COMMUNITY ACCESS NATIONAL NETWORK

Mailing Address:

Attn: Jen Laws
PO Box 3009
Slidell, LA 70459

Chief Executive Officer:

Jen Laws
Phone: (313) 333-8534
Fax: (646) 786-3825
Email: jen@tiicann.org

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Ohio State Legislature
Ohio House of Representatives
77 S. High Street, 14th Floor
Columbus, OH 43215
Sent Via Electronic Mail

RE: HB 276

Dear Honorable Speaker Huffman, Members of the Ohio House of Representative Leadership, Members of the Ohio House Finance Committee leadership, and legislative staff,

The Community Access National Network writes today respectfully in **OPPOSITION** to **HB 276**, which would expand the federal 340B Drug Pricing Program in Ohio without sufficient oversight to ensure the program appropriately serves patients, particularly those living with HIV and other chronic health conditions. We encourage the legislature to reconsider this legislation for a legislative study of the impact of the 340B program in Ohio considering the concerns and conflicts outlined in this letter.

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.

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. The legislation will be re-introduced this session and US Senate companion legislation is also anticipated.

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.

HB 276 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.

Overall, the agreements between the contract pharmacies, TPAs, and covered entities reflect a proliferation of fees across various services and settings.In CVS's response to Senator Cassidy they raked in more than 350 million in TPA fees, highlighting the need for accountability and transparency. 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.

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 drug manufacturer mandates add unnecessary burden to already strained state budgets. For example, $7,452,700 is added to state expenditures as outlined by Tennessee's fiscal note on that state's drug manufacturer mandate bills HB 1242 & SB 1414.

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."

While CANN understands that HB 276 was well intentioned, allowing unlimited contract pharmacies only benefits those who are motivated by their margins, Pharmacy Benefit Managers, and the for-profit companies they contract with. Ultimately diverting the benefit of this program from the intended vulnerable patients and into the pockets of those who aim to turn 340B into a revenue stream.

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