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340B Drug Discounts: A Simple Debate over a Complicated Program

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Opinions are my own and do not reflect those of any of the above organizations.

Senate Bill 14 (SB14) in the ongoing Kentucky legislative session relates to the federal 340B Drug Pricing Program. This program enables hospitals and other health care providers who serve a disproportionate share of low-income patients to purchase drugs filled at in-house or contracted external pharmacies at discounts from manufacturers. 340B funds help ensure that struggling safety-net hospitals do not have to reduce the provision of charity care, close relatively unprofitable departments, or in some cases even close completely. Since many of the most vulnerable hospitals are located in rural areas with relatively low-income residents and few health care options, such as Eastern Kentucky, this means the 340B program could be vital to ensuring adequate access to care. Moreover, hospitals in these areas tend to be major employers who serve as critical components of the local economy.

SB14 prevents drug manufacturers from withholding 340B pricing for a covered drug if it is offered at those prices in any other state. In effect, the bill preserves the ability of 340B providers to receive discounts through external pharmacies. Since the release of 2010 federal guidance allowing 340B hospitals to contract with an unlimited number of pharmacies, the number of such pharmacies has increased over 20-fold, and the share of eligible drugs receiving the discount has expanded accordingly. Drug companies pushed back with restrictions that cost Kentucky hospitals an estimated $122 million per year. Eight states have already enacted laws to circumvent these restrictions, and Kentucky is one of many other states considering such legislation.

In a study recently released by the Institute for the Study of Free Enterprise at the University of Kentucky, Joseph Garuccio and I provide detailed background information about the 340B program, review the scholarly literature on its impacts, and discuss the implications for federal and state policy, with a particular emphasis on Kentucky. The literature contains a wide range of empirical results, including increased charity care and oncology provision from 340B participation, a reduction in Medicare Part B drug costs, and slower adoption of low-cost drugs. However, the quality and quantity of the evidence base is generally insufficient to draw definitive conclusions.

If the 340B program sounds complicated, that's because it is. This complexity has made bills like SB14 vulnerable to unwarranted claims that it relies on taxpayer money (the money comes

from drug companies) and is part of a conspiracy to subsidize health care for illegal immigrants and gender reassignment surgeries.

Fortunately, the argument for SB14 is actually quite simple. Despite the ambiguity in the academic literature, the most obvious and direct effect of the program is indisputable: 340B drug discounts transfer money from pharmaceutical companies to safety-net health care providers. For a state like Kentucky with a number of struggling hospitals and minimal pharmaceutical manufacturing, such transfers are obviously desirable. Whenever there is an opportunity to bring out-of-state money into the state without costing taxpayers anything, it is a good idea to take advantage.

The question of whether reforms to the 340B program should be made at the federal level does not have as obvious an answer, but state legislators do not need one. From Kentucky's perspective, 340B is as close as it gets to free money laying on the floor. Extensive debates over nuanced second-order effects, while fun for professors, are an unnecessary distraction when it comes to SB14.

Should we feel sorry for the drug companies? I would argue no, because they signed up for this. The first major expansion of 340B occurred as a result of the Medicare Modernization Act of 2003, which made new types of facilities eligible. In return for agreeing to this expansion, drug companies got millions of new customers through the introduction of Medicare Part D, and secured restrictions against importing low-cost drugs and the federal government negotiating prices.

The second major expansion came from policy action in 2010. The Affordable Care Act (ACA) made Critical Access Hospitals eligible for 340B, while guidance released at around the same time allowed unlimited contract pharmacies. In return, pharmaceutical companies got millions of more new patients through the ACA's insurance coverage expansions, while again fighting off the threats of low-cost imported drugs and the government exerting downward pressure on prices.

In short, SB14 will help ensure that Kentucky gets the same benefits from the 340B program that other states passing legislation are getting. It will provide a substantial boost to the hospitals and other health care facilities most in need of support, without any cost to taxpayers.