Testimony on SB 533

Oregon Senate Committee on Health Care
March 6, 2025

Colleen Meiman
National Policy Advisor for the
Oregon Primary Care Association

Key Points about Federally Qualified Health Centers (FQHCs)

- Provide primary, behavioral, dental, lab, and preventive care.
- FQHCs are known as “the backbone of the health care safety net”, as they:
  - Are intentionally located in areas where there are large numbers of medically-underserved patients.
  - Serve largely low-income patients (roughly 70% below the poverty level.)
  - Provide care to everyone, regardless of ability to pay.
  - Charge patients using a sliding fee scale, based on their income.
  - Are community-based non-profits -- never owned or controlled by an outside organization.
  - Are managed by their own patients.
- **FQHCs serve 1 in 4 Oregonians, at more than 270 sites statewide**

TOPICS

- An Overview of 340B
  - Program Basics
  - How 340B Generates Savings, & How FQHCs Use Them
- The Need for SB 533

An Overview of 340B

Name & Overview

- **Name**: “340B” refers to the section of the Public Health Service Act that created the program in 1992.

- **Structure:** The program requires drug manufacturers to sell drugs at discounted rates to certain "safety net” providers for outpatient use.
  - Drug makers must agree to this as a condition of getting their drugs covered by Medicare and Medicaid

Key Point:
340B discounts are funded entirely by drug makers – NOT by taxpayers.
(The only cost to taxpayers is for a small staff to oversee the program.)

Which providers qualify for 340B?

"Covered Entities" – This term refers to all safety net providers that are eligible to participate in 340B.

- **Many hospitals, including those that:**
  - Have a DSH percentage of at least 11.75%.
  - Critical Access & Sole Community Hospitals
  - "Public" hospitals
  - Children's, cancer, and rural referral hospitals

85% of 340B purchases

- **Grantees** – providers who get HHS grants
  - FQHCs
  - Ryan White Clinics
  - ADAPs
  - STD, hemophilia, family planning, and other clinics

15% of 340B purchases

How big is the discount?

- **Required Discount** *(calculated off the best-guess of "sticker" price):*
  - 13.1% for generic drugs.
  - 23.1% for brand-name drugs.

- **Penalty discounts:**
  - If a drugmaker raises a drug's price faster than inflation, then an additional discount is applied.
  - The faster the drugmaker raises the price, the higher the discount.

Whenever a drug's 340B discount exceeds 23.1%, it's because the drugmaker raised the sticker price faster than inflation.

Key Point:

Drugmakers can reduce the size of 340B discounts by slowing down how fast they raise drug prices.

Why was 340B created?

- Without 340B, many small safety-net providers (e.g., CHCs) must pay the sticker price for drugs.
  - Large for-profit groups – like health systems and PBMs – can negotiate substantial discounts off sticker prices - but smaller non-profits often can't.
- Paying sticker price means small safety-net providers (e.g., FQHCs):
  - Spend relatively more on drugs, leaving less for other safety net services.
  - Often couldn't afford to offer pharmacy services at all.

Key Point:
Prior to340B, most FQHCs were unable to offer pharmacy services to their patients.
Thus, actions that undermine the 340B program threaten FQHCs' ability to continue offering pharmacy services.

Program Intent

When creating 340B in 1992, Congress said its purpose is to:

"permit covered entities ***to stretch scarce Federal resources as far as possible, reaching more eligible patients and providing more comprehensive services.***"

Two Key Points:

- **Congress intended 340B to directly support safety-net providers, rather than patients.** *The benefit to patients is real, but indirect.*
- **340B is about much more than pharmaceuticals – the funds it frees up support many different types of services.**

340B Supports Many Safety-Net Services

- 340B grantees like FQHCs are required – by law and regulation – to invest every penny of 340B savings into services that expand access for their medically-underserved patients.

