The Daily Dish

340B in the Headlines

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AAF has devoted a fair amount of description, analysis, and commentary to the 340B Program, the (outpatient) drug discount program that is required if drug manufacturers want to sell to Medicaid programs. The upshot was that manufacturers provided discounted drugs to covered entities (CEs), who then dispensed them to whomever and used the proceeds for whatever. All of which suggested the need for real reforms.

But if you want *real* attention on the problem, start with a front-page *New York Times* headline that reads "How a Hospital Chain Used a Poor Neighborhood to Turn Huge Profits" and add paragraphs that read:

> "… the hollowed-out hospital — owned by Bon Secours Mercy Health, one of the largest nonprofit health care chains in the country — has the highest profit margins of any hospital in Virginia, generating as much as $100 million a year, according to the hospital's financial data.
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> The secret to its success lies with a federal program that allows clinics in impoverished neighborhoods to buy prescription drugs at steep discounts, charge insurers full price and pocket the difference. The vast majority of Richmond Community's profits come from the program, said two former executives who were familiar with the hospital's finances and requested anonymity because they still work in the health care industry."

That's the 340B Program.

Now, let me stipulate that I have no clue about the veracity of the reporting in the entire story. But it is entirely possible for a CE to receive discounted 340B drugs, prescribe them to customers with commercial insurance, get paid the market price for the drugs, and pocket the difference. Let's think about the implications of this.

First, the intention of 340B (which, unfortunately, is not actually stated in law anywhere) is to support care for indigent patients. So, an important consideration is what the CE does with the money. If it is plowed into charity care, there is a very different social bottom line than if the funds are directed to a commercial book of business.

Second, in this simple setting – a monopoly drug manufacturer and all CEs prescribing to the commercial market – the 340B Program has no impact on drug pricing. I'm not arguing this setting is realistic, but it is a useful benchmark. Everyone buying the drug faces the market price and the manufacturer will set it accordingly.

Third, the 340B Program is a straight transfer of profits from the manufacturer to CEs. It is simply an off-the-books, clandestine tax and transfer program.

What happens if the CEs shift to providing more and more of the 340B discount drugs to poor patients? First, it more and more meets its objectives from the perspective of providing care. If at the same time the commercial pool is unchanged, then the pricing will not change. Only if the provision of charity care somehow makes the commercial pool less price-sensitive will prices rise. This is an empirical question and there is essentially no evidence on the issue. In the end, the desirability of 340B is driven by the disposition of the drugs.

Nobody should conclude that every CE is gaming the 340B Program. But neither is there enough transparency to evaluate the effectiveness of the program. As Jackson Hammond concluded: “As it stands, congressional action is needed, both to clarify the program’s purpose as well as empower HRSA [Health Resources and Services Administration] to make the changes necessary to turn 340B into an effective program.”