Understanding the 340B Drug Discount Program

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The 340B Drug Discount Program was created in 1992 by Congress to help uninsured or vulnerable patients access prescription medicines through safety net facilities. As part of the program, manufacturers provide steep, mandatory discounts on medicines to certain types of clinics and hospitals as a condition of their medicines being covered by Medicaid. Clinics eligible for the 340B program as part of a federal grant program are required to reinvest any additional resources into services for the vulnerable communities they serve, while current rules allow hospitals participating in the program to profit by reselling discounted medicines with no requirement to ensure patients benefit from the discounts.

Quick Facts About the 340B Program

45%

of **all** Medicare acute hospitals participate in the 340B program.

64%

of hospitals that receive 340B discounts have **charity care rates** below the 2.2% national average for all hospitals.

80%

of 340B sales volume is driven by **DSH hospitals**, even though these hospitals only make up 9% of all 340B entities.

Ensuring the 340B Program Benefits Uninsured or Vulnerable Patients as Originally Intended

Research shows the 340B program is growing rapidly, driving up costs for patients and payers. This is ultimately distorting the entire health care market. Without reform, the program is expected to continue to grow at an alarming rate and further impact the market.

PATIENT DEFINITION:

Covered entities are only permitted to use 340B discounts for individuals who meet the definition of patient under the 340B program. But the Government Accountability Office and Office of the Inspector General (OIG) have stated "patient" is not well-defined for the purposes of the 340B program. A clear definition is needed to ensure hospitals are not profiting off 340B discounts for individuals with only a passing relationship with a hospital.

HOSPITAL ELIGIBILITY CRITERIA:

A growing body of research raises questions about whether all participating hospitals are in fact representative of safety net facilities. The qualifying criteria for 340B hospitals are based on low-income Medicaid and Medicare insured patients and do not currently account for charity care provided to uninsured patients. Eligibility should be recalibrated to ensure proper identification of safety net facilities that serve large numbers of uninsured or vulnerable patients.

CONTRACT PHARMACIES:

Since 2010, covered entities can extend their ability to obtain prescriptions at 340B prices by contracting with an unlimited number of for-profit retail pharmacies, or contract pharmacies. There are more than 39,000 contract pharmacy arrangements and 54 percent of large 340B hospitals have 20 or more contract pharmacies. A recent OIG report found uninsured patients of hospitals often pay full price filling prescriptions at contract pharmacies, even though their hospital received the 340B discount. The contract pharmacy program should be reformed and scaled back.

CONSOLIDATION:

Hospitals are acquiring more independent physician practices, which allows formerly independent practices to access 340B discounts. This consolidation drives up costs for patients and payers and reduces patient access to community treatment options. These clinics often operate in wealthier areas and are not obligated to provide treatment for uninsured patients. The 340B program should be reducing patients' costs, not increasing them.

OVERSIGHT OF THE PROGRAM:

Increased government oversight is needed to ensure the 340B program is sustainable and directly benefits vulnerable or uninsured patients, while at the same time certifying program requirements are being met. Entities participating must be fully and readily accountable for properly and safely handling and dispensing medicines and ensuring program integrity.

Learn more at **PhRMA.org/340B**.