340B SPOTLIGHT

340B Myth vs. Fact

Congress created the 340B program in 1992 to help safety-net facilities that serve a large proportion of vulnerable or uninsured patients access discounted prescription medicines. Unfortunately, over the years a lot of myths have been perpetuated about how the program works and who it benefits.

MYTH	FACT
The 340B program doesn't cost taxpayers anything.	A 2016 *New England Journal of Medicine* analysis found the scope of 340B discounts is so broad for commonly infused or injected drugs that it is likely raising prices for all consumers. Additionally, a major trend among 340B hospitals is to purchase or acquire community-based physician practices, bring those practices under their hospital umbrella and shift patients' site of care from the community providers to more expensive hospital settings. A University of Minnesota white paper notes that 340B "will ultimately end up increasing health care costs for everyone" as a result of this shift in site of care.
There is a clear definition of a 340B patient.	The definition for a 340B patient is vague and open to abuse. The GAO and OIG have stated in reports to Congress that the lack of specificity about what constitutes a 340B patient may be leading to hospitals receiving 340B discounts for individuals who were not intended to meet the definition of a 340B patient.
Only hospitals serving needy patients participate in the program.	HRSA does not look at the amount of charity care hospitals provide or the number of uninsured patients they treat. In fact, the majority of 340B hospitals provide charity care below the national average for all hospitals.
The 340B program is a small program.	Over the last 25 years, the 340B program has grown unsustainably, reaching $19.3 billion in drug sales measured at the 340B price in 2017. While the program continues to grow at a faster pace than total pharmaceutical sales, there is little evidence that the program is actually providing benefits to needy or uninsured patients. In 2002, there were fewer than 200 340B hospitals and 284 contract pharmacies. Today there are more than 2,400 participating hospitals and more than 63,000 contract pharmacies.
340B hospitals are required to use revenue generated through the program to benefit patients.	While recipients of federal grants, known as grantees, are required to use revenue from 340B and other sources to help vulnerable patients as a condition of their grant, there are no rules regarding how hospitals use revenue from the 340B program. This means that hospitals are permitted to charge a patient who is uninsured the list price of a medicine, even if the hospital received the steep 340B discount for that medicine (averaging 50 percent). According to Drug Channels, hospitals' 340B purchases as a share of total hospital drug purchases continues to increase, but the New England Journal of Medicine found no evidence that this expansion of the 340B program has resulted in expanded care or lower mortality among low-income patients.
Hospital consolidation has nothing to do with 340B.	The 340B program should be helping patients access medicines, not increasing health care costs for everyone. However, the *New England Journal of Medicine* found that the financial incentives in 340B lead hospitals to acquire independent physician practices and bring them under the hospitals' 340B umbrella. This practice is contributing to expanding hospitals' ability to access 340B prices even though these practices may be in wealthier areas with fewer vulnerable patients. This drives up costs for patients and payers because costs for care are generally higher in the hospital setting than physician offices.
Policymakers believe the program is working as intended with no flaws.	Congress, GAO, OIG and HHS have increasingly focused on reexamining the 340B program to ensure it is benefitting patients as intended. The House Energy and Commerce Committee outlined 12 recommendations to improve the program, the OIG and GAO have testified before Congress on several occasions urging for additional program clarity and oversight and the Centers for Medicare & Medicaid Services changed 340B hospitals' reimbursement of Part B medicines to address misaligned incentives in the program, saving the government and patients millions of dollars. Additionally, legislation has been introduced in the House and the Senate to improve program oversight and begin to get the program back on track.
Pharmaceutical companies want to dismantle the 340B program.	The biopharmaceutical industry supports the 340B program and is committed to working with Congress and the administration to fix the program so it remains sustainable and meets its original intent of helping uninsured or vulnerable patients continue to have access to the discounted 340B medicines they need.

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