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Follow the Dollar Part II:

Understanding the Cost of Brand Medicines Administered to Commercially Insured Patients in Hospital Outpatient Departments

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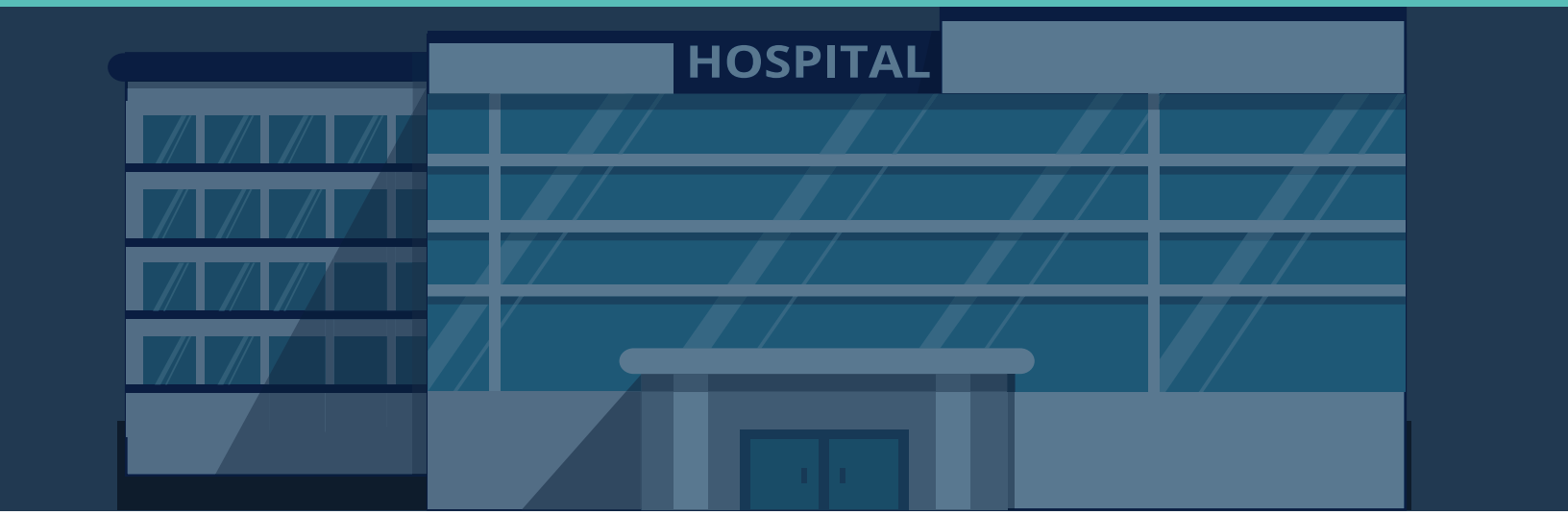
Introduction

When people think about prescription medicines, they often think about the medicines they obtain from a retail or mail-order pharmacy. However, many patients also receive medicines administered directly by medical professionals, usually via injection or infusion, in hospitals, hospital outpatient facilities, physician offices, or at home. Provider-administered medicines are typically used to treat patients with complex, serious, or rare conditions, who may have few or no alternative treatment options.

As policymakers look to reduce health care costs, provider-administered medicines have been increasingly singled out as an area of interest, even though they account for less than 5% of total health care spending.[1] Discussions about the cost of provider-administered medicines commonly assume that the cost to patients, employers, and health plans is entirely attributable to the prices charged by manufacturers. Missing from this debate is the understanding that prices may be significantly inflated by other entities in the supply chain, particularly hospitals, which retain a large share of what is assumed to be "drug spending" as profit. These markups can have significant consequences, including higher costs for patients and higher spending throughout the health care system overall.

In 2017, PhRMA published a Follow the Dollar report that examined how the financial flow through the pharmaceutical supply chain helps shape what patients, employers, and health plans ultimately pay for retail medicines. Similarly, this report—Follow the Dollar Part II—draws on published literature and interviews with industry experts to examine the product and financial flows for provider-administered medicines, specifically those administered to commercially insured patients in hospital outpatient departments (HOPDs). The report explains how the distribution system works, how payments flow between stakeholders, and how factors such as hospital consolidation, site-of-service payment differentials, and the 340B Drug Discount Program affect the cost of provider-administered medicines. Among the key findings:

- *Through consolidation, hospitals leverage their market power to extract higher payment rates from commercial health plans, including marking up the costs of provider-administered medicines.*[2,3] As a result of these markups, the payments hospitals receive from commercial health plans for provider-administered medicines are, on average, nearly 2.5 times the amount paid by the hospital to acquire them.[4] In fact, the amount an HOPD receives from administering a medicine can exceed the net revenue earned by the manufacturer who researched and developed it.[5,6] Hospital markups on medicines increase costs for health plans, employers, and patients alike.
- *As hospitals purchase competing hospitals and acquire physician practices, patient care is shifted to less efficient, more costly settings.* Hospitals are often paid more than physician offices for administering the same medicines—nearly twice as much for administering cancer medicines,[7] for example—without any corresponding increase in quality of care.[8,9] This disparity in payment rates increases costs for employers and health plans and can lead to higher out-of-pocket costs for patients.
- *Explosive growth in the 340B Drug Discount Program, particularly in the hospital outpatient setting, has resulted in significant market distortions that drive up the cost of treatment, while failing to ensure that patients benefit from the discounts hospitals receive on medicines.* Evidence suggests that hospital profits generated by the 340B program create financial incentives to further consolidate and to administer medicines in more costly hospital outpatient settings—which ultimately increases costs for patients, employers, health plans, and the health care system.[10,11]



What Is a Hospital Outpatient Department?

