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August 16, 2018

How a discount programme became the villain in US drug price wars

Jonathan Gardner

Pharma sector pushes back against a programme that mandates cheaper prices for hospitals serving the poor.

A US government programme to provide cheap medications to hospitals that mainly treat poor patients is counterintuitively a target for reform or elimination as part of the Trump administration's drug pricing proposals.

The flaw in the “340B programme” is that the government can force drug manufacturers to sell drugs at a discount, but when hospitals use these drugs to treat patients with healthcare coverage they can bill insurers at a commercial rate and profit on the difference. Pharma has a strong case that the scheme is being manipulated, consequently driving up prices for all other buyers, but policymakers are right to doubt that revamping the programme will bring about measurable relief in drug price inflation.

Small but growing

Drug discounting began in 1992 for hospitals with a high proportion of poor and uninsured patients, those serving isolated communities and children’s and cancer speciality hospitals. Section 340B of the Public Health Service Act requires that manufacturers grant these institutions a 22.5% discount.

While the 340B business represents a small proportion of America’s $329bn drug sales, policymakers have been sounding alarms about its rapid growth – from representing $12.8bn of branded drug sales at the wholesale acquisition cost in 2012 to $29.6bn in 2017.

Growth has been spurred by a couple of trends. The Affordable Care Act expanded the number of institutions eligible for discounts, and hospital buyouts of physician practices, effectively making them part of the hospital, has increased the number of places where discounted drugs can be dispensed (*As US hospitals consolidate their pharmacy muscles grow, March 6, 2018*). Hospitals that are benefiting from the programme also note that the growth has corresponded with increasing drug prices, so the pharma sector shares some of the responsibility.

While the law states which hospitals qualify, it is not clear that discounted drugs should exclusively be used on poor or uninsured patients. Thus even privately insured patients can receive them, but the hospital is free to bill at commercial rates, thereby making a profit here.

Hospitals defend this practice, however, arguing that the savings can be used to fund other healthcare activities, such as care for uninsured patients. This is common in the complex US healthcare system, where profits in one business line are used to offset shortfalls in others, so-called “cross subsidisation”.

Medicare acts

Nevertheless, the US Medicare programme for the elderly and disabled addressed part of the issue this year when it instituted a 22.5% cut in its reimbursement rates for physician-administered 340B drugs covered by Medicare’s part B.

The pharma sector is, of course, eager for the government to rein in 340B. Among its arguments is that by mandating discounts for an increasing number of customers, companies must raise list prices to make up the difference and give an extra push to inflation. This found its way into President Donald Trump’s drug pricing blueprint, although this document did not offer any specific solutions.

Mr Trump might have to do little, since Medicare has taken action and legislation has been introduced that at a minimum would prevent expansion of 340B. Among the bills now active is one that would prevent new hospitals from joining the programme as well as prevent existing ones from adding outpatient clinics with access to discounted drugs.

Whether Congress can deliver legislation to the White House before it adjourns this autumn is an open question, especially in an election year in which an effort to roll back 340B could be portrayed as an attack on poor and uninsured people led by the sector’s lobbying group, the Pharmaceutical Research and Manufacturers of America.

The pharma sector is insistent that it does not want to dismantle the programme, but rather that it just wants 340B to be reduced to serve only the target populations. This, of course, will benefit them by reducing the number of buyers who qualify for discounts.

It should be pointed out that it took passage of a law to get biopharma groups to agree to discounts for hospitals serving uninsured patients, and, while limiting use of 340B drugs to just poor or uninsured patients is a reasonable policy objective, another reasonable goal is ensuring that drugs are not priced too high for sick people to be able to afford them.

Therefore, if the pharma sector is sincere that 340B helps drive drug inflation, perhaps any law that restricts its use ought to be coupled with limits on price increases. This seems like a fair tradeoff.