


## THEN

## NOW

### GROWTH OF THE PROGRAM – NUMBER OF HOSPITALS AND SALES

**340B was created as a small program to address unintended consequences of the 1990 Medicaid drug rebate statute and ensure vulnerable patients had access to needed medicines.**

 **1992** – 50 hospitals participated in 340B when it was created (Source: HRSA OPA Database, January 2017)

 **2002** – 151 hospitals participated in 340B (Source: HRSA OPA Database, January 2018)


 **2005** – \$2.4 billion in drug sales at 340B price (Source: Apexus data)

**Insufficient guidance, historically weak oversight and other factors led to dramatic program growth, driven by the participation of large hospitals in the 340B program.**

*“The [340B] program was intended to offer affordable medicines to providers focused on low-income Americans, but has now expanded far beyond the original set of providers identified.”*

– Alex Azar, Secretary of Health and Human Services, 2018


 **2017** – 2,457 hospitals participating in the 340B program (Source: HRSA OPA Database, January 2018)

 **2018** – HRSA estimated \$19.3 billion in drug sales at the 340B price (Source: HRSA, as reported in *Drug Channels*, May 2018)

**When 340B sales are compared to Medicare Part B sales using a consistent pricing metric, 340B sales now surpass sales through the Part B program by nearly 20 percent. (Source: BRG, July 2018).**

### GROWTH OF THE PROGRAM – CONTRACT PHARMACIES

**In 1996, HRSA began allowing safety-net clinics that did not have an in-house pharmacy to contract with a for-profit retail pharmacy through which the clinic could access 340B discounts for its patients.**

 **1998** – 34 contract pharmacy arrangements (Source: HRSA OPA Database, March 2017)

**Based on a misguided 2010 HRSA policy decision, all covered entities are now allowed to expand 340B discounts to other “middlemen” by contracting with an unlimited number of for-profit retail pharmacies. This policy was meant to expand patient access to discounted medicines, but the GAO and OIG found that patients often do not see the direct benefit from the 340B discount at these pharmacies.**

*“[N]early 18,000 pharmacy locations contract with 340B-eligible covered entities. That accounts for more than one in four U.S. retail, mail, and specialty pharmacy locations.”*

– Drug Channels, August 2016

 **2017** – 51,963 contract pharmacy arrangements (Source: HRSA OPA Database, March 2017)

### GROWTH OF THE PROGRAM – CHILD SITES

**Child sites are outpatient clinics outside of the hospital building but owned by the hospital. HRSA added these child sites to the 340B program in 1994. There is no basis in the 340B statute for including these sites in the program.**

 **1994** – 34 child sites (Source: HRSA OPA Database, October 2016)

**There is explosive growth in the number of hospital child sites. These child sites are increasingly located in higher-income communities instead of the patient mix that makes their “parent” hospital 340B-eligible. Costs of care at these sites are typically higher than at physician offices.**

 **2016** – 15,021 child sites (Source: HRSA OPA Database, October 2016)


*If not fixed, the 340B program “will ultimately end up increasing health care costs for everyone, as patients are shifted from cheaper, community based care to more expensive hospital settings....”*

– S.T. Parente and M. Ramlet, “Unprecedented Growth, Questionable Policy,” Carlson School of Management at University of Minnesota

PATIENT IMPACT  
AND CONSOLIDATION

## THEN

**Hospitals and physician offices operated more independently in the health care system at the creation of the 340B program.**

 **2012** – 1 in 7, or about 14 percent, of physician practices was owned by a hospital (Source: Avalere Health analysis for Physicians Advocacy Institute, September, 2016)

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**As hospital consolidation and acquisitions of independent physician offices continues, patients are left with fewer options and are more dependent on expensive care settings.**

*“[T]he 340B Drug Pricing Program has been associated with hospital–physician consolidation in hematology–oncology and with more hospital-based administration of parenteral drugs in hematology–oncology and ophthalmology without clear evidence of expanded care or lower mortality among low-income patients.”*

– New England Journal of Medicine, February 2018


 **2016** – Nearly 50 percent of physician practices are owned by a hospital (Source: Avalere Health analysis for Physicians Advocacy Institute, March 2018)

*“Researchers from Memorial Sloan Kettering have noted 340B is helping to drive consolidation of physician practices into hospitals, and that in the absence of reforms “the trend toward consolidation will continue to drive up the cost of commercial insurance....”*

– Peter Bach and Raina Jain, January 2017


MARKET DISTORTION

**Safety net clinics, or grantees, are eligible for 340B if they receive 1 of 10 types of federal grants that provide resources for health care services for low-income, uninsured individuals. Grantees are typically required by their federal grants to invest 340B revenue into services for their low-income, uninsured populations. Grantees have always been the largest number of participating 340B entities.**

 **2004** – Grantee purchases of 340B drugs comprised 55% of the program (Source: Mathematica, *The PHS 340B Drug Pricing Program: Results of a Survey of Eligible Entities*, August 2004)

**Unlike federal grantees, there are no requirements for how hospitals use 340B discounts to help patients. In fact, uninsured patients of 340B hospitals are sometimes required to pay the full price for their medicines rather than the discounted price hospitals pay. (Source: GAO, June 2018)**

**In general, hospitals make more money off of 340B discounts when 340B patients take higher cost drugs. This may mean that the 340B program could actually be increasing out-of-pocket costs for some patients and ultimately distorting the entire health care marketplace.**

 **2017** – Grantee purchases of 340B drugs comprised only 13 percent of the program (Source: Apexus, *340B Health Summer Conference*, July 2017)

*Economists in JAMA noted that list prices for drugs are likely higher than they otherwise would be “to offset revenue losses incurred as a larger number of drug sales become eligible for 340B discounts (and thus fewer drugs are sold at full price).”*

– Rena Conti and Peter Bach, May 2013