HOPDs, while owned or affiliated with a hospital, provide outpatient care that does not require formal admittance to a hospital.

HOPDs may be located inside hospital buildings, in nearby office buildings, or in facilities far from the main hospital campus. Types of HOPDs include[12]:

- Outpatient clinics at hospitals or other medical facilities
- Medical group practices
- Surgery centers
- Infusion centers
- Imaging centers
- Cardiac catheterization centers
- Mental or behavioral health centers
- Polyclinics and referral clinics

Journey From the Pharmaceutical Manufacturer to the Hospital Outpatient Department

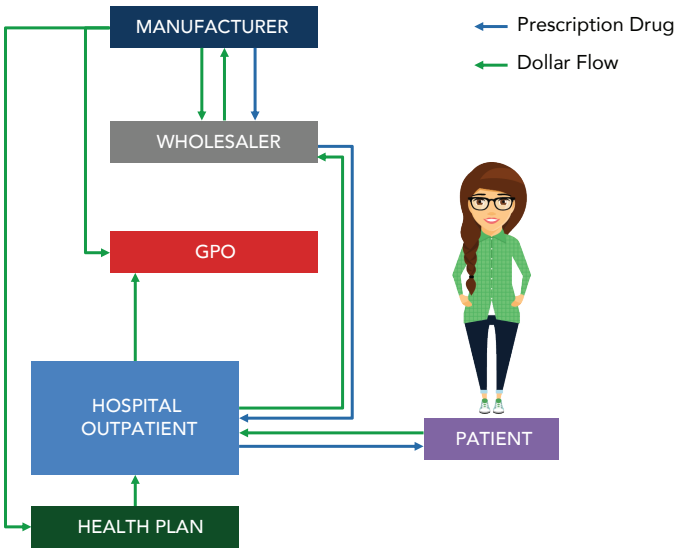
Before a provider can administer a medicine to a patient, a series of steps must occur behind the scenes to get the medicine from the manufacturer to the HOPD. Some of these steps are physical processes (e.g., producing, shipping, stocking the medicine), and others are virtual (e.g., financial transactions).

Wholesaler distributors (wholesalers) and group purchasing organizations (GPOs) serve as the intermediaries between manufacturers and HOPDs for the negotiation, purchase, and payment of medicines. Wholesalers typically purchase medicines from manufacturers at a price known as the wholesale acquisition cost (WAC). This price is also commonly referred to as the "list price" of a brand medicine and reflects the price manufacturers charge to wholesalers or other direct purchasers before any discounts, rebates, or other price concessions are applied.[13]

In return for inventory management, distribution, and data processing services, wholesalers receive a distribution service fee from manufacturers. This fee is commonly assessed as a percentage of the WAC. Contracts between manufacturers and wholesalers may also include additional incentives, such as those for bulk-purchasing or prompt payment. These fees, discounts, rebates, and other concessions are negotiated individually between manufacturers and wholesalers and may vary as a percentage of the WAC.

Wholesalers handle the physical distribution of medicines to hospitals, but the prices hospitals pay to acquire these medicines are often negotiated separately by GPOs. While some hospitals and manufacturers negotiate prices directly, contracting with GPOs may allow hospitals to negotiate for volume discounts that may be otherwise unavailable to them individually. In exchange for their services, GPOs typically receive membership fees from hospitals. GPOs also receive fees from manufacturers—typically up to 3% of the GPO negotiated price.[13,14] Most GPOs serve primarily as price negotiators, with no direct involvement in paying for or physically distributing provider-administered medicines.

Figure 1. Distribution and Payment Flow for Provider-Administered Medicines: Buy-and-Bill Acquisition Model



This graphic is illustrative and not intended to represent every financial relationship in the marketplace.

Wholesalers take physical possession of prescription medicines once they have been shipped from the manufacturer.

- Wholesalers typically earn a distribution service fee, which is set as a percentage of a medicine's WAC.
- The wholesaler market is highly consolidated. The 3 largest pharmaceutical wholesalers—McKesson, AmerisourceBergen, and Cardinal Health—account for more than 90% of the market.[15]

Group purchasing organizations (GPOs) pool together the purchasing power of multiple practices, clinics, and/or hospitals to negotiate discounts on medicines.

- Practices, clinics, and hospitals typically pay membership fees to access the discounts negotiated by GPOs.
- GPOs typically collect up to a 3% fee from manufacturers.
- Most GPOs are purely contracting entities and do not take possession of medicines.[13]

To purchase a prescription medicine, an HOPD places an order with a wholesaler. In many cases, the price the HOPD pays for the medicine reflects the price negotiated on its behalf by the GPO. To compensate the wholesaler for the difference between the amount paid to purchase the medicine from the manufacturer (based on the WAC) and the price at which the medicine was sold to the HOPD (based on the price negotiated by the GPO), the wholesaler receives a "chargeback" payment from the manufacturer. Chargeback payments prevent wholesalers from incurring losses associated with selling medicines for less than they paid to acquire them.

Once an order is placed, the wholesaler ships the medicine to the HOPD, which stores the medicine until it is needed. After the medication is administered to a patient, the HOPD submits a claim for reimbursement to the patient's health plan for the cost of the medicine and an administration fee. This acquisition model is known as "buy and bill" since the provider bills the health plan only after purchasing and administering the medicine.

