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Advancing Health in America

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May 31, 2023

The Honorable Brett Guthrie
Chair
Subcommittee on Health
Energy and Commerce Committee
U.S. House of Representatives
Washington, DC 20515

The Honorable Anna Eshoo
Ranking Member
Subcommittee on Health
Energy and Commerce Committee
U.S. House of Representatives
Washington, DC 20515

Dear Chair Guthrie and Ranking Member Eshoo:

I am writing in response to your request to address questions for the record related to my participation at the April 26, 2023, hearing before the House Energy and Commerce Subcommittee on Health, "Lowering Unaffordable Costs: Legislative Solutions to Increase Transparency and Competition in Health Care."

Attached please find responses to questions from subcommittee members.

If you have any questions about this information, please contact Aimee Kuhlman, AHA's vice president of advocacy and grassroots, government relations, at akuhlman@aha.org or (202) 626-2291.

Sincerely,

Ashley Thompson

Ashley Thompson
Senior Vice President
Public Policy Analysis and Development

Attachment

Questions for the Record

Ashley Thompson, Senior Vice President, Public Policy Analysis and Development, American Hospital Association

U.S. House Energy and Commerce Committee

Subcommittee on Health

"Lowering Unaffordable Costs: Legislative Solutions to Increase Transparency and Competition in Health Care."

April 26, 2023

In response to The Honorable Richard Hudson's questions

1. **Iqvia, a leading pharmacoeconomic and health information vendor, recently examined how patients benefit from the 340B program. In its conclusion it stated: "The 340B Drug Discount Program as it exists today is a complex system of arbitrage involving multiple stakeholders, each of which profits from 340B revenue. It's a drug discount program in which most vulnerable patients at contract pharmacies often do not get the drug discounts." Source. How do hospitals ensure that the drug benefits provided by the 340B program impact the patients to which they apply its discounts?**

The 340B program is structured in such a way that it gives hospitals flexibility to use the savings that it achieves from participation in the program to address the unique needs of the patients and communities they serve. This flexibility is extremely important, as the needs of a rural 340B hospitals' patients may be different than those of an urban 340B hospitals' patients.

For example, a rural hospital may use its 340B savings to provide access to labor and delivery services in their local community so that patients do not have to travel long distances to receive that care. On the other hand, an urban hospital may decide to use its savings to support a diabetes counseling and education program to target the city's underserved population. In each of these examples, the hospital's 340B savings are being directly applied in a way that improves access to care and ultimately the health and well-being of the patients they serve. One of the many ways that hospitals use their 340B savings is to discount the cost of drugs directly to their patients. In some cases, hospitals can offset the cost entirely for these medications. Together, 340B hospitals alone provide approximately $68 billion in community benefits, due in large part, to

these hospitals' 340B savings.[1] In addition, 340B hospitals are responsible for 77% of the inpatient care provided to Medicaid patients.[2]

Finally, the savings 340B hospitals achieve through the program — whether at the main hospital location, an offsite clinic in the local community or a community pharmacy with which the hospital contracts with — are not limited to use only for the patients at that site of care. The savings are used across the hospital to benefit all as stated in the purpose of the program and spelled out in the 340B statute: to stretch scarce resources and provide more comprehensive services to more patients.

2. **The 340B drug discount program has grown dramatically over the past several years. Total program drug purchases grew 15 percent alone in 2021. Among all of the hospital and grantee covered entities, one grew over 54 percent: Sexually Transmitted Disease Clinics (source). Interestingly, the CDC reported that STDs during this time period grew at rates of ~7-10 percent (source). Are you aware of any medical trends that could explain this rapid growth of 340B STD clinic drug purchases? Are you aware of any 340B scheme that could explain this rapid growth of 340B STD clinic drug purchases?**

One of the primary factors that influences the amount of drug purchases made by 340B covered entities are the prices of the drugs themselves — which are set by drug companies alone. These drug prices are also constantly and arbitrarily increased by drug companies. This is an unfortunate and challenging situation that all 340B entities must manage. As the prices of the drugs rise, the amount 340B entities spend to acquire those drugs also increases, especially as demand for care also grows.

One factor that may be influencing the growth in drug purchases for 340B STD clinics is the growth in drug prices to treat conditions like Hepatitis C. Drugs like Epclusa, Harvoni and Sovaldi used to treat Hepatitis C can cost anywhere from $22,000 to over $80,000 for a standard 12-week treatment. Even with 340B discounts, these drugs are extremely expensive for 340B entities to acquire and provide to their patients.

In response to The Honorable Yvette Clarke's questions

1. **Starting on October 1st, safety net hospitals will face an $8 billion annual cut this year and continuing through fiscal year 2027 for a total of $32 billion. This represents OVER two-thirds of the federal share of the program and would be a devastating blow to the health care safety net. That is why I introduced, H.R. 2665, the Supporting Safety Net Hospitals Act. Which would eliminate Medicaid Disproportionate Share Hospital (or DSH) cuts in fiscal years 2024 and 2025 – cuts that, as I said, Represent TWO-THIRDS of all federal Medicaid DSH funding.**

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[1] https://www.aha.org/2022-06-07-2022-340b-hospital-community-benefit-analysis
[2] https://www.healthaffairs.org/content/forefront/30-years-340b-preserving-health-care-safety-net

If the proposed cuts go into effect, rural and urban safety net hospitals will lose critical funding that enables them to keep their doors open and provide care to the most vulnerable Americans.

My first question is intended for Ms. Thompson. Could you describe the impact of these cuts on U.S. hospitals that serve a safety net role, if they were to go in effect? How does this legislation alleviate concerns?

Should these cuts go into effect, it would have a devastating impact on the hospitals that receive Medicaid DSH payments, as well as the patients they serve. We anticipate that hospitals would have to reduce services in their communities to adjust to state allotment cuts that, according to the Medicaid and CHIP Payment and Access Commission, vary from a 10% reduction to as much as a 90% reduction, depending on how a state's DSH program is structured.[3] H.R. 2665 would alleviate these concerns by eliminating the pending cuts for the next two fiscal years — a time when our members are still facing financial challenges coming out of the pandemic, as well as the potential of caring for additional uninsured patients who may be losing their Medicaid coverage in the next year as the redetermination process continues.

2. **You all may remember, at the beginning of the COVID-19 pandemic, my state, specifically, New York City was hit the hardest and frontline hospital workers were extremely crucial to addressing the ever-evolving needs of the pandemic.**

   Ms. Thompson, do you believe these cuts would affect the magnitude of hospitals responding to any future pandemics or health crises?

The short answer to your question is yes — any reduction to hospital funding could impact a facility's ability to respond to a future crisis. Hospitals serve as anchors in their communities, providing care to everyone, regardless of insurance status, 24/7. Any cut to their funding could have consequences for hospitals as they prepare to face the next challenge, whether that is a health care pandemic or natural disaster. The investment hospitals make in stand-by capacity is essential to ensuring they have the staff available to serve patients during both daily emergencies as well as more sustained crises.

[3] https://www.macpac.gov/wp-content/uploads/2023/03/Chapter-4-Annual-Analysis-of-Medicaid-DSH-Allotments-to-States.pdf