The Costs of the 340B Program to States



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BACKGROUND

- The 340B Drug Discount Program is a federal program in which manufacturers provide discounted outpatient drugs to participating 340B covered entities.
- The 340B program costs manufacturers and others in the health system; 340B discounts displace manufacturer rebates on the same drug, normally returned to health plans to reduce costs, raising drug spending for commercial health plans and their more than 150 million beneficiaries.¹
- Previous research estimated national 340B costs to self-insured employers,² but state 340B costs are unknown. 340B utilization, or the percentage of drugs purchased at the 340B discounted price, may vary by state and influence employer costs. Some states have introduced legislation prohibiting manufacturer contract pharmacy restrictions, which may further drive 340B utilization and costs.

OBJECTIVES

- 1. To quantify the cost of 340B to employer-sponsored and state and local government health plans for all 50 U.S. states.
- 2. Estimate the additional cost of expanded 340B utilization from state contract pharmacy legislation.

DATA & METHODS

- We used a previously reported financial model² to estimate 340B utilization and rebate losses for employees, employer-sponsored health plans, and government health plans in each state.
- 340B utilization was estimated in part by using the 1996 Health Resources Services Administration (HRSA) patient definition (status quo); we separately measured utilization using an expanded patient definition (expanded eligibility), which assumed all patient pharmacy claims were 340B-eligible within 2 years after the initial patient encounter at a 340B covered entity.
- 340B eligibility scores were aggregated at the state contract pharmacy level using claims data and the percentage of sales at list price purchased through the 340B program.
- We also examined self-administered drugs subject to manufacturers' contract pharmacy restriction policies and used claim-level and historical trend analyses to estimate additional rebates lost due to ongoing state contract pharmacy legislation.

Figure 1. Summary of Public and Proprietary Data Sources

Employer Data

- State and local employee populations (KFF, CB)
- Ratio of dependents vs employee by state (KFF, CB)
- Rates of employersponsored insurance by state (MMI and MEPS)

IQVIA Data

· LAAD Pharmacy and

- Medical claims
- 340B eligibility scores
- DDD subnational sales
 340B CE participation
- · Pharmacy affiliation

Policy Data

- Manufacturer contract pharmacy policies
- State contract pharmacy

bills

CB: Census Bureau; CE: Covered Entity; DDD: Drug Distribution Data; KFF: Kaiser Family Foundation; LAAD: Longitudinal Access & Adjudication Data; MEPS: Medical Expenditure Panel Survey; MMI: Milliman Medical Index

