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Lilly USA, LLC

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

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

Chair Nosse and members of the Committee,

I am writing to highlight one crucial factual inaccuracy in what appears to be a form letter sent by certain 340B covered entities supporting HB 2385. These entities claim that limitations on the number of 340B contract pharmacies "force patients to travel across town or across an entire county to access affordable lifesaving medication." The implication is that low-income and uninsured patients cannot access their medicines unless FQHCs, and other 340B covered entities, can use an unlimited number of contract pharmacies. **That is patently false**.

Limitations on the number of contract pharmacies does not impact patient-access to medicines for at least three reasons.

1) First, contract pharmacies do not verify whether 340B priced medicines are being dispensed to 340B patients. Covered entities and their contract pharmacies overwhelming use a system of in-kind rebates called a "product replenishment model." In this model, covered entities pay the market price for medicine up front, then later "replenish" that product at the 340B price after identifying—through post hoc data mining—prior prescriptions as having been dispensed to 340B patients. More specifically:

a) A package of medicine is purchased at market price;
b) That medicine is often dispensed in smaller quantities;
c) Sometime later, covered entities or their vendors determine whether they believe prescriptions were 340B-eligible;
d) After filling enough prescriptions to equal a full package, a "replenishment" package is purchased at the 340B price;
e) The 340B-priced replenishment package is placed in general inventory; and
f) That replenishment medicine is dispensed—regardless of whether the person filling the prescription is a patient of the 340B provider.

2) This means that a pharmacy will buy the same amount of product from a wholesaler *regardless* of whether it's acting as a 340B contract pharmacy. And it will dispense that medicine to a patient *regardless* of whether that person ever visited a 340B covered entity. Contract pharmacy restrictions thus only impact the price at which a pharmacy can purchase *replacement* product. These restrictions have no impact on whether a patient can access medicine at a pharmacy counter.

3) Second, 340B covered entities nor their contract pharmacies generally do not pass-through 340B discounts to their patients. 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%. Such mark-ups by contract pharmacies create far greater patient access issues.

4) Third, Lilly continues to allow ***unlimited*** contract pharmacies to access 340B pricing for Lilly's "penny priced" insulin, so long as the contract pharmacy and covered entity pass on the discounted price to patients. Although each covered entity who has written you has identified Lilly by name, none of them have mentioned this provision. And, to date, not a single Oregonian covered entity has accepted Lilly's offer.

5) Finally, not only is it incorrect to state that limitations on contract pharmacies limits patient access, recent studies have demonstrated that unlimited contract pharmacies, as HB 2385 purports to require, are likely to result in significantly *higher costs* to states, employers, and patients. For example:

   a) One study concluded that 340B already costs Oregon employers and workers over $131 million annually, $20M of which is associated with the state's government health plans. This number is expected to increase to ***$166M annually*** if HB 2385 passes.[1]

   b) Another study found that the 340B program is **costing Oregon $7.5 million annually** in lost tax revenue, driven by increased expenses for health plans which decreased taxable income for affected employers and workers.[2]

For your reference, we have attached copies of these reports.

* * * * * * *

As we previously highlighted in our letter regarding HB 2385, Lilly supports the intent of the 340B program and providing patients with affordable access to innovative medicines. However, continued studies have shown that patients are not benefiting from the rapid and exponential growth of the 340B program. We welcome the opportunity to discuss the program with you.

Thank you for the opportunity to clarity this important point regarding the impact of contract pharmacy limitations.

Sincerely,

Sara Kofman
Senior Director
State Government Affairs
Eli Lilly and Company

[1] https://www.iqvia.com/-/media/iqvia/pdfs/us/white-paper/2025/iqvia-cost-of-340b-to-states-whitepaper-2025.pdf.
[2] https://www.magnoliamarketaccess.com/wp-content/uploads/340B-Tax-Impact-Analysis_2025.01.23.pdf.