As an alternative to the traditional buy-and-bill acquisition model, some health plans and pharmacy benefit managers (PBMs) utilize a network of specialty pharmacy providers (SPPs) to distribute provider-administered medicines. SPPs, which have grown to play a much larger role in the distribution system over the past decade, allow payers to exert more control in managing the utilization and costs of provider-administered medicines. Whereas medicines acquired through the buy-and-bill system are typically covered under a health plan's medical benefit, provider-administered medicines obtained from an SPP are typically covered under a health plan's pharmacy benefit.

In one form of the SPP distribution model, known as "white bagging," the SPP fills the prescription for the medication and ships it directly to the HOPD, which stores the medication until the patient comes in for treatment. Alternatively, the patient may obtain the medication from the SPP directly and bring the product with them to the HOPD for administration, a practice known as "brown bagging." Payers who use white and brown bagging reimburse the HOPD for the cost of administering a medicine to a patient, but not for the cost of the medicine itself.

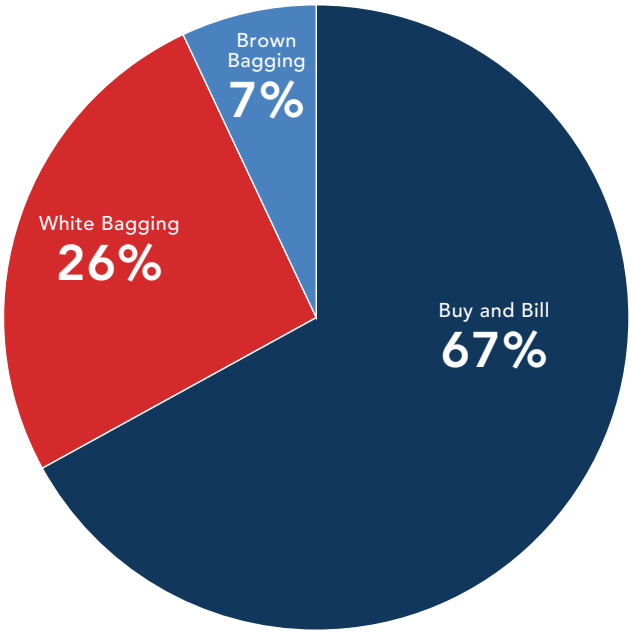
White Bagging

- HOPD receives the medication directly from a specialty pharmacy and stores it until the patient visits the HOPD for administration.[16]

Brown Bagging

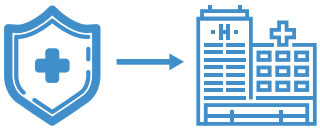
- Patient acquires the medication from a specialty pharmacy and brings it with them to the HOPD for administration.[16]

Figure 2. Distribution of Acquisition Models for Provider-Administered Medicines in HOPDs, 2018[15]



Flow of Payments Between Hospital Outpatient Departments, Patients, Commercial Health Plans, and Pharmaceutical Manufacturers

Once a provider administers a medication to the patient, the distribution process ends, but the financial flow continues.



Payments From Health Plans to Hospital Outpatient Departments

The commercial market does not have a uniform payment methodology for provider-administered medicines. Instead, payment rates and other terms for reimbursement are negotiated separately between commercial health plans and HOPDs. Three types of payment arrangements are commonly used to determine commercial reimbursement for provider-administered medicines under the buy-and-bill acquisition model.[17]

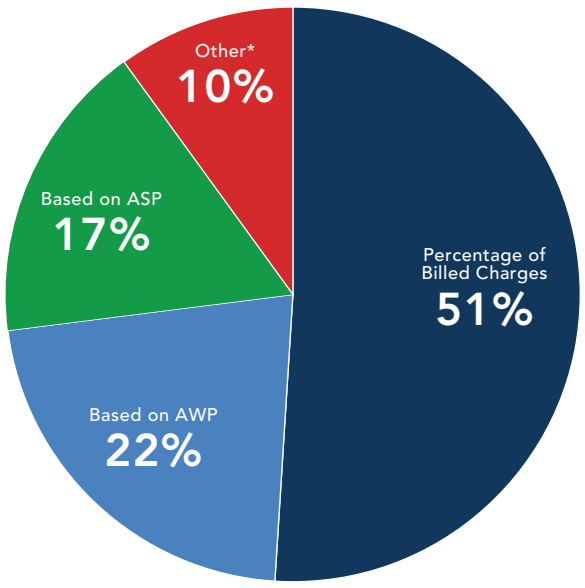
1. ***Percentage of billed charges:*** The health plan pays a negotiated percentage of the HOPD's charges for provider-administered medicine. Under this arrangement, the amount charged for medicines is determined entirely by the HOPD. This payment arrangement often lacks transparency, as the basis for the hospital's charges is typically unknown to both the health plan and the patient.

2. ***Average sales price plus a percentage:*** The reimbursement rate equals the medicine's average sales price (ASP), plus a negotiated percentage markup. ASP is published quarterly by the federal government and reflects the volume-weighted average manufacturer sales price net of all rebates, discounts, and other price concessions.[18] Price concessions offered to federal programs, such as the Department of Defense and the Department of Veterans Affairs, and statutory rebates and discounts paid under Medicaid and the 340B Drug Discount Program are excluded,[18] making the ASP roughly comparable to a medicine's average net price in the commercial market.

