COMMUNITY CARE NETWORK OF KANSAS

**Proponent Testimony for SB 284**
**Senate Committee on Financial Institutions and Insurance**
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Madame Chair Dietrich and Members of the Committee thank you for the opportunity to provide testimony in support of SB 284 on behalf of Community Care Network of Kansas. Community Care is a statewide association serving 25 health centers and community-based clinics providing care at over 90 sites across Kansas. Clinics in our network are open to anyone, with a specialty of serving the most vulnerable and underserved Kansans. Last year, the network served 350,531 patients, or one in nine Kansans. Patients visiting our centers disproportionately represent the working poor, the uninsured, and those who receive health coverage via Medicaid. These clinics provide whole-person care, including medical, dental, pharmacy, behavioral health, substance use disorder, care management, and wrap-around services to meet transportation and other social and economic needs. Clinics provided these services through more than 1.16 million patient visits in 2024.

Senate Bill 284 restricts pharmaceutical manufacturers from imposing limits on the pharmacies that 340B covered entities can contract with to supply medications to patients and keeps manufacturers from requiring data from participants beyond that required by the Health Resources and Services Administration (HRSA) to receive medications. The bill empowers the Kansas Attorney General to oversee and regulate these activities. Over the last few years, several pharmaceutical manufacturers participating in the 340B program have attempted to limit the program's benefits to low-income patients and covered entities such as disproportionate share hospitals and federally qualified health centers through these controls.

Manufacturers have limited access to medications covered under the 340B program in two significant ways in the last few years. First, they restricted the number of pharmacies covered entities could contract with to provide medications to their patients. Second, they put additional requirements on the covered entities and pharmacies providing service through the program. The manufacturers implemented additional data requirements that put an undue burden on covered entities. This data requirement is more than the data covered entities were required to provide under the existing rules of the program. Both requirements reduced patient access and increased the administrative burden of the program with no additional benefit to the patient, provider, or program.

SB 284 allows the 340B program to continue supporting the Kansas safety net as the federal program originally intended. The bill requires the manufacturers to continue their participation in the 340B program in Kansas under the program's original rules. It disallows behaviors that reduce patient access to medications and reduces care the program is intended to support.

**340B Background**

The 340B Drug Pricing Program was established in 1992 as part of the Veterans Health Care Act. Its primary goal is to enable eligible healthcare organizations, known as "covered entities," to purchase outpatient drugs at significantly reduced prices, allowing these organizations to stretch their limited federal resources to provide more comprehensive services and reach more patients, particularly those who are uninsured or underinsured.
Covered entities include various hospitals and clinics, including disproportionate share hospitals and federally qualified health centers. The overarching purpose is to ensure that these organizations can continue to provide essential health services to those in need. The program aims to lower medication costs and support the financial stability of healthcare providers that qualify as covered entities

The program was created in response to the rising costs of pharmaceuticals, which were making it difficult for safety-net providers to serve vulnerable populations. Drug manufacturers participate in the 340B program primarily because it is a requirement for their products to be covered by Medicaid and Medicare. The 340B program mandates that manufacturers provide discounts on outpatient drugs to covered entities in exchange for their drugs being included in Medicaid and Medicare Part B.

The 340B program provides two significant benefits to patients. Patients who cannot afford their medications, usually due to not being insured, can receive medications at greatly reduced costs. This allows patients to receive the medications they need to be healthier, and in several instances, that saves their lives. In addition, for those patients that do have insurance, the difference in the price the covered entity pays for the 340B medication and the contracted reimbursement received from insurance for the medication is captured and reinvested in patient care to provide more comprehensive services and reach more patients, particularly those who are uninsured or underinsured. Both of these outcomes are directly in line with the program's intent. These savings are not a loophole or unintended windfall; they are the foundation that enables these providers to continue offering care to communities that would otherwise go without. Moreover, the 340B program operates at no cost to taxpayers. The savings generated come from discounts provided by pharmaceutical manufacturers as a condition of their participation in the Medicaid and Medicare Part B programs—not from government funding.

**Impact of Current Environment**

Due to the actions of the manufacturers mentioned above, we have seen monumental negative consequences for patients. When manufacturers artificially restrict the number of pharmacies covered entities can contract with as part of the program, it does little more than reduce patient access to medications. This reduced access results in fewer prescriptions being filled and fewer necessary medications being taken by patients. These prescriptions are not filled, not because those prescriptions are fraudulent or inappropriate in any way, but simply because the manufacturers have made it unnecessarily more difficult for those needed prescriptions to be filled.

