

340B DRUG DISCOUNT PROGRAM

Issue Background

In 1992, Congress created the 340B Drug Discount Program to help uninsured and vulnerable patients gain access to affordable prescription drugs. Under the law, a health care entity is eligible to participate in the program if they either receive one of 10 different types of federal grants or are one of six different types of non-profit hospitals that meet specified standards.

Drug manufacturers provide discounts on outpatient medicines and treatments to the select health care entities — often referred to as safety-net providers. Federal grantees that participate in the program typically include clinics that offer primary and preventive care to uninsured or vulnerable patients. The program is administered by the Health Resources & Services Administration (HRSA) at the U.S. Department of Health and Human Services.

Policy Position

Over the years, concerns have been raised that the program has grown well beyond the intent of Congress and that patients are not being well-served. Policymakers should adopt reforms that address the dramatic growth of contract pharmacy arrangements between 340B entities and for-profit pharmacies. As a recent review of the program in the *New England Journal of Medicine* points out, changes are also needed to curb the financial incentives driving 340B hospitals to acquire community-based physician practices, particularly given the substantial increase in healthcare costs associated with the site of care shifting from physician offices to hospital facilities in the last decade. The study also raised serious questions as to how hospitals use program savings, finding “no evidence” that they use 340B revenues to provide more care to low-income patients.

Furthermore, Congress should revisit whether the current hospital eligibility criteria in the 340B law are appropriately targeting the program to true safety-net hospitals. HRSA also should strengthen eligibility standards for non-public hospitals and work with the Centers for Medicare & Medicaid Services (CMS) to develop new policies to prevent duplicate discounts. Finally, hospitals that participate in the 340B program should be required to have a sliding fee scale for prescription drugs for low-income or uninsured patients.

Recently introduced bipartisan legislation, the 340B PAUSE Act introduced by Reps. Larry Bucshon (R-IN) and Scott Peters (D-CA), would put in place a two-year moratorium on the enrollment of new hospitals into the 340B program, which would check program growth and allow Congress time to enact necessary reforms that will ensure that 340B is helping the intended beneficiaries of the program.

CMS has also taken steps recently to rein in the program and provide savings for patients by bringing Medicare’s drug reimbursement rates for 340B hospitals more in-line with what those hospitals actually pay to acquire a given drug. Because Medicare patients’ cost sharing requirements for drugs are based upon the cost of those drugs to Medicare, this change will save patients an estimated \$320 million on copayments in 2018 alone, according to CMS. **Together, these changes will help ensure this important program is serving the best interests of low-income patients and America’s taxpayers.**

Key Points

- ✓ Currently, **about 45% of all Medicare acute care hospitals** participate in 340B.
- ✓ Between 2014–2016, the volume of **drug purchases made in the program grew by 125%**.
- ✓ Discounted drug purchases made under the program totaled **\$16.2 billion in 2016** — up from \$12 billion in 2015.
- ✓ Growth in 340B sales continues to increase consistently and the program is expected to exceed **\$23 billion by 2021**.
- ✓ Since 2007, **340B has grown from 1.6% of the U.S. prescription drug market to 5.0% in 2016**, according to QuintilesIMS Health.