National Alliance of Healthcare Purchaser Coalitions
Driving Health, Equity and Value

The 340B Premium

New Data Shows Program Inflates Prices for Working Families

New analysis of commercial prices for high-volume procedures finds:

- **Commercial prices were roughly 7% higher at large 340B hospitals** vs. large non-340B hospitals.
- **Prices for outpatient procedures were nearly 20% higher** at large 340B hospitals vs. large non-340B hospitals.
- The 340B price premium translates to approximately **$36 billion a year in extra hospital spending by employers,** adding to the growing evidence of 340B's impact on working families.

BACKGROUND

The 340B Drug Pricing Program allows participating hospitals and clinics to purchase medicines at steep discounts ("buy low") and sell those medicines to payers, including employers, and patients at full negotiated rates ("sell high"). The profit generated was originally intended to help cash-strapped safety-net providers provide lower cost medicines and expand care for low income and underserved patients. However, due to lack of clear regulations and poor transparency and oversight, the program has grown to over $66 billion in purchase volume – making it the second-largest federal drug program after Medicare Part D. Large, well-resourced hospital systems capture the largest share of 340B profit.[i]

As the program has ballooned in size, it has become increasingly clear that 340B is contributing to the rising cost of healthcare for employers in several ways: lost rebates on prescriptions purchased at the 340B price, exorbitant hospital markups on medicines, distorted prescribing patterns, incentives for consolidation, and more.[ii]

While these incentive structures have been clearly documented in academic literature, our ability to quantify their financial impact on employers has remained limited. This gap has persisted despite the program's exponential growth and a clear desire from policymakers and stakeholders to enact reforms.

METHODOLOGY

A new study conducted by Health Capital Group sought to understand 340B's correlation with commercial hospital prices, which represent one of the largest drivers of the high cost of care and the rising premiums that employers and their workers are paying.[iii]

The study used data on actual negotiated prices from nearly 2,500 hospitals across 17 commercial health insurance payers to calculate a price index for each hospital. This index compared the prices at one hospital to the average across all hospitals for 25 high-volume procedures. These indices were used to compare average commercial prices at 340B and

non-340B hospitals, calculating the average "340B premium" for commercial payers. A more detailed explanation of the methodology is available at www.healthcapitalgroup.com.

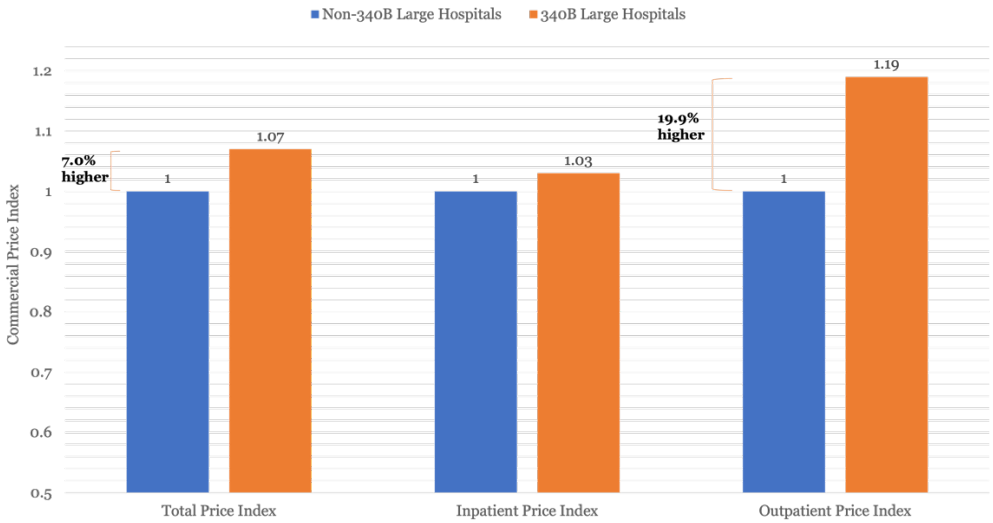
RESULTS

Overall, average commercial prices across all 340B hospitals were 1.1% higher than non-340B hospitals. However, decades of academic research and stakeholder perspectives emphasize that the 340B program is not a monolith, operating differently for varying hospital sizes and types. In fact, 340B Disproportionate Share Hospitals (DSH) hospitals, which account for the vast majority of 340B sales, had average commercial prices that were 8.5% higher than non-340B hospitals. This study sought to understand in more detail how commercial prices differ at various types and sizes of 340B hospitals, including large, integrated urban and suburban systems and small, rural safety-net facilities.

Price Differentials by Size of Hospital

Large hospitals (130 beds or more) account for the largest share of employer spending on procedures and also represent the largest price differentials. On average, large 340B hospitals appear to charge 7% higher prices than large non-340B hospitals. The premium is even higher for outpatient procedures, with 340B hospital prices nearly 20% higher.

