Johnson&Johnson

May 13, 2025

Senate Committee on Health Care

Oregon State Senate

900 Court St. NE

Salem, OR 97301

Dear Chair Patterson, Vice Chair Hayden & Members of the Senate Committee on Health Care,

Johnson & Johnson ("J&J") **respectfully opposes HB 3409-A** because it would interfere with enforcement of the federal 340B Program statute's prohibitions against duplicate discounts and diversion,[1] impede efforts to improve program integrity through increased transparency, fail to advance the 340B Program's long-term sustainability, and ultimately work against the interests of Oregon's patients, employers, workers and taxpayers.

Established in 1992, the 340B Program was created to require drug manufacturers, as a condition for receiving reimbursement for their "covered outpatient drugs" under Medicaid and Medicare Part B, to offer reduced pricing on these drugs to certain types of eligible safety-net health care entities providing direct clinical care to large numbers of low-income and uninsured patients. J&J strongly supports this purpose; however, the 340B Program has expanded well beyond what Congress envisioned in 1992. Unfortunately, the 340B Program is fundamentally broken and is not serving vulnerable patients in the way that it was intended. The 340B Program could better execute its core safety net purpose with clear federal requirements and oversight, backed by increased transparency. J&J supports ongoing efforts to enact legislative reforms to the 340B Program at the federal level.

The government's own data spotlights how the rapid growth of the 340B Program has resulted in significant rates of statutorily prohibited diversion and duplicate discounting. For example, a Government Accountability Office (GAO) report highlighted that 1,242 federal government audits of 340B providers over an eight-year period yielded more than 500 diversion-related findings.[2] These audits also found more than 400 instances of noncompliance related to duplicate discounts. The Inflation Reduction Act's (IRA's) "maximum fair price" program further increases the risk of illegal duplicate discounts, despite a federal law that protects manufacturers from providing both the "maximum fair price" and the 340B price on the same unit of a drug.[3]

Per Centers for Medicare and Medicaid Services (CMS) guidance, "State Medicaid agencies (states) are prohibited from billing manufacturers for Medicaid rebates for drugs dispensed to Medicaid patients that have already been discounted under the 340B Program. Stakeholders, including states, have indicated that avoiding duplicate discount billing has become more complex due to the increase in the number of Medicaid managed care beneficiaries as well as the number of prescriptions filled at 340B-

[1] 42 U.S.C. § 256b(a)(5)(A)-(B).

[2] https://www.gao.gov/products/gao-21-107

[3] 42 U.S.C. § 1320f-2(d).

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entity contract pharmacies."[4] This same guidance provides a range of options for available claims identifiers that may be used to avoid duplicate discounts. The use of claims identifiers is not a novel practice.

In Oregon, the 340B Program is costing its taxpayers, employers and workers millions of dollars because 340B discounts supplant manufacturer rebates otherwise provided to the government (e.g., state employee plans and Medicaid) and private employer health plans. Today, the 340B program is estimated to be costing Oregon's taxpayers $20 million and employers and workers $131 million annually because of this rebate displacement.[5] It is difficult to know the program's impact on these groups with certainty due to a lack of transparency. **The lack of transparency in the 340B Program also makes it unclear whether vulnerable patients in Oregon are truly benefiting from 340B discounts. If passed, HB 3409-A would further exacerbate that problem.**

Across the US, states are increasingly recognizing the need for greater 340B transparency. A recent North Carolina Treasurer's report identified the impact of 340B hospital mark-ups on the NC State Employees Health Plan, finding that 340B hospitals billed the NC State Health Plan 5.4 times their discounted acquisition costs for cancer drugs, collecting an 84.8% higher average price markup than hospitals outside of the program.[6] Likewise, in Minnesota, the Department of Health found steep hospital markups on medicines, with disproportionate benefits for large hospital systems and for-profit middlemen, raising serious concerns about whether patients are benefiting.[7]

We urge Oregon to study and report on the impact of 340B on the State Medicaid program, including the impact of rebate displacement, and to report on controls the state has in place to ensure the proper identification of claims to prevent duplicate discounts.

We support the original intent of the 340B Program. Increased transparency and accountability are needed to ensure the Program is fulfilling its intended purpose and working for vulnerable patients, which is why we **respectfully oppose HB 3409-A.**

If you or your staff have any questions, please contact me.

Thank you,

Terrell Sweat

Terrell Sweat
Director, US State Affairs
Johnson & Johnson Services, Inc.

[4] https://www.hrsa.gov/sites/default/files/hrsa/opa/cib-01-08-20.pdf
[5] IQVIA, https://www.iqvia.com/-/media/iqvia/pdfs/us/white-paper/2025/iqvia-cost-of-340b-to-states-whitepaper-2025.pdf
[6] https://www.shpnc.org/what-the-health/north-carolina-340b-hospitals-overcharged-state-employees-cancer-drugs
[7] https://www.health.state.mn.us/data/340b/docs/2024report.pdf