Salem Health
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The Honorable Deb Patterson, Chair
Senate Committee on Health Care

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Chair Patterson, members of the Committee, for the record my name is Dr. Andrew Sowles. I am a licensed clinical pharmacist and director of ambulatory care pharmacy for Salem Health Hospitals & Clinics. I also oversee Salem Health's 340B program and our two medication management clinics. I'm pleased to testify today in full support of SB 533.

Salem Health is a nonprofit health system that was started by community volunteers over 125 years ago. We are a nurse-led organization, and our main hospital campus is just a few blocks away from where we sit today. At Salem Health, we see all patients at all levels of care within our organization regardless of their ability to pay. We are truly a safety-net provider.

Both Salem Hospital and West Valley Hospital are covered entities under the 340B program. We use 340B savings to fund two medication management clinics: one in Salem and one in Dallas. Marion and Polk counties have a higher incidence of diagnosed diabetes compared to surrounding counties.[1] Our medication management clinics pair clinical pharmacists with patients to help them manage diabetes and related co-morbidities. ***Our work has resulted in 11,552 life years gained for 1510 patients in just under five years of operation***. We're proud of this figure because it is evidence that we are addressing a pervasive public health issue, and that our work gives families more time with their loved ones.

340B funding is critical for these clinics because clinical pharmacists do not have provider status under federal law and cannot bill or be reimbursed for providing this level of care to patients.

These clinics are possible because Salem Health and drug manufacturers *choose* to take part in the 340B program – participation isn't mandatory. However, drug manufacturers' access to profitable Medicare and Medicaid markets is conditioned on their participation in 340B. An important fact as you consider if and how you will act on this legislation.

[1] Oregon Health Authority. (n.d.). *Data Report*. Retrieved March 3, 2025, from https://app.powerbigov.us.

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Under normal and historic circumstances, covered entities like Salem Health contract with other pharmacies. This is part of federal regulation and has been the norm for many years.[2] We used to contract with independent pharmacies, chains, specialty, mail-order, and out of state pharmacies, a practice that drug manufacturers have sought to curtail or even ban outright in recent years. However, contract pharmacies are necessary because:

- Some prescriptions require the use of specialty pharmacies
- Some insurance plans limit pharmacy choice for patients (sometimes because the insurance company and pharmacy are vertically integrated);
- Providers do not (and should never) tell their patients where to fill a prescription; and
- Contract pharmacies help meet the original legislative intent of 340B – to stretch scarce federal resources as far as possible, to reach more eligible patients and provide more comprehensive services.

Contract pharmacies dispense under the authority of the covered entity. When the Health Resources and Services Administration (HRSA) audits Salem Hospital, *WE* are responsible not just for our own 340B transactions, but those handled by contract pharmacies.

In 2023, Salem Health West Valley Hospital in Dallas was audited (with no findings substantiated). Last year, Salem Hospital was audited (we're waiting for the results). You may hear that program rules for covered entities are not enforced. I'm here to tell you that's not true.

Some will tell you that patients don't benefit from 340B savings. That couldn't be further from the truth – and the 11,552 life years gained by our patients are proof.
Some will complain that patients don't benefit financially when they pick up their prescriptions. Frankly, every nonprofit hospital in Oregon has a generous financial assistance program. At Salem Health, that extends to helping patients pay for medical expenses, by consistently offering financial assistance totaling more than $50 million annually – something we've been doing long before there was any state legislation on financial assistance or community benefits.[3]

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[2] Notice Regarding 340B Drug Pricing Program—Contract Pharmacy Services. Volume 75, No. 43. Fed. Reg. page 1 (2010, March 5). Retrieved from https://www.govinfo.gov/content/pkg/FR-2010-03-05/pdf/2010-4755.pdf

[3] Salem Health Hospitals & Clinics. (2024). *Community benefit reports | About us | Salem Health*. SalemHealth.org; Salem Health Hospitals & Clinics. https://salemhealth.org/about/community/community-benefit-reports

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Drug manufacturers and PhRMA will point to the growing size of the 340B program as justification for their efforts to shrink it. Frankly, the size and cost of the 340B program has grown in direct proportion to exponential increases in the cost of prescription drugs. Safety-net providers don't control drug pricing. Drug manufacturers and pharmacy benefit managers (PBMs) do.

Both Arkansas and Louisiana have passed legislation like what you're considering today. The result is that people in those states are benefitting from fully leveraged 340B savings invested in access to care. Right now, Oregonians are missing out on those dollars.

I hope this helps you understand that SB 533, if passed into law, can help low-income, uninsured, and rural Oregonians and those who care for them.

Thank you for the opportunity to testify this afternoon.

Sincerely,

Andrew J. Sowles

Andrew J. Sowles, PharmD
Director, Ambulatory Care Pharmacy