The Hidden Costs of 340B to Employers

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BACKGROUND

- The 340B Drug Discount Program is a $124B federal program in which manufacturers provide discounted outpatient drugs to participating 340B hospitals and clinics. The narrative by some 340B providers is that the program doesn't cost taxpayers anything.
- 340B revenue is generated by participating hospitals and clinics via arbitrage: providers buy products at a large discount and are reimbursed by commercial and Medicare Part B and Part D payers at a higher price.
- More than 100M U.S. workers receive healthcare through self-insured employers,[1] all of which depend on rebates — a discount paid by a manufacturer to a PBM and passed through to the payer — to lower drug costs. A simplified example showing how drug costs can increase with 340B is illustrated in **Figure 1**.

Figure 1. How Employers and Workers Pay More with 340B

OBJECTIVES

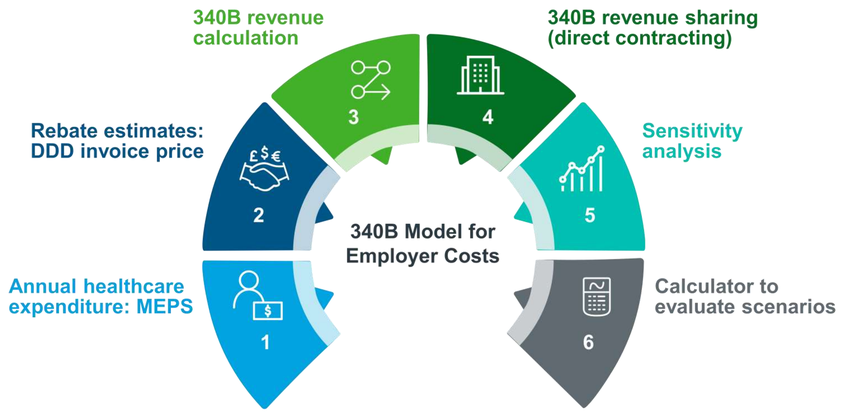
1. To quantify the financial impact of the 340B program on drug and total healthcare costs to self-insured employers.
2. To study 340B revenue-sharing agreements: a proposed type of direct contract in which a 340B hospital shares 340B revenue with a self-insured employer.

METHODS

- Our model included factors such as 340B eligibility, manufacturer rebates, and lost rebates due to product purchased at the 340B discount price, and model parameters were estimated using national samples of consumers, payers, products, and providers.
- Our approach is summarized in **Figure 2**. Annual healthcare costs and premiums were estimated using the Medical Expenditure Panel Survey (MEPS).[2] Rebates were estimated using manufacturers' annual financial statements and from wholesaler sales data for branded self-administered and physician-administered products. The likelihood a drug is 340B-eligible was calculated as described elsewhere based on the 1996 patient definition.[3] We also considered scenarios involving expanded 340B eligibility.
- To study 340B revenue sharing, we broadened the model to account for the shift in the site of care to the hospital and the resulting increase in the 340B eligibility of workers. 340B revenue was estimated as the product of the 340B discount and pre-rebate drug costs estimated from MEPS.

METHODS (cont.)

Figure 2. Financial Model Inputs to Estimate Cost of 340B



RESULTS: OBJECTIVE 1

The first part of the research studied the impact of the 340B program on healthcare costs of self-insured employers and their workers. Three scenarios were studied:

- **Scenario 1: No 340B.** This was a counterfactual scenario in which no drugs were 340B-eligible. It was used as a benchmark for scenario 2.
- **Scenario 2: 340B Status Quo.** Some workers received healthcare from 340B providers, and 340B eligibility was defined by the 1996 patient definition.
- **Scenario 3: Expanded 340B Eligibility.** It was assumed 340B providers could generate 340B revenue from all of the drugs dispensed to their patients, regardless of where care was delivered.

Findings are summarized in **Figure 3**.

- Assuming the 340B program did not exist (scenario 1), the average cost of drugs per worker per year was $1,197 which included rebate discounts of $292 for self-administered drugs and $41 for physician-administered drugs.
- Taking into account the 340B program (scenario 2), there was a 4.2% increase in drug costs versus scenario 1.
- If expanded 340B eligibility was considered (scenario 3), drug costs increased 8.4% versus scenario 1.

Figure 3. Total Drug Cost Estimates by Scenario.
Rx: self-administered drugs. Mx: physician-administered drugs.

	Scenario		
Item	**1: No 340B**	**2: 340B Status Quo**	**3: Expanded 340B Eligibility**
Drug Cost before Rebates	$1,530	$1,530	$1,530
Rx Drug Rebates	($292)	($248)	($204)
Mx Drug Rebates	($41)	($35)	($29)
Drug Cost after Rebates	$1,197	$1,247	$1,297

RESULTS: OBJECTIVE 2

The second part of this study assessed how costs changed if employers contracted directly with a 340B hospital to share the hospital's 340B revenue.

- This could increase employer costs through shifts in site of care, lost rebates, and higher cost of care from hospital markups due to the potential for hospital outpatient services to be substantially more expensive than services delivered in independent facilities.
- Such markups apply to all healthcare services, not just drugs.

A sensitivity analysis on the effect of healthcare costs was done on a two-dimensional grid of points for the shift in the site of care and the degree of 340B revenue sharing.

- For all positive shifts in the site of care towards the 340B hospital, costs for the self-insured employer and its workers increased, even when up to 100% of the hospital's 340B revenue was given to the employer.

A stakeholder analysis was used to estimate the impact of the 340B revenue-sharing agreement on all stakeholders in the model.

- Lost rebates, shifts in site of care to the 340B hospital, and hospital markups redistributed healthcare revenue from the employer plan, non-hospital provider, and manufacturer to the 340B hospital. Note that in baseline scenario 1, 340B status quo, only $122 went to the 340B hospital.
- Due to direct contracting, higher 340B eligibility, and shifts in site of care to the hospital, that amount rose to $2,173 in Scenario 2 (Revenue Sharing with Markups), resulting in a healthcare cost increase of 14.0% ($560 per worker) versus scenario 1.
- Additionally, Scenario 3 (Expanded eligibility) resulted in $2,313 going to the 340B hospital, and total employer costs were 15.2% higher than Scenario 1 ($611 per worker).

Figure 4. Revenue and Costs (Per Covered Worker) by Stakeholder and Scenario

STAKEHOLDER	1: 340B STATUS QUO	2: REV. SHARING WITH MARKUPS	3: EXPANDED 340B ELIGIBILITY
Cost to Employer	($4,014)	($4,574)	($4,625)
PBM Administration Income	$31	$23	$16
340B Hospital Net Revenue	$122	$2,173	$2,313
Non-Hospital Net Revenue	$4,612	$3,228	$3,228
Manufacturer Net Revenue	$1,094	$995	$913

CONCLUSIONS & DISCUSSION

The 4.2% increase in the cost of drugs due to the 340B program in the first part of this study corresponds to a $5.2B increase in costs for self-insured employers and their workers.

- In light of this finding, the narrative that "the 340B program costs taxpayers nothing" should be reconsidered.
- In addition, the same dynamic may be occurring for Medicaid and Medicare, which if true, would mean the 340B program could be generating hidden costs for state and federal programs. Further research is warranted in this area.

In the second part, 340B revenue-sharing agreements led to increased healthcare costs for the employer and its workers regardless of how much 340B revenue was shared.

- Participating in a 340B revenue-sharing agreement may sound enticing, but it is likely to exacerbate revenue loss for employers and other healthcare stakeholders.
- This is because 340B revenue is generated only on drugs while hospital markups apply to all medical costs. A full description of both studies is available.[4,5]

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