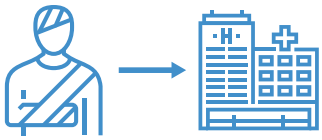
3. ***Average wholesale price minus a percentage:*** The reimbursement rate equals the medicine's average wholesale price (AWP) minus a negotiated percentage discount. AWP is frequently used as a basis for reimbursement because the data are continuously updated and publicly available.[19]

Under each of these arrangements, the HOPD earns a gross profit equal to the difference between the reimbursement rate negotiated with the health plan and the HOPD's acquisition cost. Hospitals can earn sizable gross profits on provider-administered medicines administered to commercially insured patients. On average, commercial health plans reimburse hospitals at rates that are nearly 2.5 times the amount paid by the hospital to acquire the medicine.[4]

Figure 3. Reimbursement Methods for Medicines Administered in an HOPD in the Commercial Market, 2017[17]



* Other includes capitation, WAC-based reimbursement, and use of multiple reimbursement methods.
Key: ASP – average sales price; AWP – average wholesale price; HOPD – hospital outpatient department.



Payments From Patients to Hospital Outpatient Departments

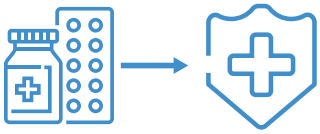
Patient cost-sharing for provider-administered medicines varies based on the health plan's benefit design and the location where the medication is received.[20,21] While some health plans do not have separate cost-sharing for medicines administered by providers, most require patients to pay a fixed dollar copayment or a percentage of the medicine's cost, known as coinsurance.[20,21] Patients with coinsurance pay a percentage of the reimbursement rate negotiated between the health plan and the provider for the medicine. For medicines administered in HOPDs, the median coinsurance paid by the patient is 20%.[20,21]

Because coinsurance is based on the reimbursement rate negotiated between the health plan and the provider, patients may face higher out-of-pocket costs when a medicine is administered in a higher-cost setting like an HOPD rather than a lower-cost setting like a physician's office. Most commercially insured patients have a limit on the amount of cost-sharing they can be required to pay each year, known as an out-of-pocket maximum. Once a patient has reached this annual limit, the health plan generally pays the full cost for all covered prescription medicines and medical services for the remainder of the year.

To drive utilization toward lower-cost therapies, health plans increasingly use prior authorization and step therapy to manage access to provider-administered medicines and may require patients to pay more in cost-sharing for certain medicines or when medicines are used to treat certain indications.[20] Patients may also face significantly higher out-of-pocket costs if they receive provider-administered medicines in facilities outside of their health plan's network. If the price charged by an out-of-network HOPD exceeds the amount that the health plan would reimburse an HOPD participating in its network, then the patient may receive a bill for the difference. This practice, known as "balance billing," can subject patients to high costs in addition to their standard cost-sharing.

Before administering medicines to patients, HOPDs often seek preauthorization for provider-administered medicines to comply with health plan requirements and to ensure that the health plan will reimburse the HOPD. Once the patient receives the medication, the HOPD submits a medical claim to the health plan, which reimburses the HOPD for the medication and the cost of administration, minus the cost-sharing amount owed by the patient. Typically, the HOPD then sends a bill to the patient, who pays the cost-sharing amount directly to the HOPD.

Because the patient receives the bill after the medicine has been administered, the HOPD assumes the financial risk for collecting the patient's cost-sharing amount. With growing enrollment in high-deductible health plans—which can require patients to pay thousands of dollars out of pocket before their insurance applies—and increased cost-sharing amounts due to coinsurance, more HOPDs are having upfront cost discussions with patients to mitigate the risk of nonpayment and enacting policies that require patients to pay a percentage of the estimated cost before treatment is administered.[22]



Payments From Manufacturers to Health Plans

With the increasing availability of competing medicines to treat many complex conditions, health plans and manufacturers may negotiate rebates in exchange for favorable coverage terms such as less stringent utilization management restrictions or a lower cost-sharing amount.[20] Rebates are paid retrospectively from manufacturers to health plans and reduce the medicine's final net cost to the health plan. These rebates do not affect the prices HOPDs pay to acquire medicines or the patient's cost-sharing amount.

Other Factors Affecting the Cost of Provider-Administered Medicines

In the commercial market, the cost of provider-administered medicines is also influenced by broader market dynamics that interact with the payment and distribution system. These dynamics, which include hospital consolidation and higher payment rates for HOPDs relative to other sites of care, can substantially increase the costs of provider-administered medicines for health plans, employers, and patients. As discussed below, research shows that this is especially true for hospitals that receive deep discounts for medicines purchased through the 340B Drug Discount Program. Hospitals participating in the 340B program have particularly strong financial incentives to expand the number of outpatient clinics and facilities within their networks and to shift care to more costly hospital outpatient settings.[10,11]

Hospital Consolidation

The impact of hospital consolidation on health care costs has been the subject of extensive debate. While advocates of consolidation, particularly hospitals, claim that mergers and acquisitions generate operational efficiencies and improve the quality of patient care, a growing body of evidence shows that consolidation has led to substantial price increases without improvements in either quality or efficiency.[2,3,23-25] Increased prices have translated into higher insurance premiums, higher costs for employers, and higher out-of-pocket costs for patients.[10,24] A recent government study found that hospital-physician consolidation grew substantially between 2016 and 2018, with the share of physicians affiliated with a hospital or health system increasing from 40% to 51%.[26]

By purchasing competing hospitals or acquiring physician practices, hospitals can leverage their market power to extract payment rates for provider-administered medicines that far exceed their acquisition costs. On average, the payments that hospitals receive from commercial health plans for medicines are nearly 2.5 times the amount paid by the hospital to acquire them.[4] As a result of these markups, patients, employers, and health plans pay higher costs for provider-administered medicines, and the payment an HOPD receives for administering a medicine can exceed the net revenue earned by the manufacturer who researched and developed it.[5,6]

