and Human Services (HHS) indicated to the U.S. District Court of the District of Columbia that the federal agency charged with regulating the 340B program would be "issuing guidance" regarding 340B, rebates, and the IRA "within the next 30 days." Moving this bill forward now, absent that expected guidance, is premature and will likely result in the proposed Oregon law conflicting with the federal government's posture toward the 340B program and parties' obligations.

"Revenue is revenue." Or How Entities Can and *Do* Avoid Responsibility to Use 340B Revenue to Serve Patients

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In Bon Secours Mercy Health (BSMH) response to Senator Bill Cassidy's request for information when asked how 340B revenues were used (ie. exec compensation v patient benefit and charity care), their response was "we don't segregate revenue. revenue is revenue."

Based on written responses and the accompanying documents produced pursuant to Chairman Cassidy's investigation, BSMH and Cleveland Clinic each generated hundreds of millions of dollars in 340B savings and revenue from the 340B Program between 2018 and 2023. In responses to Chairman Cassidy's letter, both BSMH and Cleveland Clinic explained that it "does not directly pass on all savings generated from the 340B Program to patients in the form of savings on health care expenses."

One common claim made to legislators is that providers, pharmacists, and/or payors are unaware of the value of a 340B discount, preventing them from applying these savings to patients' out-of-pocket costs. However, this claim is false. Many 340B entities employ "third-party-administrators" (TPAs). These TPAs are often vertically integrated with pharmacy benefit managers (PBMs) and contract pharmacies. TPAs provide electronic medical record systems integrations, allowing providers to know the approximate or exact value of 340B revenue a specific medication will generate while seeing a patient—before the patient even reaches a pharmacy counter. In CVS's response to Senator Cassidy they raked in more than 350 million in TPA fees, highlighting the need for accountability and transparency.

Overall, the agreements between the contract pharmacies, TPAs, and covered entities reflect a proliferation of fees across various services and settings. With multiple for-profit entities receiving substantial financial benefits, the incentives are aligned to exert more payment pressure on covered entities, thereby diverting resources from the 340B Program's intended purpose of allowing covered entities to stretch scarce federal resources as far as possible.

Chairman Cassidy's investigation underscores that there are transparency and oversight concerns that prevent 340B discounts from translating to better access or lower costs for patients. Congress needs to act to bring much-needed reform to the 340B Program, HB 2385 as written, stands in opposition to ensuring patients benefit from this federal program that intended to ***"...reach more eligible patients, and provide more comprehensive services."***

It is important to note that in the statutory intent of 340B, patients come first. The state of Oregon would do well to put patients first as well. **HB 2385** subverts patient interests for hospital interests. All a single legislator needs to do is review medical GoFundMe campaigns to see how toxic such an assumption of interests is for patients. We encourage you to reflect on this fact deeply.

If this body seeks to positively impact patient access to care, priority on PBM reform is a must. PBM reform, not unchecked 340B expansion, speaks most directly to patient concerns regarding pharmacy access, benefit design, and medication affordability.

To be clear, CANN supports a strong 340B program. When 340B operates the way it is intended, safety-net providers thrive and vulnerable communities, families, and individuals gain access to healthcare they might otherwise not have. CANN welcomes discussion on instituting appropriate guardrails into legislation that would serve to strengthen the program, shield good stewards, and hold accountable bad actors within the appropriate limitations of state powers associated with this federal program.

We would be happy to discuss this legislation or any other matters of public health, please feel free to reach out by email or phone at kalvin@tiican.org , 913-954-8816, or jen@tiicann.org, 313-333-8534.

Respectfully submitted,

Sincerely,
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On behalf of
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Community Access National Network