- In Oregon, FQHCs use 340B to support under- or unreimbursed care and services such as:
    * Dental care for the uninsured
    * Mobile units
    * Mental Health and Substance Use Disorder Treatment
    * Expanded service offerings: transportation, translation, CHWs
    * Free or discounted prescriptions

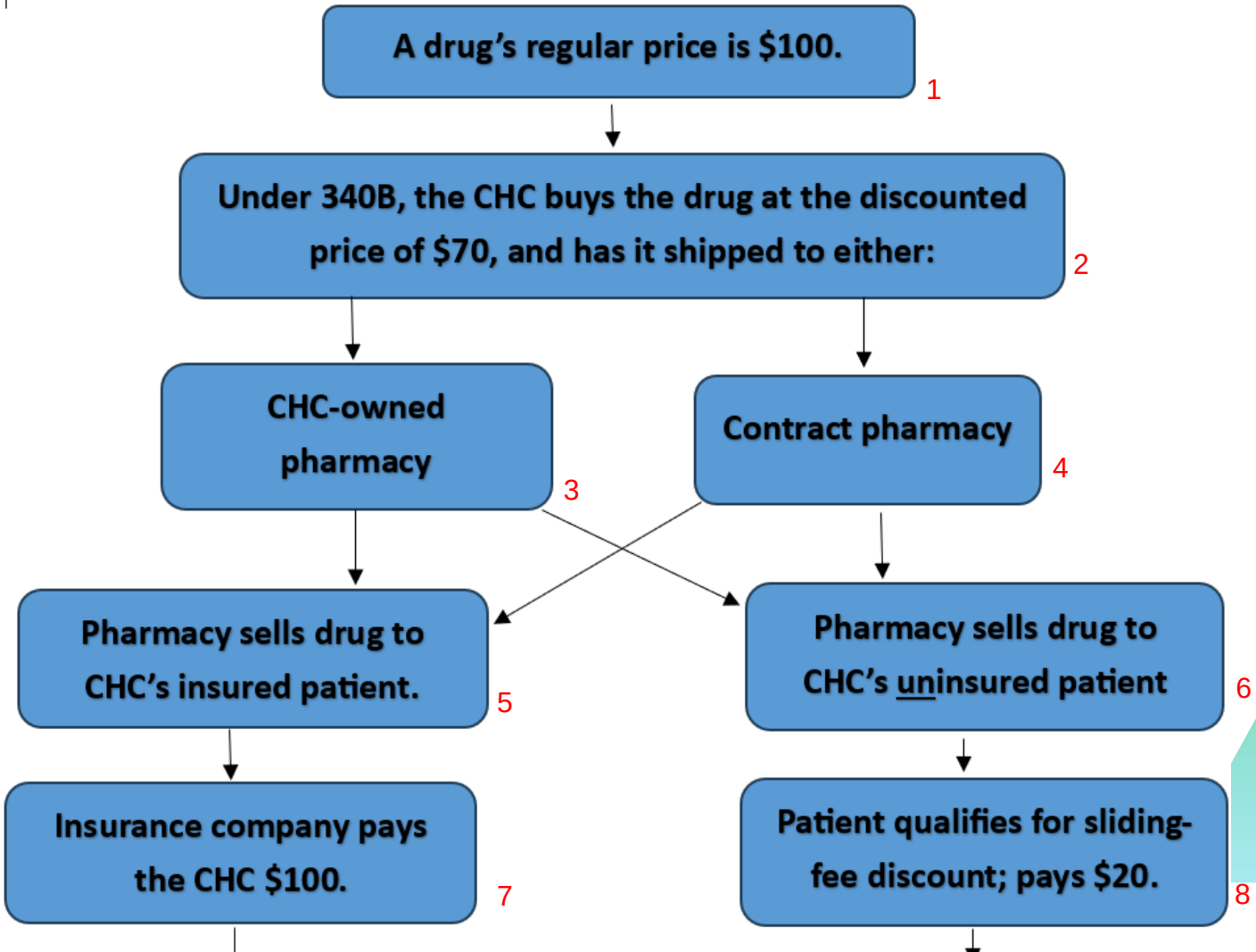
340B is Essential to the Financial Stability of Many Safety Net Providers

