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 have a clinician and economist interest in the 340B program I have been studying for several years.

As I understand it, SB 533 Creates a civil penalty for drug manufacturers that interfere directly or indirectly with certain entities acquiring 340B drugs, delivering 340B drugs to certain healthcare providers, or dispensing 340B drugs. Unfortunately, this legislation will prohibit transparency for a program desperately requiring transparency.

Let me first share some specific data regarding the state of Oregon.

The following data is regarding 340B hospitals and contract pharmacies that operate within the state of Oregon. The following data is available on the Pioneer Institute Website - https://pioneerinstitute.org/340babuse/. The data was gathered through HRSA, RAND Insitute, a think tank similar to the Pioneer Institute, and the U.S. Census Bureau.

In Oregon, 8 out of the top 10 340B contract pharmacies with the most contracts are for-profit chain drug stores, for-profit pharmacies owned by for-profit Pharmacy Benefit Managers (PBMs), or pharmacies affiliated with health plans. This legislation can be correctly characterized as corporate welfare that drives revenue toward profitable companies.

Almost half of the contract pharmacies affiliated with the top 340B hospital in Oregon are out-of-state

Oregon Health Sciences University: 2024 (44%), 2025 (45%) – pharmacies as far as Texas, Florida and Hawaii

Location of pharmacies IN state: Only 51% are in Low-Income legislative house districts

Charity care provided by 340B hospitals in Oregon dropped year over year:

2021 U.S. (2.18%) Oregon (1.97%) OHSU (1.4%)

2022 U.S. (2.15%) Oregon (1.86%) OHSU (1.52%) vs Pioneer Memorial Hospital (5.19%)

In Oregon, most of the charity care is provided to insured than uninsured patients, which is very unusual and does not follow the pattern nationally or in neighboring states of CA, WA, or NV – where more charity care is provided to uninsured patients.

But let's discuss the contract pharmacy provision in front of the committee; this legislation will essentially expand the program by discouraging transparency for a government program that will soon eclipse Medicare's drug program. As the Minnesota Legislative report points out, almost 16% of revenue gained by the 340B hospitals is funneled to contract pharmacies and vendors. Millions of dollars of revenue that should go towards patient care are instead is enriching the coffers of big for-profit entities. This legislation can be correctly characterized as corporate welfare that drives revenue toward profitable companies.

The 340B program requires more transparency, not less. In fact, through transparency, pharmacies and institutions that do right by patients will be rewarded. The prohibition of biopharmaceutical companies from determining whether a drug was dispensed for an eligible 340B patient through contract pharmacies creates an environment for further opacity and potential for abuse.

Further, federal law explicitly prohibits "duplicate discounts," where manufacturers must give both a steep 340B discount to hospitals and substantial rebates to State Medicaid programs for

the same dispensed drug for the same patient. That's why biopharmaceutical companies need the information to ensure compliance with federal law. The General Accountability Office (GAO) has already voiced that the potential for noncompliance is a reality.

It is also essential to note that HRSA requires enforcement of compliance related to program eligibility, duplicate discounts, and diversion. Explicitly focusing on diversion, HRSA states that diversion occurs when a 340B drug is dispensed or administered to an ineligible patient who does not meet HRSA's definition of a "340B patient."

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

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

The first option -- which would give policymakers 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 policymakers 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 that they could be exempted from these additional transparency requirements.

I know some hospitals and clinics 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 State of Minnesota, as stated earlier, has taken this massive step toward transparency and accountability, and so should the state of Oregon.

The second policy option that would help patients would be to 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 for hospitals to pass on 340B discounts to patients, which seems to be a significant omission. Some 340B hospitals give their patients a discount card 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, meaning 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 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 revenue as they would pass along the identical discounts that drug makers provide. 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 benefit from paying only a penny for their drug.

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