The Cost of 340B to Oregon

Introduction

The 340B Drug Pricing Program is a federal program in which manufacturers provide heavily discounted drugs to qualifying hospitals and clinics. Despite claims by its advocates that it is "free", it increases healthcare costs for employers and their workers due to lost drug rebates.[1] New research has estimated the financial impact of the 340B program on each state.[2]

The Cost of the 340B Program

- 340B is costing Oregon employers and workers $131M annually (see table)
- This will increase to $166M if Oregon passes a law mandating contract pharmacies
- The cost of 340B per beneficiary for state and local government employers is about 6% higher than for commercial employers
- Oregon has above average 340B activity, as summarized in "Oregon's 340B Landscape" below

Annual Cost of 340B to Oregon

Per Beneficiary	Type	Total Cost	Cost to Government[3]
$67	Lost rebates	$131M	$20M
$18	Contract pharmacy mandate	$35M	$5M
$85	**Total**	**$166M**	**$25M**

Oregon's 340B Landscape

340B Utilization[4]		340B facilities / 100k pop.		Medicaid Expansion[5]	
19%	This is above the national average of 12%	**22.3**	This is above the national average of 15.8	**Yes**	Helped hospitals qualify for 340B

1 The cost of the 340B program part 1: self-insured employers

2 The cost of the 340B program to states

3 Cost to Government is defined as the costs of 340B to all state and local governments' health plans in a state.

4 340B Utilization is defined as % of drugs (sold or administered) estimated to be 340B eligible.

5 Unintended consequences: how the ACA helped grow the 340B Program

HOW THE 340B PROGRAM IMPACTS FEDERAL & STATE TAX LIABILITY

DATA ANALYSIS

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Understanding the Economic Burden on Federal and State Tax Liability of Forgone Commercial Rebates Due to the 340B Drug Pricing Program

Under the 340B Drug Pricing Program, eligible hospitals and clinics purchase drugs from manufacturers at reduced prices and usually receive reimbursement for those drugs from payers and cash-paying patients based on their undiscounted price. This program has seen exponential growth since its enactment in 1992 and is now the second largest federal drug program behind only Medicare Part D.[1] The 340B program is designed to support eligible providers furnishing services to a high volume of uninsured or low-income patients; however, the program has been criticized for lack of oversight and transparency into eligible providers' use of profits generated by 340B drug sales.[2]

The 340B program has often been touted as cost-free to taxpayers, as the discounted pricing comes from drug manufacturers directly.[3-6] However, a recent IQVIA study found that contrary to this narrative, discounted pricing on drugs sold under the 340B program displaces manufacturer rebates to commercial health insurance plans (including employer health plans) as duplicative discounts in the commercial market are often prohibited by contracts. This displacement of manufacturer commercial rebates in favor of 340B discounted pricing corresponded to a $5.2B increase in healthcare costs for self-insured employers and workers in 2021.[7] The increase in healthcare costs associated with drugs sold under the 340B program corresponds to a decrease in taxable income for affected employers and workers, resulting in lost tax revenue for the federal and state governments.

To assess the lost tax revenue from forgone employer rebates due to the 340B program, Magnolia Market Access expanded upon the IQVIA analysis to include fully insured employers and workers and assessed how forgone rebates due to the 340B program affect tax revenue to the federal government and states. Magnolia Market Access' analysis found:

ANALYSIS HIGHLIGHTS

- The combined increase of $7.8B in healthcare costs for both self-insured and fully insured employers and workers from forgone manufacturer rebates due to the 340B program resulted in $1.8 billion in lost federal and state tax revenue in 2021.
- This total accounts for $1.4B in lost federal tax revenue and $418M in lost state tax revenue in 2021.
  - California, New York, and Pennsylvania are the most affected states, with annual losses of $77M, $32M, and $26M, respectively, in 2021.

Forgone commercial rebates are just one way 340B drives up costs for employers, the government and taxpayers. Research suggests 340B also contributes to increased spending by incentivizing the use of more and higher-cost medicines, shifting care to more expensive settings, and driving provider consolidation.[8-10] These other sources of increased cost are outside the scope of this analysis, which suggests its findings are a conservative estimate of the true cost of the program to employers, the government and taxpay.

