March 4, 2025

Senate Committee on Health Care
Oregon State Legislature
900 Court St. NE
Salem, OR 97301

Lilly USA, LLC

Lilly Corporate Center
Indianapolis, Indiana 46285
U.S.A.
+1.317.276.2000
www.lilly.com

Dear Chair Patterson, Vice-Chair Hayden and members of the Committee,

I am writing to express Eli Lilly and Company's opposition to Senate Bill 533 (SB 533), which proposes to alter the federal 340B program by requiring that pharmaceutical manufacturers extend federal 340B discounts to for-profit contract pharmacies. Not only would SB 533 expand the 340B program – a program that recent studies have shown results in higher costs for patients and payers – but it would also intrude into an exclusively federal program, making it patently unconstitutional. In fact, West Virginia was recently enjoined from implementing a nearly identical proposal. For these reasons, we encourage the legislature to focus on reforms that help ensure patients benefit from the discounts and rebates that are paid into the healthcare system.

1. **Although the 340B program has exponentially expanded,[1] patients do not benefit from the 340B program. In fact, patients' costs may go up.**

Recent studies demonstrate that participation in the 340B program does not result in additional patient benefit – at the pharmacy counter or otherwise. For example, the North Carolina State Treasurer's Office recently found that North Carolina 340B hospitals charged cancer patients – on average – 5.4 times more than what the hospitals paid to acquire the oncology medicines.[2] In addition, the New York Times recently reported that **an Oregon 340B hospital charged an *insured* Oregonian more than $2,500 for her cancer drug**, more than half her take-home salary for a month. Even though the medicine's *list price* was about $2,700, and the hospital purchased the medicine for less than $2200, the hospital billed Mrs. King's insurance company $22,700.[3] This type of mark-up is directly harming Oregonians.

This is consistent with our experience. 340B hospitals can purchase many of our insulins for a penny per milliliter (mL), but contract pharmacies frequently charge patients significantly more. For example, one pharmacy we interviewed charged an uninsured patient over $500 for a vial of insulin that the pharmacy purchased for 15 cents – a markup of over 330,000%.

Although proponents of state 340B contract pharmacy bills argue that 340B profits are used to help patients in other ways, data show this is false – 340B hospitals do not spend more on charity care than non-340B hospitals. For example, the North Carolina Treasurer's Office concluded that the vast majority of 340B hospitals did not provide enough charity care to equal the estimated value of their tax exemptions and were among those that reported the **lowest investments in charity**

---

[1] In 2023, the number of hospitals participating in the 340B program has grown from 45 to more than 2,600. The number of contract pharmacy arrangements has grown over 9,500% from 2,300 to 220,000, and discounted purchases have reached a record $66.3 billion. See: https://www.gao.gov/products/gao-23-106095; https://www.drugchannels.net/2024/10/the-340b-program-reached-66-billion-in.html; https://www.drugchannels.net/2024/10/hospitals-are-relying-more-on-pbms-to.html

[2] ttps://www.shpnc.org/what-the-health/north-carolina-340b-hospitals-overcharged-state-employees-cancer-drugs.

[3] https://www.nytimes.com/2025/01/15/us/340b-apexus-drugs-middleman.html. A 340B hospital's purchase price generally will be at least 23% less that the medicine's list price.

care from 2011 to 2021.[4] Another study found that "at least 56% of 340B profits do not go to patients in any form."[5] And another found that 340B hospitals make up all 10 of the non-profit hospitals found to provide the least amount of community benefit relative to the value of their tax breaks.[6]

2. **Large hospitals and for-profit pharmacies are benefiting from the expansion of the 340B program through contract pharmacy arrangements – smaller hospitals and payers (like Medicaid) are not.**

A first of its kind report from Minnesota highlights how large hospital systems and their contract pharmacies are using the 340B program to increase their profits. The Minnesota Department of Health determined that large 340B hospitals benefited the most from the program, accounting for only 13% of all entities **but comprising 80% (approximately $500 million)** of state 340B revenue.[7] Additionally, the report found that one out of every six dollars in 340B profit went to for-profit contract pharmacies or other vendors, underscoring the significant share of financial benefits captured by these entities. In fact, certain small grantees **reported losing money** on 340B purchases as a result of payments to contract pharmacies and other vendors.