Site-of-Service Payment Differentials

Research shows that spending is higher for medicines administered in HOPDs relative to non-hospital-owned physician offices because of differences in reimbursement rates, rather than differences in the type or intensity of treatment.[7,27] Compared to the significantly inflated rates commercial health plans pay for medicines administered in HOPDs, physicians generally receive, at most, a slight premium to the purchase price of the medicine. This premium covers the medication's storage, handling, and other considerations and is estimated at approximately 16% of the acquisition cost.[28]

Payment differentials across sites of service can significantly impact the cost of provider-administered medicines for health plans and employers. According to recent research, health plans paid 86% more per unit for infused oncology medicines when they were administered in an HOPD setting vs. a physician office setting.[7] The same study reported that employers and commercial health plans could reduce per-patient oncology costs by nearly 50% if they paid hospitals at the same rates as physician offices. Analysis by a large commercial health plan similarly found that costs could be reduced by up to 52% if patients received provider-administered medicines in physician offices and patients' homes rather than hospital outpatient settings.[29]

340B Drug Discount Program

Distribution and Payment for Medicines Administered by 340B-Covered Entities

The distribution system for provider-administered medicines is similar for 340B hospitals and non-340B hospitals, with the exception that Disproportionate Share Hospitals (DSHs), children's hospitals, and freestanding cancer hospitals that are 340B-covered entities may not obtain medicines for outpatient use through a GPO.[30]

The discounts available to hospitals participating in the 340B program alter the financial flow between stakeholders. Health plans typically pay the full negotiated reimbursement rate to hospitals, regardless of whether the medicine was purchased at a discount through the 340B program.* This means that an HOPD affiliated with a 340B hospital can purchase medicines at a significant discount, receive the full negotiated reimbursement rate from the commercial health plan, and retain the difference as gross profit.[35] There is no requirement that hospitals extend a medicine's discounted 340B price to the patient. As a result, patients with coinsurance and deductibles must pay cost-sharing based on the medicine's full negotiated reimbursement rate.[36]

Financial Incentives Created by the 340B Program May Impact Hospitals' Behavior

Participation in the 340B program has grown significantly since its inception. The number of participating hospitals has more than quadrupled over the past 15 years, growing from 591 in 2005 to more than 2,500 in 2019.[37-39] Since 2012 alone, hospital participation has nearly doubled.[38-40] Today, more than 2 out of every 5 hospitals in the US participate in the 340B program. While this growth is partly attributable to changes enacted as part of the Patient Protection and Affordable Care Act in 2010, which expanded the types of hospitals eligible to participate in the program, HRSA guidance and lax oversight have also resulted in dramatic growth in the program.[38]

Background on the 340B Drug Discount Program

In 1992, Congress established the 340B Drug Discount Program to ensure access to outpatient prescription drugs for uninsured or otherwise vulnerable patients treated by designated providers under the law, called covered entities. Covered entities eligible to participate in 340B include certain categories of nonprofit hospitals (e.g., Disproportionate Share Hospitals [DSHs†], children's hospitals, certain cancer hospitals, sole community hospitals, rural referral centers, and critical access hospitals) along with federal grant recipients, including Federally Qualified Health Centers, Title X-funded centers, the Ryan White HIV/AIDS Program, and Section 318 STD clinics.[31,32]

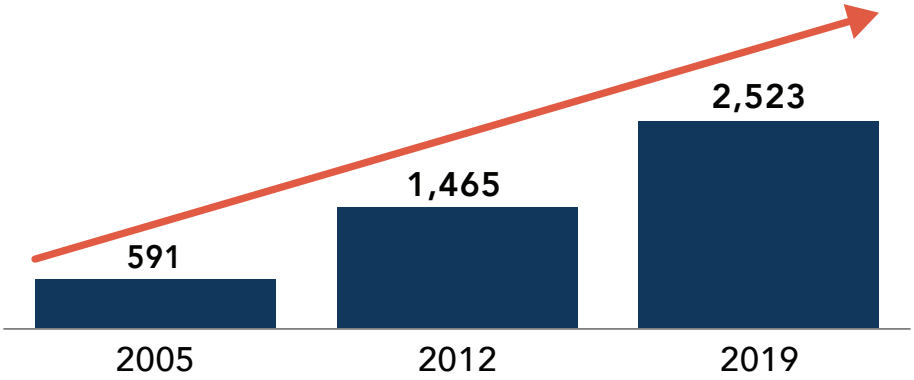
Pharmaceutical manufacturers are required to participate in the 340B program in order to have their medicines covered by Medicaid and Medicare Part B. Manufacturers must make available covered outpatient drugs, including provider-administered medicines, to participating hospitals and other covered entities at or below deeply discounted prices, known as 340B ceiling prices. Hospitals and other covered entities may purchase medicines at even lower prices by negotiating additional voluntary discounts from manufacturers. These lower prices are referred to as 340B sub-ceiling prices. According to a recent survey, 340B hospitals purchase medicines at an average discount of ASP minus 58%.[33]

Hospitals and other covered entities may only administer medicines purchased through the 340B program to individuals meeting the program's definition of a 340B patient, which does not limit eligibility based on income level or insurance status.[34]

† DSHs serve a disproportionate number of low-income patients compared to other hospitals and, therefore, receive payments from the CMS to cover the costs of providing care to uninsured patients.

