Testimony on SB 533

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Thank you for the opportunity to share my views on this bill. I do not represent any interest group, but I do have an intellectual interest in the 340B program which I have been studying for several years.

As I understand it, SB 533 requires drug manufacturers to supply all 340B contract pharmacies in Oregon with their products. Since the vast majority of 340B contract pharmacies are for-profit chain drug stores or for-profit pharmacies that are owned by for-profit Pharmacy Benefit Managers (PBMs), this bill can be correctly characterized as corporate welfare that will drive revenue for very profitable companies.

The effect of this legislation is, essentially, to expand the 340B program or to ensure its continued growth, a program that has seen spectacular growth in recent years and, in all likelihood, will become the largest federal drug program next year, eclipsing Medicare's drug program. The number of active 340B contract pharmacies nationwide was 368 in 2009; last year the number totaled 32,579.

Let me first point out that the 340B program is deeply flawed. The program began as a noble attempt to "stretch resources" for genuine safety net hospitals and clinics who serve vulnerable populations. That noble mission is continuing today in many federally qualified health centers and a small percentage of hospitals that serve vulnerable populations, ***and which provide charity care to these populations at rates above the national average.*** Unfortunately, for many, if not most, 340B hospitals, the program has simply become a profit center with rising 340B revenues and declining rates of charity care spending. Charity care spending for Oregon's 340B hospitals averages 1.86% of operating revenues while the national average is 2.15%.

Legislators should understand that the 340B program allows hospitals to "pocket the spread" between the low 340B purchase price and the much higher reimbursement that the hospital may receive from a patient's insurance or Medicare plan. This program generates revenue for hospitals by "arbitraging the discounts" on 340B drugs by buying them at a low price and selling them at a much higher price. This arbitrage can increase hospital revenues so patients may receive an indirect benefit from hospital programs, but it seems that many, if not most, hospitals do not devote substantial 340B revenues to charity care.

This ability to arbitrage the discounts provides a perverse incentive for hospitals to treat patients who have strong insurance coverage (and healthy drug reimbursement) rather than treating uninsured or underinsured patients as the program was intended. Hospital incentives to target patients with stronger insurance coverage helps explain the fact that the majority of 340B contract pharmacies in Oregon are located in affluent neighborhoods, where residents are likely to have better insurance coverage or Medicare.

I understand that the 340B program is important to some hospitals and clinics and state legislators may want to provide support for their efforts. But let me suggest that providing corporate welfare to for-profit pharmacy chains and PBMs may not be the best policy option.

Let me suggest a couple other policy options for state legislators to consider, with one option providing useful information to policymakers and the other option supporting patients who are treated at 340B facilities.

The first option -- which would give policy makers a window into how effectively the 340B program is operating in Oregon – is simply transparency. The state should require 340B hospitals to disclose to state officials how much revenue they secure from the 340B program and where they spend that revenue. This transparency would not entail cuts to the program, it would simply allow policy makers to see which institutions were spending the majority of their 340B money wisely and effectively. I should note that, unlike 340B hospitals, 340B clinics currently have substantial audit and charity care requirements so they could be exempted from these additional transparency requirements.

I know there are hospitals and clinics that are "doing the right thing" with their 340B revenues but we simply do not know which ones. The program could be supported and even bolstered for these worthy institutions, but not for those institutions that fail to spend adequately on charity care.

The second policy option – and one that would help patients – would be to simply require that the entire 340B discount be passed through to cash-paying patients. About 7 percent of 340B drugs are paid for in cash, probably because the patient is uninsured or has a high deductible. These patients would benefit greatly if the 340B discounts were passed to them. There is currently no legal requirement that hospitals pass on 340B discounts to patients, which seems a significant omission. Some 340B hospitals give their patients a discount card that allow patients to access 340B discounts at the pharmacy counter. Unfortunately, according to a recent study, only 1.4% of claims for 340B drugs were processed using a discount card which means that many cash-paying uninsured patients may be paying full price.

These discount cards should be in wider use, and the state might consider requiring 340B hospitals to provide these cards to their patients and might require all 340B contract pharmacies to accept them. The state could also require that the entire 340B discount be passed to patients, not a partial discount. This option would not deprive the hospital of any revenue as they would simply be passing along the identical discount that is provided by drug makers. For example, I know of a 340B drug that has a list price of $7000 per month yet sells for one penny at the 340B discount. An uninsured patient would surely benefit from paying only a penny for their drug.

I want to thank the committee for the opportunity to submit my views.