RESULTS

Figure 2. 340B Utilization Varies by State

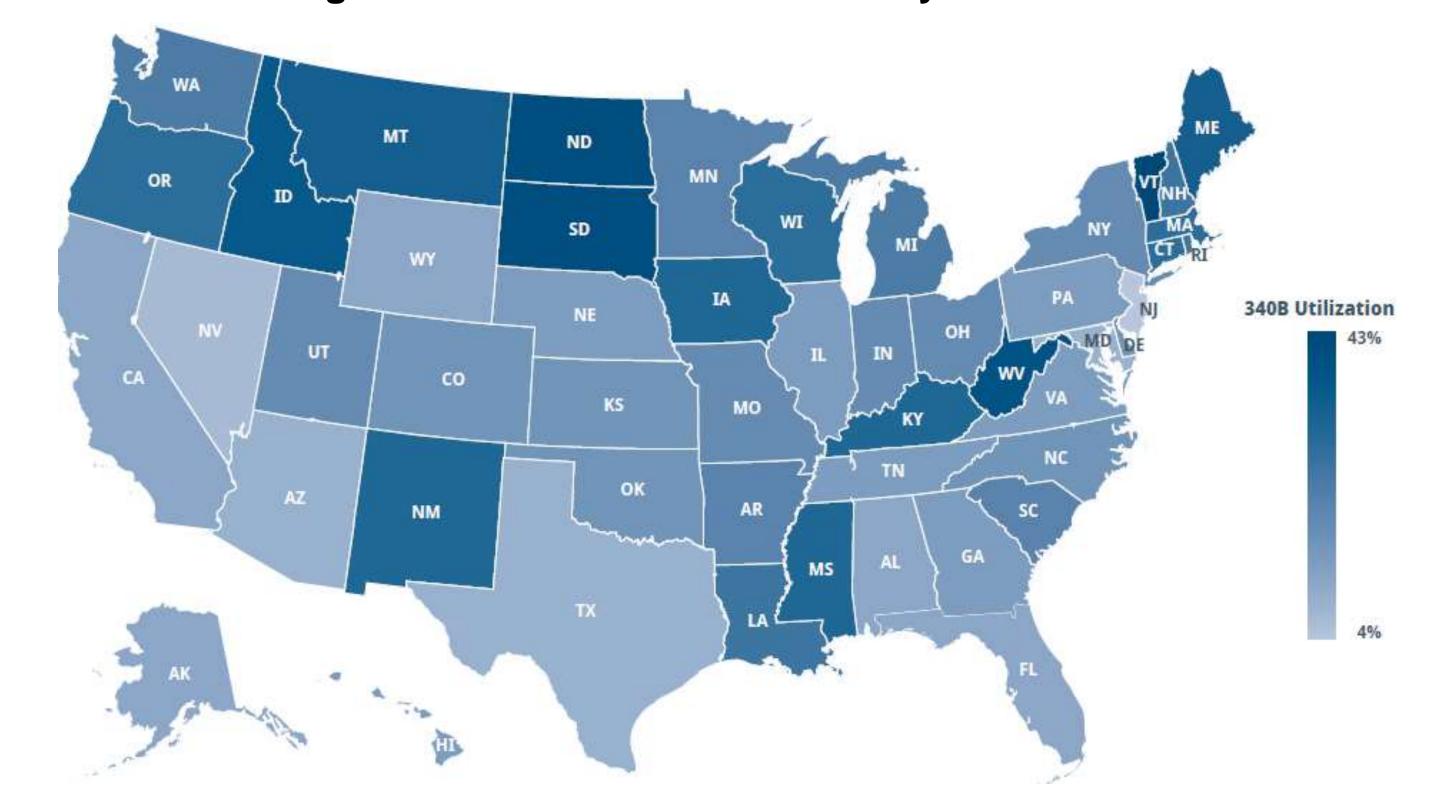