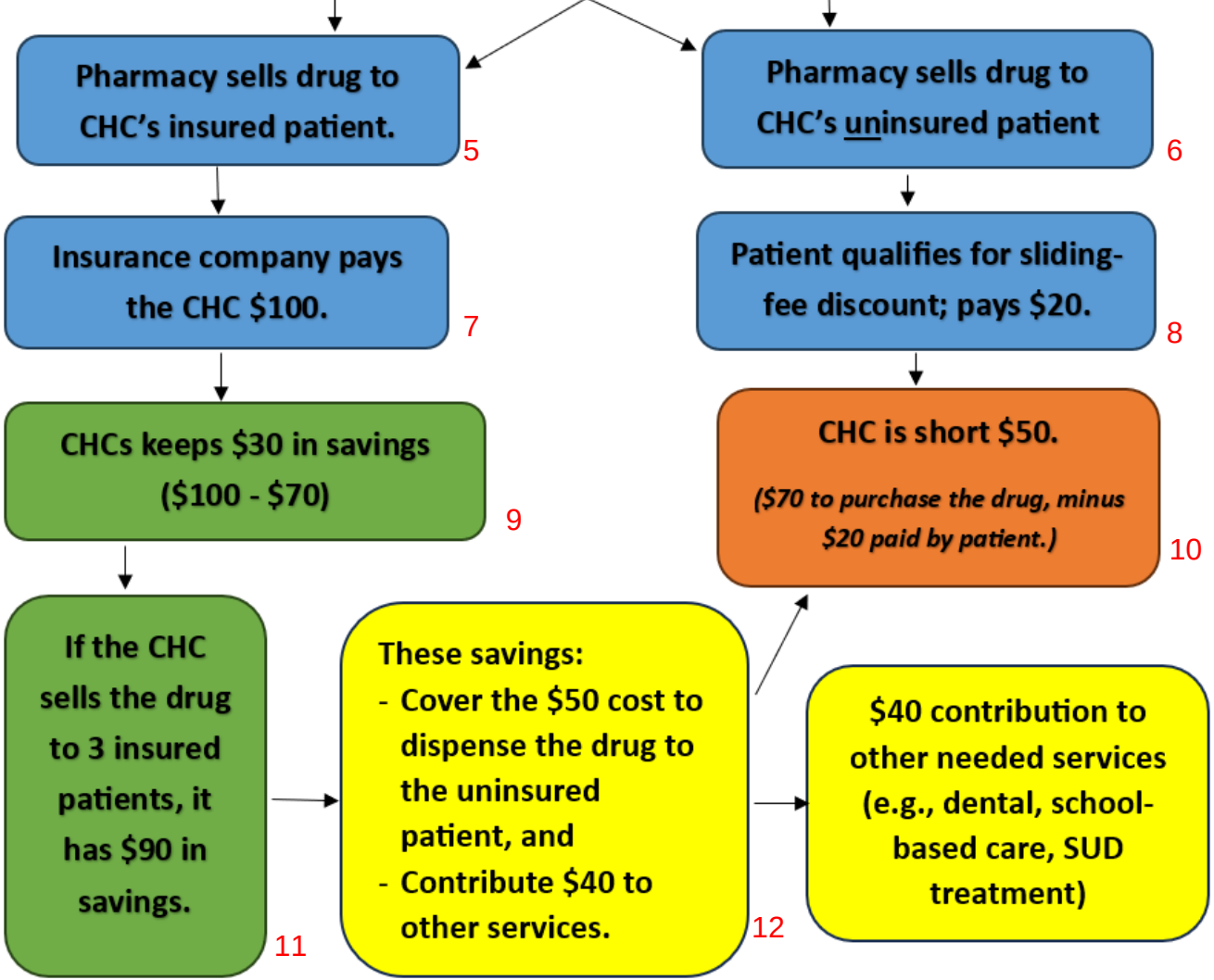
This is not an overstatement. For example:

- In 2023, Oregon FQHCs lost $10.5 million in contract pharmacy savings due to drug manufacturers' restrictions

If 340B went away, many safety net providers – including FQHCs – would have to significantly scale back their operations, or close their doors entirely.

