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

February 4, 2026

Washington State Legislature
Senate Ways and Means Committee
416 Sid Snyder Avenue SW,
Olympia, WA 98504
Via Electronic Portal

RE: SB 5981

Dear Honorable Madam Chair Robinson, Vice Chair Stanford, Vice Chair Trudeau, Vice Chair Frame, Ranking Members Gildon, Ranking Member Schoesler, Members of the Washington State Senate Ways and Means Committee, and your well respected staff,

Community Access National Network (CANN) respectfully submits written **OPPOSITION** to **SB 5981** which would expand the federal 340B Drug Pricing Program in Washington **without sufficient oversight to ensure the program appropriately serves patients**, particularly those living with HIV and other chronic health conditions.

ABOUT CANN: The Community Access National Network (CANN) is a 501(c)(3) national nonprofit organization (formerly incorporated under the "Ryan White CARE Act Title II Community AIDS National Network") 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 supports for people living with HIV/AIDS and/or viral hepatitis through advocacy, education, and networking. CANN's coalition-based work is done on behalf of the patient advocacy groups, pharmaceutical partners, and government agencies.

SB 5981 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 or oversight – particularly, those necessary to ensure proper transparency and accountability.

Numerous Reports Highlight 340B's Problems
The flaws in the current state of the 340B program are well documented. In the recent Congressional Budget Office (CBO) report, the agency identified how the program incentivized behaviors such as hospital and clinic consolidation that have led to the rapid growth of the program, and its impact on federal (and state) budgets.

These incentivized behaviors have caught the attention of the federal government, Senator Bill Cassidy, Chair of the Senate Health, Education, Labor and Pensions (HELP) Committee recently released a report which highlights the proliferation of fees across the health ecosystem, diverting the intended purpose of 340B "to reach more eligible patients, and provide more comprehensive services." to benefit large health systems, large for-profit chain pharmacies, Pharmacy Benefit Managers (PBMs), Third Party Administrators (TPAs), and calls for reform at the federal level.

The primary harm of contract pharmacies in the 340B program is that they can divert revenues intended to benefit low-income patients by allowing large, for-profit retail pharmacies to capitalize on discounted drug prices, leading to less money being reinvested in patient care and a lack of transparency regarding how the savings are being used; this is 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 chain and PBM-associated mail-order pharmacies, 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 helping patients, it's about adding more hands to the 340B cookie jar, at the expense of patients.

340B Threatens Medicaid Sustainability

In April 2025, researchers published an issue brief on the potential impact to state Medicaid programs from state contract pharmacy mandates in the 340B Drug Pricing Program, noting that such mandates would cost Medicaid $1.2 billion more annually, of which $437 million would impact state budgets directly and the 340B program's broader current fiscal impact related to Medicaid.

Importantly, a July 2025 analysis assessed how much each state loses in Medicaid Rebates due to providers opting to bill claims under the 340B program rather than Medicaid. For Washington, that realized loss is about $187,100,000. The specific impact here means that Washington actively lost almost $81.97 million in re-investable Medicaid rebates which would outwise have contributed to the state's mandated "share" of Medicaid payments. With anticipated reductions in federal matching dollars (FMAP) due to last year's federal Reconciliation bill, the state simply cannot afford to surrender these dollars which would otherwise be used to sustain the state's Medicaid program.

Taken as a whole, directly, 340B without guardrails, which is what is being suggested in **SB 5981,** drives up costs to patients and states and reduces available reinvestments for state Medicaid programs, which might otherwise be used to offset the program's budgetary impact. The state has a fiduciary duty to taxpayers and patients alike to ensure 340B is not being used to divest from the Medicaid program.

Another study found that entities 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 entities 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 benefits reach the intended population.

Many entities 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.

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 third-party administrators.

States use various methods to identify and exclude 340B drugs from Medicaid rebate invoices, including provider exclusion lists and claim-level identifiers. However, **SB 5981 specifically prohibits claim-level identifiers** (Section 3), leading to inconsistencies and potential diversion of 340B drugs.

Recent State-level Legislation Conflicts with Federal Actions

These reports are not the only federal movement to reform the 340B program, the Health Resources and Services Administration (HRSA) proposed rebate model pilot, the Centers for Medicare and Medicaid Services (CMS) draft guidance on the interactions of Inflation Reduction ACT's drug price negotiations with the 340B drug pricing program, the introduction of the 340B Affording Care for Communities and Ensuring a Strong Safety-Net Act (340B ACCESS Act), and federal rule-making occurring at present.

The draft guidance related to the IRA's interaction with 340B allows pharmaceutical manufacturers to delay payment for a medication for up to 10 days when a claims modifier is not present. As previously mentioned, SB 5981 would prohibit claims modifiers. In June, CANN published a blog which highlights the functional problems related to state legislative behaviors that summarizes the issue. It is also worth noting that the ACCESS act will also specifically prohibit the types of state-based legislation being discussed today.

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 company's value extraction effort and 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.

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. **SB 5981,** 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 we appreciate the authors' engagement with stakeholders to incorporate amendment language, the amendments to the substitute bill worsen existing issues with the federal 340B program and divert attention from vulnerable patients who don't benefit from reduced healthcare and medicine costs. The added reporting requirements risk violating federal law that protects the confidentiality of 340B ceiling prices, which are proprietary due to the underlying data. The Health Resources and Services Administration ("HRSA"), which administers the 340B program, calculates these prices using a statutory formula based on the formula used to calculate Medicaid drug rebates. Federal law permits HRSA to disclose ceiling prices to 340B covered entities (with access restricted to designated representatives), but not to state Medicaid programs, other government agencies, or the general public.

While CANN understands that **SB 5981** was well intentioned, enacting state-level legislation on a federal program 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.

Warmly in service,

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

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