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March 26, 2025

Illinois General Assembly
House Appropriations-Health and Human Services Committee
401 S. 2nd St,
Springfield, IL 62707

Delivered via electronic mail

RE: HB 3350

Dear Honorable Chairwoman Moeller, Vice Chair Lilly, Spokesperson Weber, Members of House Appropriations-Health and Human Services Committee, and your respected staff,

The Community Access National Network writes today respectfully in **OPPOSITION** to **HB 3350**, which would expand the federal 340B Drug Pricing Program in Illinois without sufficient oversight 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.

On May 28th, 2024 the "340B Affording Care for Communities and Ensuring a Strong Safety-net Act" or "340B ACCESS Act" was unveiled in the United States House of Representatives. The bill represents a careful negotiation between a variety of stakeholders affected by the 340B program, including but not limited to the National Association of Community Health Centers, a trade organization representing pharmaceutical manufacturers, and several patient advocacy organizations. CANN is proud to count ourselves among the members working to find consensus on reforming the 340B drug discount program.

HB 3350 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 and accountability.

The primary harm of contract pharmacies in the 340B program is that they can divert profits intended for low-income patients by allowing large, for-profit retail pharmacies to capitalize on discounted drug prices, potentially leading to less money being reinvested in patient care and a lack of transparency regarding how the savings are being used; this can be considered an abuse of a program designed to help vulnerable populations access affordable medications.

340B has been the primary driver behind contract pharmacy expansion. Many community, and rural pharmacies are unable to secure contracts with covered entities favoring large entities, reducing competition, *leading to pharmacy consolidation* often to wealthier communities and away from disadvantaged and impoverished communities, exacerbating the growing patient access issue. Directly, expanding contract pharmacies under the 340B program isn't about patients, it's about adding more hands to the 340B cookie jar, at the expense of patients.

A study found that hospitals eligible for the 340B Drug Pricing Program, intended to support low-income populations, significantly marked up outpatient infusion drug costs for privately insured patients. These hospitals retained a substantial portion of insurer drug expenditures, undermining the program's intended purpose and potentially impacting patient access and pharmaceutical innovation. The findings highlight the need for program reform to ensure its intended benefits reach the intended population.

Many hospitals eligible for the 340B Drug Pricing Program, intended to help underserved patients, are significantly marking up prices for physician-administered drugs. This practice, which keeps a large portion of insurer spending, is seen as misuse of the program and contributes to higher insurance premiums.

The Optimal Cancer Care Alliance (OCCA) advocates for optimal dosing of cancer drugs, believing that many are approved at excessive doses. They argue that this not only increases costs but also potentially leads to unnecessary toxicity for patients. While the FDA's Project Optimus aims to address this issue for new drug approvals, OCCA is now focusing on optimizing the dosing of already approved drugs.

Hospitals purchase 340B medicines at such steep discounts (averaging nearly 60%) that some medications cost them a mere penny. Instead of sharing these discounts with patients, large 340B hospitals bill patients and their insurers, who then mark up prices and pocket the difference as profit.

Consequently, the average cost per prescription for patients at 340B hospitals is significantly higher (over 150%) compared to patients at non-340B hospitals. Since deductibles and coinsurance are often based on the cost of prescriptions, the prescribing patterns of 340B hospitals can lead to higher cost-sharing for patients and, consequently, increased premiums for all commercially insured patients.

Issues arise from the expansion of Medicaid managed care and contract pharmacies, making it difficult for states to determine if a 340B drug was dispensed to a Medicaid beneficiary. While the Medicaid exclusion file helps prevent duplicate discounts in fee-for-service, it does not apply to contract pharmacies or managed care.

States use various methods to identify and exclude 340B drugs from Medicaid rebate invoices, including provider exclusion lists and claim-level identifiers. However, claim-level identifiers can be challenging leading to inconsistencies and potential diversion of 340B drugs.

Adding to the complexity of this issue are Pharmacy Benefit Managers (PBMs) and their practice of "spread pricing" which refers to the difference between the discounted price a 340B-covered entity pays for a drug and the higher reimbursement rate they receive from payers (like commercial insurance) and has caught the attention of the Federal Government, during the 118th Congress called for an end to this practice.

Pharmacy Benefit Managers (PBMs) who profit off the spread PBMs act as middlemen between 340B-covered entities, drug manufacturers, and Medicaid programs. They reimburse pharmacies at a low rate but charge Medicaid managed care plans a much higher rate, keeping the "spread" as profit. This drives up overall drug costs for Medicaid, leading to higher state spending.

340B expansion is certainly becoming attractive to the ever growing private equity control of large health systems, highlighting the growing corporate exploitation of the U.S. healthcare system. Private equity firms, driven by profit motives, often cut staffing and increase charges, prioritizing quick profits, often neglect patient care and safety. This raises concerns about the impact of profit-driven healthcare on patient well-being and the need for a reevaluation of healthcare priorities.

There is ever growing evidence that manufacturer mandates add unnecessary burden to already strained state budgets adding $7,452,700 to state expenditures as outlined by Tennessee's fiscal note on the state's manufacturer mandate bills HB 1242 & SB 1414.

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,
Kalvin Pugh
Director of State Policy, 340B
Community Access National Network (CANN)

On behalf of
Jen Laws
President & CEO
Community Access National Network