Our members provide care to patients that can span several counties or live across the breadth of the urban areas they serve. In both situations, patients not being able to access medications at the pharmacies that are closest to them limits access. Often, transportation issues lead to patients needing access to their medicines at

local, nearby pharmacies. The lack of accessibility due to manufacturers trying to control the volume of 340B covered medications being used leads to poorer individual health and sicker people, which in turn leads to higher utilization of acute care (i.e. emergency rooms). This is just another example of the misguided actions of the manufacturers hurting those patients that the 340B program was designed to help and driving up the total cost of care.

In addition, several manufacturers are requiring data to be submitted to them to continue receiving their product that is far above that required by the 340B program, which has led to a redirection of resources from patient care. Members have had to dedicate positions to simply complying with these excessive data requirements. The result of this is a reduced availability of resources to engage with patients. We have had instances where to provide the additional information required by a manufacturer, members have had to leave direct patient care positions unfilled to allow them to hire administrative staff to handle the additional workload related to this data. Again, this additional data is not required by the federal program and in many cases, it is highly suspect as to how the data relates to the stated issue the manufacturer is trying to remedy.

For most of these requests, the stated intent is that the data is needed to guarantee that prescriptions are not receiving duplicate rebates or discounts. We have serious concerns that some manufacturers require data, such as diagnosis codes, that we believe have nothing to do with identifying administrative issues, such as duplicate discounts. These requirements support the belief that the requirements are not meant to help resolve an administrative problem and are instead being implemented to tax provider resources and limit the reach of the 340B program. They are more punitive and do not benefit the patient, the provider, or the greater health system.

Recently, several manufacturers have forwarded plans requiring covered entities to buy medications at full price and then receive a rebate on the back end to account for the discounted price of the drugs. HRSA has told manufacturers that they would not allow this disruptive practice, and in response, the manufacturers have sued HRSA. This process would have a disastrous impact on our members' ability to fund services throughout the year. The basic process in most of these plans includes the manufacturers requiring covered entities to purchase drugs at prices based on an artificial cost platform that, in many cases, has drugs listed at higher prices than providers can purchase in their regular course of business. After charging them a higher-than-market rate to buy the drug, the manufacturers want to hold that cash until they determine the prescription meets their criteria for a rebate. Because health centers operate under tight margins with limited cash on hand, widespread use of this rebate model would severely limit the ability of our members to participate in the 340B program. This process will increase the costs to the system while, once again, providing no additional benefit to anyone other than the manufacturer.

**Other Considerations**

You may have heard arguments against SB 284, and I would like to address two of the more pervasive arguments we have heard in preparing this bill and that have been forwarded during discussions on other bills like it across the country.

One argument is that this is a federal program and should get a federal fix. We agree that in a perfect world, the issues often cited by manufacturers as being weaknesses of the program would receive a federal fix. We



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also think that until the federal government addresses those issues, the actions of the manufacturers that harm our patients and safety net providers' ability to provide the services the 340B program was designed to support need to be controlled. Rightly or wrongly, the protection of those most at risk in this scenario, patients and safety net providers has fallen to the states. This bill puts Kansas in the company of 29 other states that have passed or are considering similar legislation. While manufacturers have questioned several of the new state laws in court, SB 284 was drafted using language that has been upheld in various courts.

Another argument you might hear is that providers are profiting off 340B instead of helping patients. This is not the case at any of our member facilities. Critics often argue that covered entities use 340B savings for financial gain rather than patient care. However, this overlooks the crucial fact that insured patients drive the savings that sustain uncompensated care. These savings are not government subsidies but are manufacturer discounts designed to help safety-net providers reinvest in patient care. Health centers are required by law to reinvest 340B savings back into services for patients and must demonstrate to HRSA that they are meeting this requirement.

Many CEs operate on razor-thin margins and heavily depend on the revenue generated through 340B to keep their doors open. These savings partly fund free clinics, additional service lines at our clinics, medication assistance programs, and community health initiatives for uninsured and underinsured patients. Without 340B, many of these safety-net providers would be forced to reduce services or close altogether, leaving vulnerable populations with even fewer options for care. All providers that participate in 340B qualify for the program because they provide a high volume of care to poor or other vulnerable patient populations, such as those located in remote rural areas.  Each of them uses their savings to invest in more services and programs for these patients, such as expanded labs, free mobile clinics, transportation, nutrition, or dental programs.

**Request**

Thank you again for providing us with the ability to testify in support of SB 284. This bill protects Kansas safety net providers from predatory, punitive practices that pharmaceutical manufacturers have implemented over the last few years. These practices are being touted as protecting the program. They do not. They only harm the patients and those providers who have dedicated some or all of their practices to serving the uninsured or underinsured.

We ask for your support of SB 284 and its favorable passage from the Committee.

Thank you for your time and consideration of this critical issue. I would be glad to stand for questions when appropriate and am available to you at any time to discuss this issue.



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