How 340B Generates Savings, & How FQHCs Use Them

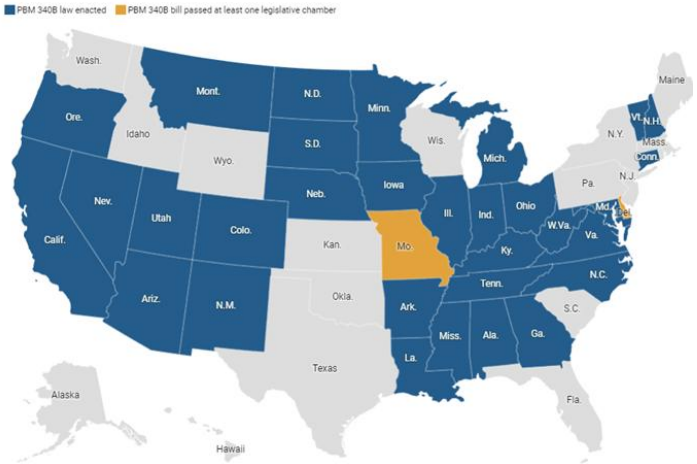

A drug's regular price is $100.
1
Under 340B, the CHC buys the drug at the discounted price of $70, and has it shipped to either:
2
CHC-owned pharmacy
3
Contract pharmacy
4
Pharmacy sells drug to CHC's insured patient.
5
Pharmacy sells drug to CHC's uninsured patient
6
Insurance company pays the CHC $100.
7
Patient qualifies for sliding-fee discount; pays $20.
8


Pharmacy sells drug to CHC's insured patient.
5
Pharmacy sells drug to CHC's uninsured patient
6
Insurance company pays the CHC $100.
7
Patient qualifies for sliding-fee discount; pays $20.
8
CHCs keeps $30 in savings ($100 - $70)
9
CHC is short $50.
($70 to purchase the drug, minus $20 paid by patient.)
10
If the CHC sells the drug to 3 insured patients, it has $90 in savings.
11
These savings:
- Cover the $50 cost to dispense the drug to the uninsured patient, and
- Contribute $40 to other services.
12
$40 contribution to other needed services (e.g., dental, school-based care, SUD treatment)
13

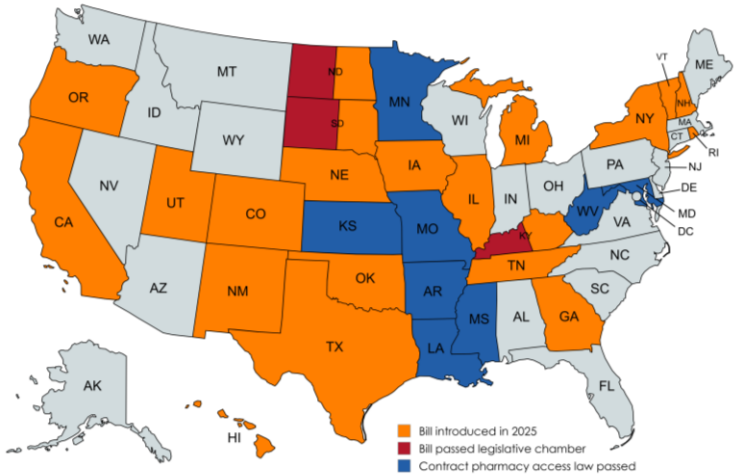
The need for SB 533

Congressional Inaction has led States to Step In

Despite multiple efforts, Congress has yet to update the 340B statute to address multiple challenges within the program. So states are stepping in:



Over 30 states have enacted laws to keep **PBMs** from taking 340B savings away from safety-net providers.



Eight states -- including West Virginia, Arkansas, Kansas, Louisiana, Mississippi, and Missouri – have passed law **banning contract pharmacy restrictions.**

Bans on Contract Pharmacies

- Since 2020, some PhRMA companies have refused to ship 340B-priced drugs to contract pharmacies. Currently:
  - 37 drugmakers ban contract pharmacies for hospitals.
  - 24 drugmakers have extended these bans to FQHCs.
- HHS has tried to stop the drugmakers' actions, but the situation has been languishing in the courts for years.
  - This has enabled PhRMA companies to continue and expand their bans (& avoid offering discounts), which in turn…
  - Deprives FQHCs and other covered entities of the savings from contract pharmacies – which they have relied on for over many years to support many underfunded services.

Key Point:
In another rural state, the losses due to contract pharmacy restrictions forced 75% of FQHCs to lay off staff in 2024

Colleen Meiman
National Policy Advisor for Oregon Primary Care Assn.
colleen@fachc.org
301-906-5958