* In 2017, the Centers for Medicare & Medicaid Services (CMS) sought to reduce the spread between hospitals' acquisition costs and Medicare reimbursement rates by finalizing a regulation that reduces Medicare hospital outpatient payments for 340B outpatient drugs purchased by 340B hospitals from 106% of ASP to 77.5% of ASP. According to CMS, this reduction in Medicare payments for 340B medicines "is especially important because of the inextricable link of the Medicare payment rate to the beneficiary cost-sharing amount."[41]

Figure 4. Number of Hospitals Participating in the 340B Drug Discount Program, 2005-2019[37,38]



Along with the number of 340B hospitals, there has also been a significant increase in the number of hospital-owned off-site outpatient clinics and facilities, known as "child sites," established by 340B hospitals.[40] Between 1994 and 2020, the number of child sites increased from 34 to more than 28,000.[42] As the number of hospitals and child sites participating in the 340B program has increased, so has the volume of 340B drug sales. Discounted sales of medicines purchased through the 340B program have grown at an average rate of 23% per year since 2012, reaching $29.9 billion in 2019.[43,44] Today, nearly 75% of discounted 340B sales are made at hospitals and clinics.[45]

Medicines purchased through the 340B program can generate large profits for participating hospitals. A growing body of evidence suggests that the program creates strong incentives for hospitals to expand access to 340B discounts by acquiring physician practices, outpatient clinics, and other child sites, which in turn increases a 340B hospital's profits.[10,11,46] For example, a 2018 study published in the *New England Journal of Medicine* demonstrates the link between the 340B program and hospital-physician consolidation, finding that 340B program eligibility is associated with a significantly higher number of specialists practicing in facilities owned by the hospital than would be expected in the absence of the program.[11] Other research has shown that the program creates incentives for hospitals to shift the delivery of care to more costly hospital outpatient settings and that hospital acquisition of physician practices leads to fewer lower-cost community-based provider options.[27,47,48]

Income generated by hospitals from administering prescription medicines has generated controversy as to whether the 340B program incentivizes the use of costlier medications, even where clinically similar, less costly treatment options exist. While evidence on the extent to which financial considerations drive prescribing behavior is mixed, multiple studies suggest that 340B hospitals prescribe more medicines and/or more expensive medicines than non-participating hospitals and that 340B facilities may "shift toward more expensive drugs because profit margins will, in general, be larger."[10,49,50] For example, actuarial analysis shows that the average per-patient spending on outpatient medicines is nearly 3 times higher for commercially insured patients treated at 340B DSH hospitals than for those treated at non-340B hospitals, and that the differential cannot be explained by differences in the health status of the 2 populations.[49]

A lack of program and eligibility standards, combined with the significant growth in the number of participants, has dramatically transformed the 340B program and created incentives that increase costs for patients, employers, health plans, and the health care system.[36] According to economists and clinicians, the 340B program has evolved "from [a program] that serves vulnerable communities to one that enriches hospitals."[46]

Jane and Erik: How the System Functions for Patients

Drawing from published materials and interviews with industry experts, the following examples highlight the financial flows that occur as provider-administered medicines move through the supply chain. An illustrative example is provided for 2 patients, Jane and Erik, who are enrolled in the same commercial health plan and are each receiving the same provider-administered medicine used in the treatment of cancer. To illustrate differences in the funding and product flows for non-340B and 340B-covered entities, Jane receives her medicine in a traditional non-340B-covered HOPD, and Erik's medicine is administered in an HOPD owned by a 340B hospital.

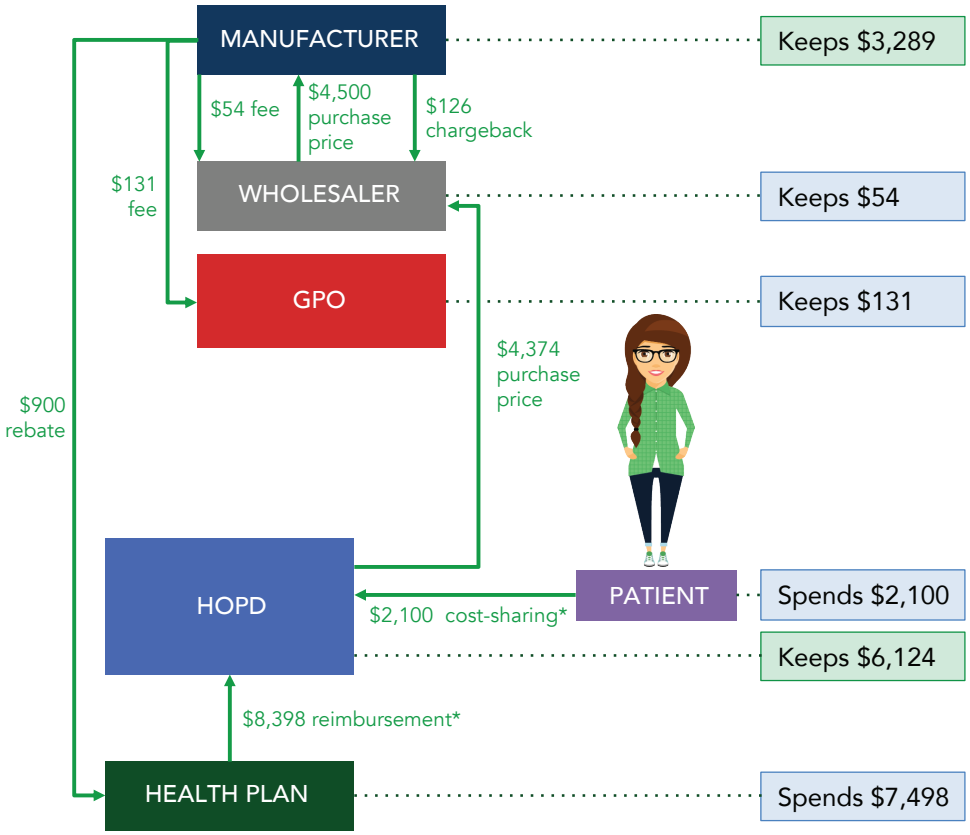
The medicine has a list price (WAC) of $4,500, and the manufacturer has negotiated a 20% rebate with the health plan to gain preferential coverage and formulary status over competing treatment options.[20] The health plan requires Jane and Erik to pay 20% coinsurance for medicines administered in an HOPD before reaching their annual maximum out-of-pocket spending limit, which neither patient has yet met.