Annual Tax Impact for Self-Insured and Fully Insured Employers and Workers, 2021 ($ in millions)

Tax Impact	Self-Insured Employers & Workers	Fully Insured Employers & Workers	Total
Federal	$903.0	$457.1	$1,360.1
All States	$277.4	$140.4	$417.8
Total (Federal + All States)	**$1,180.3**	**$597.5**	**$1,777.9**

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HOW THE 340B PROGRAM IMPACTS FEDERAL & STATE TAX LIABILITY

DATA ANALYSIS

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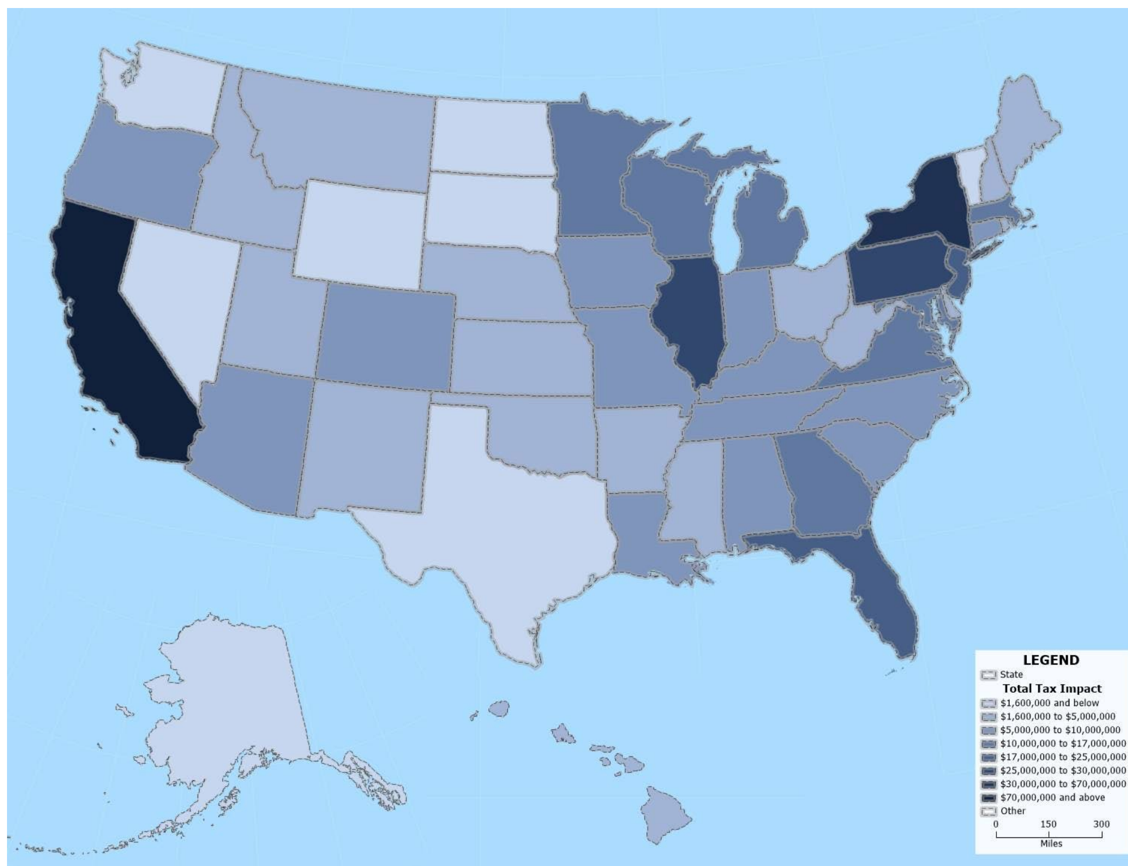

Despite the 340B program's goal of improving access to more affordable medicines for vulnerable patients, the program results in forgone rebates in the commercial market and comes at a significant cost to states due to lower taxes collected. It is important to consider the true financial impact of the 340B program on all stakeholders in the system.

