Responses to Common 340B Questions

Are patients benefiting from 340B? How do we know if hospitals are using 340B to support care for low-income patients?

Hospitals routinely share how they use 340B to support patient care. 340B Health encourages hospitals to complete impact profiles, providing details on the value of 340B to their institutions and the services they provide to low-income and rural patients.[i] Survey data also reflect how hospitals use 340B savings to support patient care in a variety of ways.

One way that hospitals use 340B is to provide free or discounted drugs to low-income patients. However, 340B is not just about providing low-income patients with access to affordable medications; the program also supports patient access to broader health care services, beyond prescription drugs. Hospitals use 340B to open clinics to treat underserved populations, maintain and support uncompensated care, and offset low Medicaid reimbursement.[ii] Hospitals report that a loss of 340B savings would affect their ability to provide patient services, including the provision of primary care, oncology, and diabetes services as well as their provision of free or discounted drugs.[iii] More than 90 percent of rural hospitals report relying on 340B to keep their doors open.[iv]

Are the correct hospitals in the 340B program? Do 340B hospitals provide a significant level of care to low-income patients?

340B hospitals are among the most transparent of all organizations, with strict eligibility rules and federal reporting requirements in place that demonstrate the high level of care they provide to low-income and rural patients, which is often uncompensated or underpaid. Hospitals report their costs and charges to HHS through Medicare Cost Reports, and non-profit hospitals must report various categories of revenue spent to serve low-income patients and communities at large to the IRS. These existing federal reporting requirements show the high levels of care 340B hospitals provide to low-income patients for which they do not get paid or are underpaid.

For example, 340B disproportionate share (DSH) hospitals (those that qualify for 340B due to their disproportionate treatment of low-income patients):

38/60 Are 38 percent of hospitals but provide 60 percent of all uncompensated care;[v]

Treat significantly more Medicaid and low-income Medicare patients than non-340B hospitals;[vi]

Are significantly more likely to offer vital health care services that are critical to low-income patients but are often unreimbursed, including trauma centers, HIV/AIDS services, and immunizations;[vii] and

Treat many more Medicare Part B beneficiaries who are low-income cancer patients, dually eligible for Medicaid, disabled, or are racial or ethnic minorities.[viii]

Does 340B cause manufacturers to increase drug prices?

Research shows that the total 340B discount is such a small share of the overall U.S. drug market that it cannot plausibly cause manufacturers to increase drug prices.[ix] Published research shows 340B discounts represented less than two percent of total drug sales in the U.S. in 2015 and less than two percent of drug manufacturer net revenues.[x] This research, based on 2015 data, the most recent year for which the government has issued an estimate of total 340B discounts, is illustrative of the size of 340B in the context of the broader health care system.

References

[i] 340B Health, Impact Profiles, https://www.340bhealth.org/members/advocacy-tools/impact-profiles/profile-page/.

[ii] 340B Health, "Evaluating 340B Hospital Savings and Their Use in Serving Low-Income and Rural Patients: Results From a Survey of 340B Health Members" (June 2018), https://www.340bhealth.org/files/2017_Annual_Survey_Report_final.pdf.

[iii] 340B Health, "Evaluating 340B Hospital Savings and Their Use in Serving Low-Income and Rural Patients: Results From a Survey of 340B Health Members" (June 2018), https://www.340bhealth.org/files/2017_Annual_Survey_Report_final.pdf.

[iv] *Id.*

[v] L&M Policy Research, Analysis of 340B Disproportionate Share Hospital Services to Low-Income Patients (March 12, 2018). https://www.340bhealth.org/files/340B_Report_03132018_FY2015_final.pdf.

[vi] *Id.*

[vii] *Id.*

[viii] Dobson DaVanzo, Analysis of the Proportion of 340B DSH Hospital Services Delivered to Low-Income Oncology

Drug Recipients Compared to Non-340B Provider (2017), http://www.340bhealth.org/files/LowIncomeOncology.pdf; L&M Policy Research, A Comparison of Characteristics of Patients Treated by 340B and Non-340B Providers (April 8, 2019), https://www.340bhealth.org/files/340B_Patient_Characteristics_Report_04-10-19.pdf.

[ix] Dobson DaVanzo, Assessing the Financial Impact of the 340B Drug Pricing Program on Drug Manufacturers 4 (July 2017), http://www.340bhealth.org/files/340B_Financial_Impact_7_17.pdf.

[x] S. Dickson, A. Coukell, and I. Reynolds, "The Size of the 340B Program and Its Impact on Manufacturer Revenues," Health Affairs Blog (Aug. 8, 2018), https://www.healthaffairs.org/do/10.1377/hblog20180807.985552/full/.