Ohio Association of Community Health Centers
House Health Committee
Testimony on Senate Bill 263
December 8, 2020

Chairman Lipps, Ranking Member Boyd and Members of the House Health Committee, my name is Julie DiRossi-King, and I am the Chief Operating Officer for the Ohio Association of Community Health Centers (OACHC). Thank you for the opportunity to provide proponent testimony on Senate Bill 263.

The Ohio Association of Community Health Centers (OACHC) represents Ohio's 56 **F**ederally **Q**ualified **H**ealth **C**enters and FQHC Look-Alikes (more commonly referred to as Community Health Centers (CHCs)), providing care across 400+ sites spread throughout the entire state. Community Health Centers are non-profit health care providers that deliver affordable, quality comprehensive primary care to medically underserved populations, regardless of insurance status.

For more than 50 years, Community Health Centers have provided integrated whole person care, often times providing **medica**l, **dental, behavioral, pharmacy, vision and other needed supplemental services under one roof.** Community Health Centers are the nation's largest primary care network, located in every state and territory, serving more than 29 million patients in roughly 12,000 communities nationwide. Last year in Ohio alone, this translated to over 850,000 patients, 3.3M patient visits.

Health Center patients are among the nation's most vulnerable populations – people who are isolated from traditional forms of medical care because of where they live, who they are, the language they speak, and their higher levels of complex health care needs. As safety net providers, health centers have a proven record of delivering high-quality, low-cost health care, coupled with a strong presence in vulnerable/highest need communities – including impoverished urban neighborhoods, small towns and rural counties where poverty and unemployment are historically higher. Health Centers produce positive results for their patients and the communities they serve while their **costs of care rank among the lowest.**

As safety net providers, Community Health Centers are eligible for the federal 340B Drug Pricing Program. Established in 1992 by Congress, the 340B Drug Pricing Program provides certain safety net providers, referred to as covered entities, access to prescription drugs at reduced prices. Drug Manufacturers participating in Medicaid/Medicare are required to provide outpatient drugs to 340B covered entities at significantly reduced prices. When creating the Program in 1992, Congress stated that it intended eligible safety net providers to use the savings to "to stretch scarce Federal resources as far as possible, reaching eligible patients and providing more comprehensive services."

By purchasing medications at a lower cost, covered entities pass the savings along to their patients through reduced drug prices, and can then use any additional savings to support their mission to expand access to services, and improve health outcomes with their patients, and for their communities. Eligible covered entities are defined in federal statute and include FQHCs and FQHC Look-Alikes, Ryan White Clinics, Hemophiliac Treatment Centers, Medicare/Medicaid Disproportionate Share Hospitals, Children's Hospitals, and other safety net providers.

Under the 340B Program, Community Health Centers are federally mandated to pass the savings from the reduced drug prices to their patients, helping our low-income uninsured and underinsured patients afford their medically necessary medications. **It is important to note, Health Centers are required by law, regulation, and mission to invest every penny of 340B savings into activities that expand access to care for our medically-underserved patients.** Health centers exemplify the type of safety net provider that the 340B Program was intended to support. Savings generated under 340B help health centers provide their low-income patients with access to affordable pharmaceuticals, and also support many other programs and services that they otherwise could not financially sustain. This includes:

- expanded access to dental care
- wraparound services to combat opioid and substance use disorders and end the HIV epidemic
- adding or extending early morning, evening and weekend hours so that patients who work during the day can still access their primary care provider after normal business hours

The ability to reinvest savings to support or expand primary care services – whether inside or outside the pharmacy space - ultimately increases patients' access to the right kind of care, at the right time, and in the appropriate, most cost-effective setting, thus reducing costs elsewhere in the healthcare system.

Ohio has been at the forefront of exposing predatory practices by certain Pharmacy Benefit Managers (PBMs), and we applaud this body and all members of the General Assembly for tackling the issue. SB 263 shines the spotlight on another related practice: PBMs in Ohio and in other states across the country are targeting 340B providers with discriminatory contracts. Discriminatory contracting refers to a range of practices that effectively transfer the benefit of 340B savings from health centers and their underserved patients to private for-profit entities including but not limited to Pharmacy Benefit Managers (PBMs) and private and public insurers. While there are many ways to engage in discriminatory contracting, common examples include:

- Offering lower reimbursement for a drug purchased under 340B than for the same drug if purchased outside 340B which undercuts the intent of the Program and redirects the benefit to the above mentioned for-profit entities.
- Refusing to cover drugs purchased under 340B, either directly or by refusing to allow 340B pharmacies to participate in their networks altogether.
- Charging more than fair market value or seeking "profit-sharing" in exchange for services involving 340B drugs.

Unfortunately, due to a lack of options, 340B covered entities are left in "take-it-or-leave-it" contract scenarios. If a covered entity signs a discriminatory contract, they give away their savings and support for services. However, if the covered entity does not sign, they both lose the savings and support, and can only offer few, if any, options for their patients to access needed medications. Both paths present significant access to care issues, regardless of the patient's insurance status, in some of our most medically underserved and economically depressed communities across Ohio, many of which are already known to be pharmacy deserts.

SB 263 passed out of the Senate unanimously last week and the companion bill, House Bill 482, passed out of this committee last week as well. This legislation prohibits the predatory practice of imposing fees or reducing reimbursement to Ohio 340B providers - simply because they are a 340B provider and payers know there is a margin of savings to target. The bill protects the intent of the 340B Program by ensuring these savings are directed to our most vulnerable and not PBMs.

Thank you for your time and consideration for SB 263, I am happy to answer any questions you have at this time.