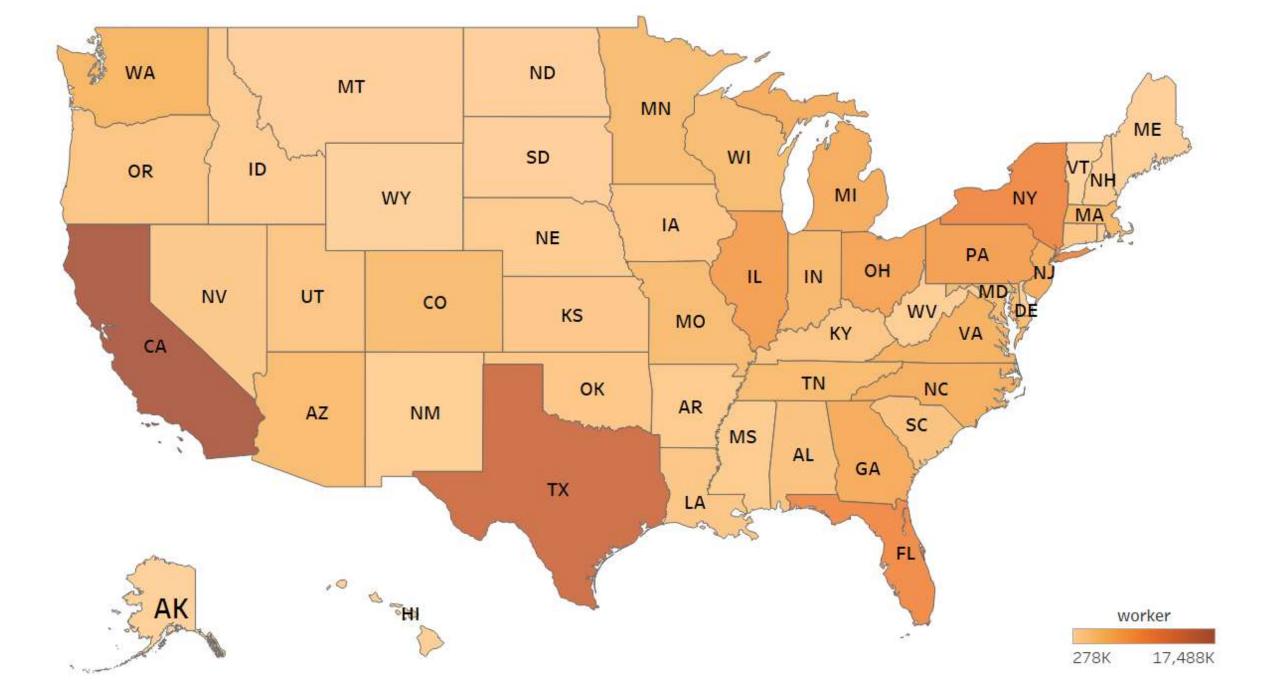
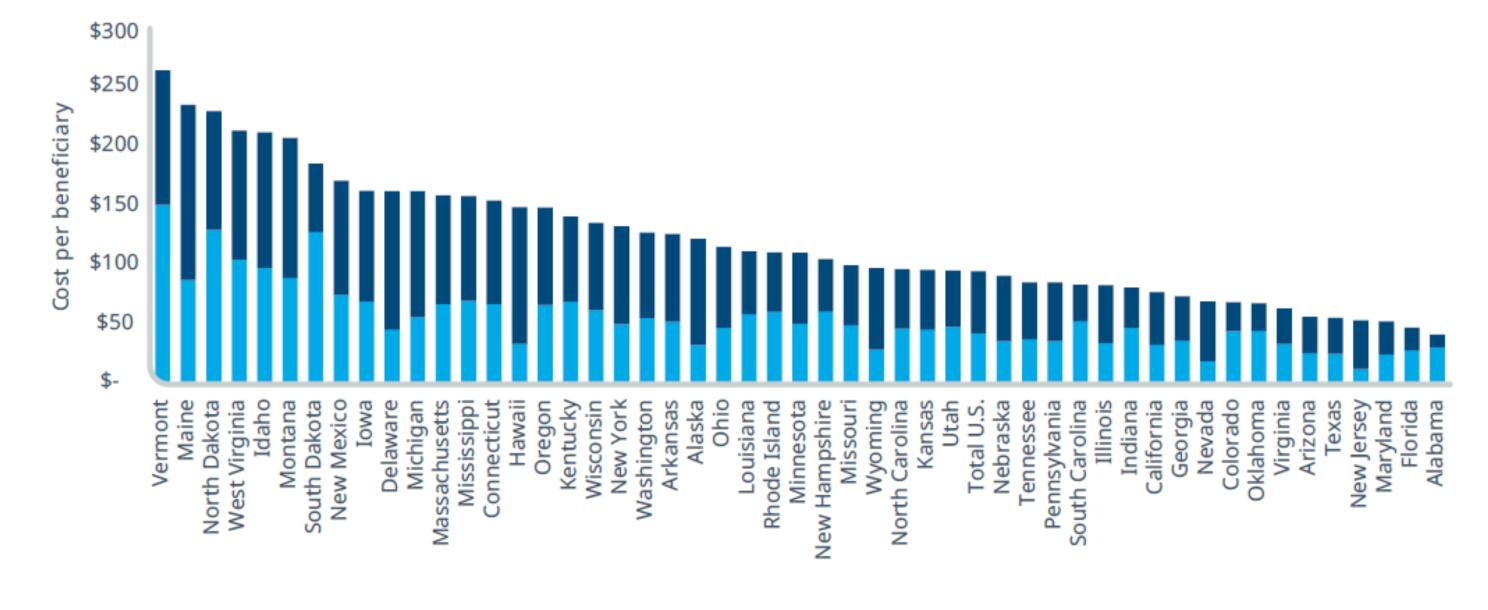