Methodology: The number of self-insured workers, annual drug cost per worker, and differences in total rebates between scenarios with and without 340B eligibility were obtained from a previous analysis completed by IQVIA.[7] The healthcare cost difference for fully-insured workers compared to self-insured workers was obtained from an article published in Health Affairs and was applied to scale costs for the fully-insured population.[11] The total population for the analysis was determined using the distribution of self-insured and fully-insured workers obtained from the Kaiser Family Foundation 2021 Annual Survey and the distribution of single and family coverage obtained from the Medical Expenditure Panel Survey (MEPS).[12,13] Healthcare costs were distributed to employees and employers using data obtained from the Kaiser Family Foundation 2021 Annual Survey.[12] Federal and state taxes for these employee and employer costs were calculated using rates obtained from Tax Foundation reports, a Prudential report, and a Government Accountability Office report.[13-17] The taxes in each state were subsequently weighted by the distribution of US population by state obtained from the US Census Bureau.[18]

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HOW THE 340B PROGRAM IMPACTS FEDERAL & STATE TAX LIABILITY

DATA ANALYSIS

Annual State Tax Impact for Self-Insured and Fully Insured Employers and Workers by State ($ in millions)

Tax Impact	Self-Insured Employers & Workers	Fully Insured Employers & Workers	Total
Alabama	$4.8	$2.5	$7.3
Alaska*	$0.4	$0.2	$0.6
Arizona	$5.1	$2.6	$7.6
Arkansas	$2.0	$1.0	$3.0
California	$50.8	$25.7	$76.6
Colorado	$4.1	$2.1	$6.2
Connecticut	$3.9	$2.0	$5.9
Delaware	$1.3	$0.6	$1.9
Florida*	$14.4	$7.3	$21.6
Georgia	$9.6	$4.9	$14.4
Hawaii	$1.4	$0.7	$2.0
Idaho	$1.8	$0.9	$2.7
Illinois	$17.1	$8.7	$25.7
Indiana	$4.8	$2.4	$7.2
Iowa	$3.8	$1.9	$5.7
Kansas	$2.6	$1.3	$3.8
Kentucky	$3.5	$1.8	$5.3
Louisiana	$3.8	$.9	$5.7
Maine	$1.4	$0.7	$2.0
Maryland	$7.2	$3.7	$10.9
Massachusetts	$8.1	$4.1	$12.1
Michigan	$8.9	$4.5	$13.4
Minnesota	$8.2	$4.1	$12.3
Mississippi	$2.1	$1.1	$3.2
Missouri	$4.2	$2.1	$6.3
Montana	$1.2	$0.6	$1.7
Nebraska	$2.0	$1.0	$3.0
Nevada**	$0.0	$0.0	$0.0
New Hampshire	$1.5	$0.8	$2.3
New Jersey	$11.9	$6.0	$18.0
New Mexico	$1.7	$0.9	$2.6
New York	$21.2	$10.7	$32.0
North Carolina	$5.1	$2.6	$7.6
North Dakota	$0.3	$0.2	$0.5
Ohio	$1.4	$0.7	$2.0
Oklahoma	$2.6	$1.3	$3.9
Oregon	$5.0	$2.5	$7.5
Pennsylvania	$17.2	$8.7	$26.0
Rhode Island	$1.1	$0.6	$1.7
South Carolina	$4.3	$2.2	$6.5
South Dakota**	$0.0	$0.0	$0.0
Tennessee	$5.9	$3.0	$8.9
Texas**	$0.0	$0.0	$0.0
Utah	$2.5	$1.3	$3.7
Vermont	$0.7	$0.4	$1.1
Virginia	$8.0	$4.1	$12.1
Washington**	$0.0	$0.0	$0.0
West Virginia	$1.8	$0.9	$2.7
Wisconsin	$6.9	$3.5	$10.5
Wyoming**	$0.0	$0.0	$0.0
Total (All States)	**$277.4**	**$140.4**	**$417.8**

**State does not impose a personal income tax but does levy an employer payroll tax.*

***State does not impose any personal income or employer payroll taxes.*

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