Jane

Jane's HOPD acquires her medicine at the GPO-negotiated price of $4,374, which is less than the medicine's $4,500 list price. After applying the average markup for provider-administered medicines (2.4 times the HOPD's acquisition cost),[4] the HOPD bills Jane's health plan for the negotiated rate of $10,498. The health plan reimburses 80% of this amount ($8,398), and Jane's cost-sharing is the remaining 20% ($2,100). Once Jane reaches her annual maximum out-of-pocket spending limit, her cost-sharing for future treatments will be $0, and the health plan will pay 100% of the cost.

The HOPD receives $6,124 for administering Jane's medicine, nearly double the $3,289 retained by the pharmaceutical company that researched, developed, and manufactured the treatment.

Figure 5. Jane: Flow of Payment for a Medicine Administered in the HOPD of a Non-340B-Covered Entity



* The reimbursement rate negotiated between the health plan and the HOPD is $10,498, of which the health plan pays 80% ($8,398) and the patient pays 20% ($2,100). This graphic is illustrative of a hypothetical product with a WAC of $4,500 and is not intended to represent every financial relationship in the marketplace.

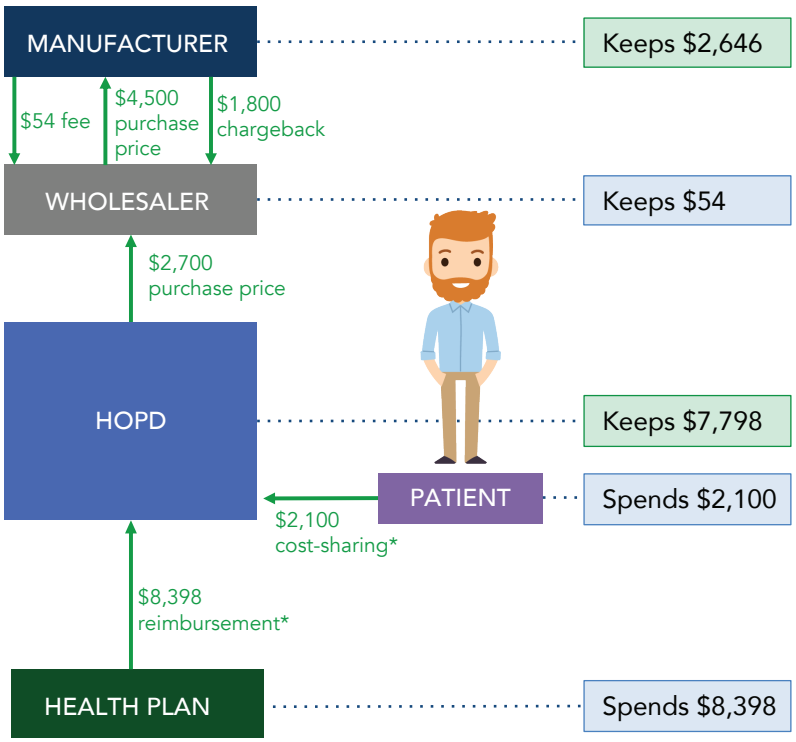
Erik

As a 340B-covered entity, the HOPD where Erik receives care can purchase medicines at a deep discount, which lowers the HOPD's acquisition cost to $2,700. Despite having obtained the medicine at a significant discount, the HOPD still bills the health plan for the full negotiated amount of $10,498. Again, the health plan reimburses 80% of this total amount ($8,398), and Erik's cost-sharing is the remaining 20% ($2,100). Once Erik reaches his annual maximum out-of-pocket spending limit, his cost-sharing for future treatments will be $0, and the health plan will pay 100% of the cost.

The HOPD receives $7,798 for administering Erik's medicine, nearly 3 times the $2,646 retained by the pharmaceutical company that researched, developed, and manufactured it. Compared to the non-340B facility where Jane receives care, Erik's HOPD earns nearly $1,700 more for administering the exact same medicine.

In this example, the manufacturer does not pay a rebate to Erik's health plan for his medication. As a result, the health plan's costs are 12% higher for Erik, who receives his medicine in a 340B facility, than for Jane, who receives the exact same medicine in a non-340B facility ($7,498 vs $8,398). If the HOPD does not notify the manufacturer that Erik's medicine was purchased through the 340B program, the manufacturer could unknowingly pay a rebate to the health plan, on top of the 340B discount it has already provided to the hospital for this unit of medication. If the manufacturer were to pay a rebate for Erik's medicine, the health plan's costs and the net amount retained by the manufacturer would both decrease by $900; however, the rebate would not reduce Erik's out-of-pocket costs.

Figure 6. Erik: Flow of Payment for a Medicine Administered in the HOPD of a 340B-Covered Entity



* The reimbursement rate negotiated between the health plan and the HOPD is $10,498, of which the health plan pays 80% ($8,398) and the patient pays 20% ($2,100). This graphic is illustrative of a hypothetical product with a WAC of $4,500 and is not intended to represent every financial relationship in the marketplace.

