May 1, 2025

Honorable Members of the Senate
Oregon State Legislature
900 Court Street, NE
Salem, Oregon 97301

Re: HB 2385-A – Fiscal Cost to Oregon Medicaid Program & Relationship to 340B Program

To Members of the Senate Health Committee:

I am writing to provide some background information on my experience and background in working with Medicaid and the 340B program, and to explain how state Medicaid programs, including Oregon's, lose rebates and see increased expenditures as a result of the 340B program.

I served as the Director of the California Department of Health Care Services between 2015 and 2019 (managing a program covering 14 million beneficiaries with an annual budget of almost $110 billion) and served in other executive roles in the Department dating back to 2004. I have worked in state government for three different gubernatorial administrations (Schwarzenegger, Brown and Newsom) and have spent the bulk of my professional career working in or with state Medicaid programs. It is in this shared experience that I would like to briefly detail why California removed the pharmacy benefit from the state's Medicaid managed care program in 2019 and shifted the benefit back to the fee-for-service program, and provide some thoughts for Oregon to consider.

How Medicaid Loses Money on 340B

Simply put, **STATES LOSE REBATES UNDER 340B**. If the covered entity is correctly noting 340B drugs when dispensing to Medicaid patients, the Medicaid program CANNOT collect rebates (mandatory or supplemental) from the manufacturer. In addition to losing both mandatory (and potentially supplemental) rebates, the state **PAYS MORE** because managed care rates are built on higher-than-necessary drug expenditures. Because covered entities get the discount up front and the state Medicaid program gets the rebate on the back of the transaction, state Medicaid programs forego rebates in an environment that allows 340B drugs to be dispensed to Medicaid patients (or through contract pharmacies).

Based on an internal assessment of the excess pharmacy spending as a component of the managed care capitation rates, the Department of Health Care first proposed to eliminate the use of contract pharmacies in the Medi-Cal program in 2017. This effort was

unsuccessful. The Department then proposed to eliminate the use of 340B drugs in the Medicaid program in the 2018-19 budget. The proposal was strongly opposed by the covered entities and summarily rejected as part of the budget subcommittee hearing process. This rejection was in spite of a favorable analysis from the nonpartisan Legislative Analyst's Office (link) indicating that there were state savings available.

Governor Gavin Newsom was elected in November 2018 and his first Executive Order directed the Department of Health Care Services to carve the pharmacy benefit out of Medi-Cal managed care and return the pharmacy benefit to fee-for-service. This effectively eliminated the use of 340B drugs in the Medi-Cal program. The Governor's reasons for returning the pharmacy benefit to fee-for-service were threefold:

- Standardize the prescription drug benefit for all Medi-Cal beneficiaries across the state rather than having each managed care plan maintain a formulary.
- Increase the ability for the state to negotiate supplemental rebates with manufacturers.
- **Eliminate the excess spending by the state Medicaid program for discounted drugs under the 340B program.**

As part of its analysis of the Governor's 2019-2020 budget, the Legislative Analyst's Office also analyzed the Governor's Executive Order and concluded that significant state savings were likely (in the hundreds of millions). (link) **The last official budget savings documents that note the savings from the pharmacy carve out were included in the Governor's 2023-2024 Medi-Cal Estimate and estimated that $2.87 billion were due to mandatory rebates (with little to no duplicate discount disputes and higher brand utilization) and $386 million in state supplemental rebates** (Estimate link; Pgs. 440-441) These savings continue on, but are no longer called out specifically in the Medi-Cal budget, but considered part of the "base" policy.

States also pay more for prescription drugs if state employees are receiving care at a 340B facility or by a 340B provider since the covered entity is able to bill the employee's health plan and receive a higher reimbursement for the drug. There has not been an analysis in California on the costs related to 340B in the Public Employees Retirement System due to lack of transparency in the pricing between covered entities, contract pharmacies and the manufacturer.

Considerations for Oregon

While the state of Oregon's Medicaid program is smaller than California's, the general financing through the Coordinated Care Organizations is the same – and those risk-based organizations are not otherwise able to access 340B pricing, so the state is setting rates for its CCOs based on pharmacy expenditures – which are higher than what the state would otherwise be paying if the pharmacy benefit were either in fee-for-service or if 340B were excluded from the Medicaid program.

New York, shortly after California, performed a similar analysis and carved its prescription benefit out of its Medicaid managed care contracts. While it is difficult for states that have not gone through a process like the one conducted in California to identify these losses, I would argue that it is important to understand the magnitude of potential loss in rebates and/or excessive expenditures in capitation as all state Medicaid programs and budgets go through periods of fiscal shortfalls. To the extent that the state conducts this analysis and concludes that the potential loss is acceptable, it would be an informed decision on the part of state policymakers. **It is reasonable to estimate that the loss of mandatory and supplemental rebates would be in the tens of millions annually for Oregon's Medicaid program, and the expansions included in HB 2385-A would only exacerbate these losses.**

I am happy to answer questions your committee may have regarding the interaction between Medicaid and the 340B program.

Respectfully submitted,

Jennifer Kent

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Sacramento, California

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