How Physicians View the 340B Drug Pricing Program

The 340B Drug Pricing Program was designed to encourage health care facilities to provide care for uninsured or underinsured patients. The program works by providing facilities a significant discount on prescription drugs in exchange for their treatment of indigent patients.

But whom does 340B really benefit? Has it fulfilled its original intent? And how do health care providers view the program's impact?

Findings Summary

In an Institute for Patient Access poll of 256 physicians from the field of oncology, rheumatology, dermatology and gastroenterology, participants reported:

- The 340B program is being inappropriately used, allowing hospitals to profit (44%/plurality)
- Patients have not benefited from lower pharmaceutical costs because of the 340B program (46%/plurality)
- The 340B program incentivizes the consolidation of community-based practices with hospitals (39%/plurality)
- The 340B program has had no effect, an unclear effect or has actually decreased patients' access to care (54%).

A Lucrative Endeavor

One thing is clear: Participating facilities are reaping a substantial financial benefit from the 340B program.

Today, 340B discounts range between 25 and 50 percent of a drug's retail or wholesale price.[1] These discounts saved participating providers an estimated $6 billion in 2015,[2] up nearly 60 percent from the $3.8 billion saved just two years earlier.[3]

In addition to their savings from front-end discounts, 340B facilities also generate revenue when the reimbursement they receive for the drug exceeds the discounted price they paid for it. This occurs when hospitals receive more than the discounted purchase price for drugs administered to patients who have Medicare or commercial health care coverage.

Ideally, participating facilities would pass the savings along to the patients, or apply the revenue to uncompensated charity care. There are no federal rules, however, about how hospitals can use the funds generated through 340B. Thus, the revenue covers all manner of expenses, including administrative costs, capital projects and facility overhead.

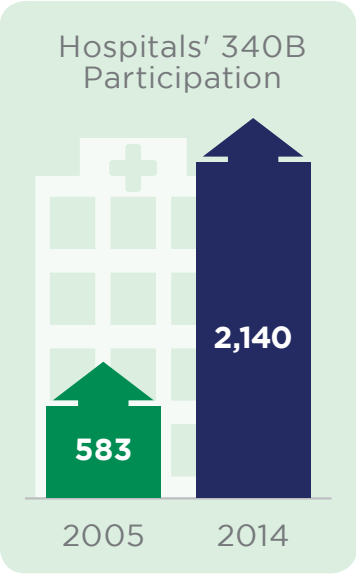
A Growing Advantage

While the Affordable Care Act helped reduce the number of uninsured Americans, it also expanded 340B eligibility criteria. As a result, participation surged. Facilities covered by 340B jumped from 583 in 2005 to 2,140 in less than a decade's time. By 2014, more than 40 percent of the nation's hospitals were participating. Yet nearly two-thirds of them spent less on charity care than the national average.[4]

The steady increase in hospitals acquiring clinics in wealthy markets could be one driver.

A hospital's participation in the program allows for its satellite clinics to receive the same 340B discounts.[5] Thus, hospitals see offices in affluent areas as opportunities to increase their profit margin because privately insured patients provide higher reimbursement rates on prescription drugs. These hospital-owned clinics compete with independently owned physician practices that are unable to benefit from the 340B program.

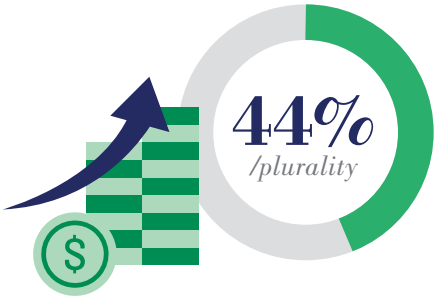
Often the financial pressure is too great for community physician practices, forcing them to first affiliate, then merge with the hospital.[5] Called "vertical integration," the practice of hospitals acquiring physician practices more than doubled between 2002 and 2008.[6] Initially recognized for its potential to generate more communication among providers and to improve quality of care, vertical integration is now associated with higher prices and spending.[7]



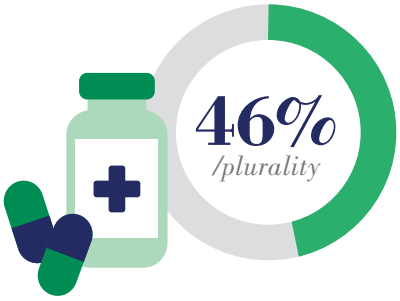
The Physician Perspective

To explore the impact of the 340B program on physicians and on patient access, the Institute for Patient Access commissioned a nationwide survey of physicians. The survey was conducted January-February 2018 among 256 physicians who spanned the fields of oncology, rheumatology, dermatology and gastroenterology. Physicians reported that:

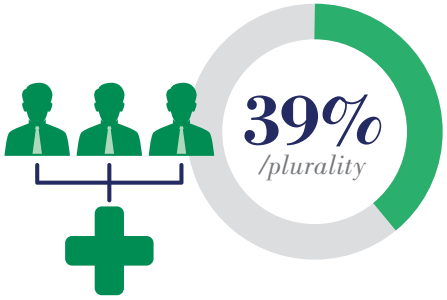
The 340B program is being **inappropriately used**, allowing hospitals to profit.



Patients have not benefited from lower pharmaceutical costs because of the 340B program.



The 340B program **incentivizes the consolidation** of community-based practices with hospitals.



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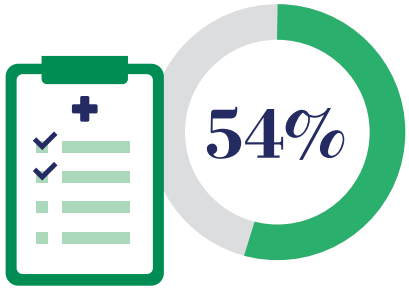

Survey Demographic Breakdown

Oncology (29%)	18-34 (8%)	Northeast (25%)	Urban (50%)
Rheumatology (21%)	35-44 (27%)	Midwest (19%)	Suburban (40%)
Gastroenterology (21%)	45-54 (28%)	South (34%)	Rural (10%)
Dermatology (29%)	55-64 (24%)	West (21%)	
	65+ (10%)		

In Their Own Words

Overall, the physicians surveyed expressed negative feelings about how the 340B program affects access for their patients and the communities they serve. The merging of hospitals and community-based practices leaves all patients with fewer options, but this behavior has a particularly painful impact on patients who live in rural or suburban communities, where consolidation could eliminate a patient's only choice.

"The program is saving hospitals and covered entities money, but they are not passing it onto patients through lower costs, just increasing profits."

–Rheumatologist

"The spirit of the 340B program may have strayed from who it intended to help initially."

–Dermatologist

"The 340B program has not been effective in its original mission."

–Oncologist

Moving Toward Patient-Centered Policy Solutions

Critics argue that the 340B program's design has encouraged hospitals to adopt a more profit-minded approach—at patients' expense. That includes the consolidation of community-based physician practices, which leave patients with fewer options and less access to their physicians' offices.

Hospitals are also redirecting some patients to outpatient locations for treatment. In one study, researchers found cancer patients received treatment at outpatient care centers at a higher rate in markets with a 340B hospital than in those without one. These locations are potentially less convenient for patients.[8] Moreover, this behavior has the potential to drive up the overall cost of care and patients' out-of-pocket expenses.

Policy discussions should include a review of the program's design, which incentivizes hospitals to make profit-oriented, not patient-oriented, decisions. An assessment of the long-term impact on patients as well as the sustainability of the program may also be warranted.

In short, needed reforms should center on returning the program to its original intention: appropriate health care for needy patients.

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