Figure 3. Number of Employer-Sponsored Plan Beneficiaries by State



- 340B utilization varied from 4% to 43% across states (**Figure 2**). The number of beneficiaries covered under employer-sponsored plans also varied by state (**Figure 3**). 340B resulted in cost increases for employer-sponsored plans, ranging from \$13 to \$152 per covered beneficiary, totaling \$6.6B over the entire US for 2023.
- Some rural states had 340B utilization as high as 75% under expanded eligibility, translating to \$265 per beneficiary (**Figure 4**).
- We found slightly higher 340B costs for state and local governments, ranging from \$14 to \$160 per covered beneficiary under the status quo and \$45 to \$281 under expanded eligibility. In aggregate, 340B increased healthcare costs for state and local governments by \$1.0B.

Figure 4. 340B Cost Per Beneficiary by State (Descending Order of Cost)



Patient definition
 Expanded eligibility

RESULTS (cont.)

- State contract pharmacy bills could add \$1.8B to existing 340B drug costs. This represents a 27% increase in the total cost of the program from \$6.6B to \$8.4B.
- The impact of contract pharmacy bills varied significantly by state. For all employers, the estimated rebate loss per worker from state bills would rise from \$9 to \$21 under the status quo and surge to \$41 under expanded eligibility.
- State and local governments face acute cost increases, rising from \$234M without contract pharmacy mandates to \$506M (\$965M under the expanded eligibility). See **Figure 5** for a summary of estimates.

Figure 5. Total cost of state contract pharmacy bills at a national level

	KEY METRICS	NO STATE BILLS	STATE BILLS + PATIENT DEFINITION	STATE BILLS + EXPANDED ELIGIBILITY
Size of 340B	340B expansion factor vs trend	1	2.2	4.2
	340B utilization	5%	10%	20%
Financial impact of 340B	Cost per beneficiary	\$9	\$21	\$41
	Cost of 340B for employer- sponsored plans	\$1,516M	\$3,305M	\$6,309M
	Cost of 340B for state and local government plans	\$234M	\$506M	\$965M

LIMITATIONS

- 340B utilization might not be accurately attributed to states with significant crossborder commuting or mail-order pharmacies.
- All employer-sponsored plans were assumed to have the same average premiums, healthcare spending, and rebates; separate estimates were used for government plans, and federal and military employees were excluded.
- Cost estimates for contract pharmacy bills assumed continued pre-bill sales growth.
- Physician-administered drug spend might be underestimated as it is generally covered under medical benefits.

CONCLUSIONS & DISCUSSION

- Our findings suggest that the 340B program has significant drug costs for employers through lost rebates, and that employers may have incremental costs from state contract pharmacy bills.
- Costs vary across states due to differences in 340B utilization, which is likely due to state differences in populations (urban versus rural), the number of 340B hospitals and clinics, and Medicaid expansion adoption.
- Employers and workers are being asked to pay a disproportionate share of the cost of the 340B program, and due to a lack of transparency regarding how the program raises costs, employers and workers are likely oblivious to these costs.
- The mechanism modeled by the current study explores how the 340B program increases drug costs by displacing manufacturer rebates. Others have reported how 340B could raise the cost of healthcare services in general via hospital consolidation, hospital markups,^{3,4} and patients getting into more medical debt.⁵
- Future empirical studies can further this research by testing for factors contributing to state variation in 340B utilization and investigating relationships between 340B utilization, hospital consolidation, and markups.

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