The Daily Dish

Oversight and Reform of the 340B Program

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Tomorrow the House Energy and Commerce Committee will hold a hearing before the Oversight and Investigations Subcommittee entitled "Examining How Covered Entities Utilize the 340B Drug Pricing Program." It is worth taking a close look.

Recall that the 340B program is the misbegotten offspring of price controls in the Medicaid program. Specifically, in 1990 Congress created the Medicaid Drug Rebate Program that required manufacturers to offer Medicaid the 'best price' offered to any other health insurance provider. As it turned out, however, best price included drugs donated to health facilities with large numbers of low-income patients. Continuing this practice would mean that the Medicaid best price was zero; nada; and zilch. Free donations dried up so Congress fought price-fixing fallout with price fixing and created the 340B program in 1992. It created a 'ceiling price' — the maximum that drug manufacturers can charge health care providers who qualify as having low-income patients.

This might seem like a relatively benign rifle-shot policy that affects a few patients. Hardly. The program has expanded steadily. The ACA expanded the definition of eligible health care providers to include outpatient settings, free-standing cancer hospitals, rural referral centers, sole community hospitals, and critical access hospitals. Simultaneously, between 2004 and 2013, 340B purchases grew from $0.8 billion to $7.2 billion per year, and the affected drugs rose from 3 percent of purchased drugs in 2004 to over 25 percent of those drugs in 2013. By February 2014, about one-third of all hospitals participated in the 340B program, accounting for about 62 percent of all hospital outpatient drug spending.

As the federal government pays for roughly 40 percent of all prescription drugs in the United States, these discounts are intended to allow "scarce Federal resources [to be stretched] as far as possible." However, because the law does not require the health care providers who receive these discounts to pass their savings along to consumers, many question whether the program's goal is being met and if reforms are needed.

The Department of Health and Human Services (HHS) kicked off the reform effort earlier this year, proposing a rule to take on a part of this problem. As it turns out, it is possible for a hospital to acquire a drug via the 340B program — i.e., at a very steep discount that averages 22.5 percent — and use it to treat a Medicare beneficiary. When this happens, Medicare reimburses the hospital at the usual rate, which happens to be the average sales price plus 6 percent. So, hospitals can acquire a drug at 22.5 percent below the sales price (on average) and get reimbursed at 6 percent above (on average). Great work if you can get it! As a kicker, Medicare beneficiaries' co-pays are tied to the reimbursement price, so the "340B arbitrage" is coming out of their pocket as well.

HHS proposes that if a hospital acquires a drug in the 340B program, it gets reimbursed at the average sales price minus 22.5 percent. This in part shifts the program from being a slush fund for hospitals to passing along savings to Medicare beneficiaries and taxpayers. But there are a lot more participants than Medicare beneficiaries. Hence, at the hearing, "members will hear directly from entities participating in the program to get a better understanding of how the program is used, including how much money is saved, the types of drugs purchased and prescribed within the program, how entities track their savings, and how those savings are used

to improve patient care.”

The 340B program is a reaction to the original sin of Medicaid best price. But if best price is to remain on the books, making sure that 340B is a targeted program that actually helps the intended patients is essential.