One state concluded that "[t]oo many hospitals have converted the 340B drug discount program into a **profit center** at the expense of state employees, cancer patients, and taxpayers."[8] For example, North Carolina found that 340B hospitals charged higher rates – billing 84.8% higher prices on average than non-340B hospitals. And recent studies revealed that the growth in 340B provider participation drove an increase in Medicaid spending of $1100 per patient,[9] and over $32 billion per year.[10]

3. **State proposals to modify the federal 340B program are unconstitutional.**

SB 533 would expand the ability of for-profit pharmacies and large hospital systems to use the 340B program to generate profit at the expense of patients. Doing so raises significant legal concerns, both under the United States Constitution and in light of several recent court rulings. In particular, recent rulings in the D.C. Circuit Court and the Third Circuit Court have affirmed that pharmaceutical manufacturers can impose restrictions on contract pharmacies.

In addition, on December 17, 2024, a federal district court judge ruled that West Virginia's contract pharmacy law (SB 325) is unconstitutional and officials cannot enforce the law while three

---

[4] https://www.shpnc.org/documents/overcharged-state-employees-cancer-drugs-and-340b-drug-price-program/download?attachment

[5] N. Masia and F. Kuwonza, Health Capital Group, Measuring the 340B Drug Purchasing Program's Impact on Charitable Care and Operating Profits for Covered Entities, 2022.

[6] Lown Institute 2022 Hospitals Index, https://lownhospitalsindex.org/2022-fair-share-spending/. *See also* New England Journal of Medicine, "Consequences of the 340B Drug Pricing Program." (2018). Consequences of the 340B Drug Pricing Program | NEJM (finding that although 340B hospitals purchase drugs at steep discounts the "[f]inancial gains for [340B] hospitals have not been associated with clear evidence of expanded care or lower mortality among low-income patients.").

[7] The report excluded physician administered drugs, which the state believed resulted in under reporting of 2-3X 340B revenues. https://www.health.state.mn.us/data/340b/docs/2024report.pdf.

[8] https://www.shpnc.org/documents/overcharged-state-employees-cancer-drugs-and-340b-drug-price-program/download?attachment (emphasis added).

[9] Jung, J., Xu, W.Y. and Kalidindi, Y. (2018), Impact of the 340B Drug Pricing Program on Cancer Care Site and Spending in Medicare. Health Serv Res, 53: 3528-3548. https://doi.org/10.1111/1475-6773.12823.

[10] https://www.healthcapitalgroup.com/340b-and-total-medicaid

drug industry legal challenges play out.[11] SB 325, like the Oregon bill, would have required that manufacturers extend discounts to contract pharmacies and would have prohibited manufacturers from requiring claims data submissions. The court found that the claims data provision conflicted with the 340B statute's goal of preventing fraud by putting covered entities in control of whether manufacturers can audit. As the court aptly put it, the "340B Program certainly did not establish a system where the fox guards the hen house." Oregon's proposed SB 533 attempts to impose similar restrictions on manufacturers. Such enforcement is inconsistent with the West Virginia rule.[12]

4. Lawmakers should focus on reforms that benefit patients, not big business.

Lilly supports other state policies that make medicines more affordable for patients such as first dollar coverage for insulin, cost-sharing based on net price, ensuring patients benefit from cost-sharing assistance at the pharmacy counter, and increasing awareness of affordability programs. We commend Oregon for passing policies such as copay caps for insulin and we encourage the legislature to evaluate other policies that have a more direct impact on patients' out-of-pocket experiences. We would welcome the opportunity to speak with you about these policies.

* * * * * * *

We appreciate the opportunity to express our views on SB 533. Given the bill does not advance patient drug affordability goals, and raises serious federal preemption concerns, we respectfully request that you oppose.

Sincerely,

Sara Kofman
Senior Director
State Government Affairs
Eli Lilly and Company

[11] *Pharm. Rsch. & Mfrs. Of Am. v. Morrisey*, 2024 U.S. Dist. LEXIS 227964 (S.D.W.V. Dec. 17, 2024); *See also Sanofi Aventis U.S. LLC v. U.S. Dep't of Health & Human Servs.*, 58 F.4th 696 (3d Cir. 2023) (holding that the government cannot require manufacturers to "[deliver] discounted drugs to an unlimited number of contract pharmacies," and that "drug makers' policies [with respect to contract pharmacies] are lawful); *Novartis v. Johnson*, No. 21-5299, (D.C. Cir. May 21, 2024) (rejecting "HRSA's position that section 340B prohibits drug manufacturers from imposing any conditions on the distribution of discounted drugs to covered entities").

[12] The court also found that the State's enforcement scheme was preempted because any enforcement action would require West Virginia to decide multiple questions of federal law, including whether a manufacturer was required to sell a certain medicine at the 340B price.