Conclusion

This report describes the process and stakeholders involved in distributing and paying for medicines administered to commercially insured patients in the hospital outpatient setting. It follows the physical path of a medicine as it travels from a pharmaceutical manufacturer to a wholesaler or specialty pharmacy, en route to an HOPD to be administered to a patient. It also discusses the numerous financial transactions that occur between stakeholders—many of which take place behind the scenes or after the medicine has been administered—and how these financial flows shape what patients, employers, and health plans ultimately pay for medicines.

A closer look at these financial flows disputes the common misconception that the cost of provider-administered medicines is entirely attributable to the prices charged by pharmaceutical manufacturers. As this report demonstrates, prices may be significantly inflated by other entities in the supply chain, particularly hospitals, which translates into higher costs for health plans, employers, and patients alike. Specifically:

- Hospitals commonly inflate the prices charged to commercial health plans for medicines administered in HOPDs. These routine markups increase costs for patients, whose cost sharing may be based on a price that far exceeds what the HOPD paid to acquire the medicine. The amount an HOPD receives from administering a medicine can also exceed the net revenue earned by the manufacturer who researched and developed it.
- Significant consolidation has given hospitals increased leverage to negotiate higher payment rates and shift utilization to more costly sites of care.
- Explosive growth in the 340B Drug Discount Program, particularly in the hospital setting, has resulted in significant market distortions that drive up cost of treatment, while failing to ensure that patients receiving treatment benefit from the discounts hospitals receive on these medicines.[10,11]

Hospital care has grown to account for nearly 40% of employer and other private health insurance spending, far more than any other health care service.[51] The shift in the delivery of provider-administered medicines to more expensive hospital outpatient settings and the significant revenue streams tied to hospital markups on medicines suggest that financial incentives in the current system may not be appropriately aligned to produce the lowest costs for patients, employers, or the health care system. Further, these trends also suggest that policies targeted narrowly at pharmaceutical manufacturers and the list price of medicines are unlikely to produce the expected magnitude of reductions in health care spending.

Broader efforts are needed to address the underlying market dynamics driving health care costs in the commercial market. These include encouraging the delivery of care in less costly and more efficient settings, supporting informed decision making by payers and patients by improving transparency into the markups charged by hospitals, and reforming the 340B program to ensure discounts are used to help the vulnerable patients the program was originally intended to serve. Strengthening incentives for health plans and providers to focus on rewarding value would also benefit patients and the health system holistically. Although it is encouraging that the market is starting to move in this direction, such efforts are largely undone if the cost of medicines to patients, employers, and health plans are inflated artificially.

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Appendix

Jane: Flow of Payment for a Medicine Administered in the HOPD of a Non-340B Covered Entity

No.		Item	Amount	Computation
		Wholesale Acquisition Cost (WAC)	$4,500	
Wholesaler	[1]	Wholesaler purchases medicine from manufacturer at WAC	$4,500	WAC
	[2]	Manufacturer pays wholesaler fee based on WAC	$54	WAC * 1.2%
	[3]	HOPD purchases medicine from wholesaler at GPO negotiated price	$4,374	WAC - (WAC * 2.8%)
	[4]	Manufacturer pays wholesaler chargeback	$126	WAC * 2.8%
	Wholesaler Retains		**$54**	**[2] + [3] + [4] - [1]**
GPO	[5]	Manufacturer pays GPO fee based on GPO negotiated rate	$131	[3]* 3%
	GPO Retains		**$131**	**[5]**
HOPD	[6]	HOPD purchases medicine from wholesaler at GPO negotiated price	$4,374	[3]
	[7]	Health plan reimburses HOPD for medicine	$8,398	Commercially Negotiated Rate * 80%
	[8]	HOPD receives coinsurance from patient	$2,100	Commercially Negotiated Rate * 20%
	HOPD Retains		**$6,124**	**[7] + [8] - [6]**
Health Plan	[9]	Health plan reimburses HOPD for medicine	$8,398	[7]
	[10]	Health plan receives retrospective rebate from manufacturer	$900	WAC * 20%
	Health Plan / Plan Sponsor Cost		**$7,498**	**[9] - [10]**
Patient Cost			**$2,100**	**[8]**
Manufacturer Retains			**$3,289**	**[1] - [2] - [4] - [5] - [10]**

Erik: Flow of Payment for a Medicine Administered in the HOPD of a 340B Covered Entity

No.		Item	Amount	Computation
		Wholesale Acquisition Cost (WAC)	$4,500	
Wholesaler	[1]	Wholesaler purchases medicine from manufacturer at WAC	$4,500	WAC
	[2]	Manufacturer pays wholesaler 340B Drug Discount chargeback	$1,800	WAC * 40%
	[3]	Manufacturer pays wholesaler fee based on WAC	$54	WAC * 1.2%
	[4]	HOPD purchased medicine from wholesaler at 340B Drug Discount price	$2,700	WAC - (WAC * 40%)
	Wholesaler Retains		**$54**	**[3] + [2] + [4] - [1]**
HOPD	[5]	HOPD purchased medicine from wholesaler at 340B Drug Discount price	$2,700	[4]
	[6]	Health plan reimburses HOPD for medicine	$8,398	Commercially Negotiated Rate * 80%
	[7]	HOPD receives coinsurance from patient	$2,100	Commercially Negotiated Rate * 20%
	HOPD Retains		**$7,798**	**[6] + [7] - [5]**
Health Plan	[8]	Health plan reimburses HOPD for medicine	$8,398	[6]
	Health Plan / Plan Sponsor Cost		**$8,398**	**[8]**
Patient Cost			**$2,100**	**[7]**
Manufacturer Retains			**$2,646**	**[1] - [2] - [3]**

Key: GPO – group purchasing organization; HOPD – hospital outpatient department.

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