Jason B. Reddish – Proponent
House Health Committee
Testimony on House Bill 482
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Chairman Lipps, Ranking Member Boyd and Members of the House Health Committee, my name is Jason Reddish, and I am at attorney at the law firm Feldesman Tucker Leifer Fidell LLP. I work almost exclusively on 340B program issues on behalf of 340B program participants – most notably federally qualified health centers and Ryan White HIV/AIDS Clinics – nationwide. We represent the National Association of Community Health Centers, Ohio Association of Community Health Centers, and more than a dozen hospitals, health centers, and HIV clinics throughout the State of Ohio. Thank you for the opportunity to provide testimony in support of House Bill 482.

The 340B Program and Covered Entities

The federal 340B drug discount program was designed to reduce outpatient drug costs for certain types of safety net providers called "covered entities." Covered entities include federally qualified health centers, hemophilia treatment centers, Ryan White HIV/AIDS Program grantees, children's hospitals, and hospitals that treat a disproportionate share of low-income Medicaid and Medicare patients. Drug manufacturers that participate in the 340B program must offer their outpatient drugs for purchase by covered entities at or below a ceiling price specific to each drug formulation and dosage. The discount approximates the price paid by Medicaid programs, after application of Medicaid rebates. Manufacturers participate in the 340B program voluntarily, but they must participate in order to have their drugs covered by Medicare and Medicaid, so nearly all do.

Covered entities benefit from the program in two ways. When discounted drugs are dispensed to **uninsured patients**, covered entities **lose less** and can discount the drug price for the patient. When discounted drugs are dispensed to **insured patients**, the covered entities can leverage the savings from the improved margin to **subsidize costs**.

Health centers have a statutory obligation to ensure that all patients can access required primary health care services, including pharmacy services, regardless of their ability to pay. Health centers use 340B program savings exactly as Congress intended – to stretch scarce federal resources to provide more comprehensive services to more eligible patients. The discounts are often extended directly to patients, but the savings are also used to provide necessary services to health center patients for which no reimbursement is available.

The Benefits of the 340B Program Are Being Appropriated by Payers and PBMs

Congress did not intend for 340B program discounts to be captured by pharmacy benefit managers (PBMs) or private insurers. Increasingly, PBMs and payers are establishing two levels of payment for pharmacy-dispensed drugs – one for chain and retail pharmacies unaffiliated with 340B providers, and another **significantly lower** rate of reimbursement for drugs purchased through the 340B program.

We have seen examples of this predatory behavior in the State of Ohio. One Ohio health center and Ryan White HIV/AIDS clinic was told that it would have to accept reimbursement at the 340B cost of the drug dispensed, plus a minimal dispensing fee, in order to participate in the nationally known payer's network. Each time that safety net clinic dispenses a drug covered by that payer, it would **lose** money.

A federal grantee would be subsidizing a **Fortune 100** entity for the privilege of ensuring that its patients got the medication prescribed to them. Another nationwide PBM informed Ohio 340B pharmacies in early 2019 that it would cut 340B drug reimbursement if drug manufacturers stopped paying the PBM privately negotiated kickbacks on 340B drugs.

PBMs and insurers "pickpocket" 340B savings because they currently can. A pharmacy must participate in the major PBM networks in order to have a viable business. PBMs know that pharmacies have lower acquisition costs for 340B drugs and reduce reimbursement to essentially shift those savings from the covered entity's account to their own.

House Bill 482 prevents pickpocketing by requiring PBMs and payers to pay at least the National Average Drug Acquisition Cost (NADAC) for 340B drugs. NADAC is the average price paid by retail pharmacies for a given drug. NADAC does not represent a windfall for covered entities, but rather ensures that they realize the value of the 340B discount. House Bill 482 also prohibits other discriminatory contracting tools, such as 340B-specific fees.

Covered Entities Rely on Medicaid Drug Reimbursement

Dwindling managed Medicaid reimbursement has also imposed a staggering burden on safety net providers, and on federally qualified health centers in particular. Covered entities are required to bill 340B drugs to fee-for-service Medicaid at cost, plus a uniform professional dispensing fee ranging from $8.30 to $13.64 depending on the pharmacy's prescription volume. Because covered entities pass the 340B discount onto the Ohio Department of Medicaid when billing fee-for-service Medicaid directly, the state refrains from seeking a Medicaid rebate on the drug.

When Congress expanded the Medicaid drug rebate program to include drugs covered by Medicaid managed care plans, it excluded 340B drugs from those for which the state can claim a rebate. Congress recognized that federally qualified health centers and other safety net providers rely on reimbursement from Medicaid managed care plans, and their PBMs, to stay afloat. You have taken a national leadership role in prohibiting PBM "spread pricing" in Medicaid, in which the PBM charges the state more than it actually pays pharmacies, and the Ohio Department of Medicaid is implementing a single PBM model for Medicaid managed care that is projected to further reduce drug spending.

Federally qualified health centers and other covered entities are reliant on managed Medicaid drug reimbursement to be able to offset drug costs for the uninsured and underinsured. House Bill 482 preserves the intent of the 340B program – that covered entities receive the benefit of the 340B discount when managed Medicaid pays for a drug – by using NADAC as the reimbursement floor. Since the managed care plans presumably pay retail pharmacies at least their average acquisition cost for drugs, and since drugs purchased through the 340B program and billed to managed Medicaid are not eligible for a Medicaid rebate, the minimum payment threshold should not have any fiscal impact.

Protection for Covered Entities Must Come at the State Level

Congress certainly did not intend for drug manufacturers to give discounts to vulnerable safety net providers only to have those discounts taken by for-profit payers and PBMs, but it did not give the federal regulatory authorities the power to defend the 340B savings on behalf of covered entities. Rather, those protections have fallen to state legislatures. At least six states (West Virginia, Oregon, Utah, Minnesota, South Dakota, and Montana) have passed 340B pickpocketing protections, and

legislation has been proposed in a handful of additional states.

House Bill 482 prohibits discriminatory reimbursement of 340B covered entities and their pharmacies. It protects the savings that Congress intended and ensures that health centers and other covered entities can continue to provide the services that vulnerable Ohioans need most and often cannot obtain in any other way, during the ongoing COVID-19 pandemic and beyond.

Ohio has been at the forefront of breaking the stranglehold that PBMs have over pharmacies, Medicaid, and insurers. On behalf of the Buckeye State's covered entities, I sincerely thank you for that work. I would like to thank Representatives Manchester and Clites for introducing this legislation, and I hope you will agree that it provides necessary protection for the state's safety net providers.