Figure 1: Comparison of Prices for Large 340B vs Large non-340B Hospitals



Notably, 340B discounted pricing only applies to drugs in the outpatient setting. The fact that the price premium is particularly pronounced for outpatient procedures raises interesting questions regarding the connection between prices and 340B eligibility. For example, it may reflect that large 340B hospitals have significant pricing power in the outpatient market power, due to their acquisition of previously independent outpatient physicians' offices, and that 340B participation is associated with a shift in site cancer drug administration to hospital outpatient departments.[iv,v]

This trend is not consistent for small hospitals. Commercial prices at small 340B hospitals (less than 130 beds) were found to be 8.4% *lower* than non-340B small hospitals. The largest price differentials were observed among outpatient services, where small 340B hospital prices were 15% lower than those at small non-340B hospitals.

Price Differentials by Type of Covered Entity

These converse findings by hospital size can be partially explained by behavioral differences between types of 340B covered entities. The majority of large hospitals qualify for the 340B program as Disproportionate Share Hospitals, while smaller hospitals are more likely to be Critical Access Hospitals (CAHs). Results show prices overall at CAHs are 32.3% lower than prices at similarly sized 340B DSH hospitals. As DSH hospitals account for the largest share of 340B purchases and revenue, this category of hospitals drives the overall trend observed among all 340B and non-340B hospitals.

Disproportionate Share Hospitals (DSH)

DSH hospitals qualify for the 340B program if their DSH adjustment percentage – which measures the proportion of inpatient days attributable to Medicaid and low-income Medicare patients – is at least 11.75%.[vi] In 2023, DSH accounted for 78% of 340B revenue.[i] Evidence suggests that large hospital systems strategically adjust their DSH percentage to gain access to the 340B program,[vii] and several of the nation's most profitable health systems qualify via this pathway, including Mass General, NYU Langone, and Cedars-Sinai Medical Center.[viii]

340B DSH hospitals charge, on average, 8.5% *higher* commercial prices than non-340B hospitals. Consistent with the results among all 340B hospitals, the largest price differentials are observed among outpatient procedures, where 340B DSH hospital prices are 12% higher than non-340B hospitals. Price differentials for outpatient procedures are most dramatic among large 340B DSH, which charge 24% more than large non-340B hospitals.

Figure 2: Comparison of Prices for 340B DSH vs. non-340B Hospitals, by size

	All 340B DSH vs. All Non-340B	***Large 340B DSH vs. Large non-340B***	***Small 340B DSH vs. Small non-340B***
Total Price Index	8.5%	7.5%	4.4%
Inpatient Price Index	7.6%	3.4%	0.7%
Outpatient Price Index	11.8%	24.3%	14.2%

Critical Access Hospitals (CAHs)

CAHs qualify for 340B by providing emergency services to rural areas, with a 25-bed maximum.[ix] This designation was created in response to a wave of rural hospital closures in the 1980s and 1990s to reduce the financial vulnerability of small, struggling facilities and keep essential services in rural communities.[x] These facilities, however, made up just 1.4% of 340B revenue in 2023.[i]

The data shows that CAHs charge substantially *lower* prices compared with similarly sized (i.e., smaller than 130 beds) 340B DSH hospitals and non-340B hospitals. In line with the previous findings, price differentials are most dramatic for outpatient procedures. Outpatient prices were nearly 40% lower at CAHs than non-340B small hospitals.

Figure 3: Comparisons of Prices for 340B CAHs vs. Small 340B DSH and non-340B Hospitals

	CAHs vs. Small 340B DSH	*CAHs vs. Small Non-340B*
Total Price Index	-32.2%	-24.1%
Inpatient Price Index	-33.6%	-22.1%
Outpatient Price Index	-37.1%	-37.7%

Impact on Employer Health Care Spending

While these figures are concerning at the individual hospital level, there are profound implications for employers when extrapolating to the overall commercial insurance market. In the sample, commercial plans spent $6 out of every $10 on hospital care at large 340B hospitals, which collectively generated over $365 billion in total commercial revenue. The 7.5% 340B price premium for employers translates to roughly $36 billion in extra spending each year, a substantial component of commercial hospital spending. The impact is particularly severe for employers in areas with high 340B concentration, for whom large 340B hospitals may represent practically *all* of their hospital spending.

CONCLUSION

While this study does not make any claims about causation, it finds that prices, on average, are higher at large 340B hospitals – particularly at 340B DSH hospitals. This could be due to a variety of factors, including the association between 340B hospitals and provider consolidation, which can increase a given hospital's pricing power and therefore its commercial prices. Even after controlling for state-level effects, membership in a hospital system, hospital size (beds), teaching status, DSH percentage, and other variables via regression analysis, prices at large 340B hospitals remain higher (see technical appendix).

This study adds to the growing body of evidence[xi,xii] that the $66 billion and growing 340B program is contributing to higher costs for commercial employers and their workers, rather than offsetting the cost of care. The effect is especially pronounced at the largest hospital systems, which reap the majority of the program's proceeds.

As hospital prices and healthcare premiums continue to rise across the country, employers are increasingly taking notice of 340B's inflationary effects. The National Alliance is proud to contribute to the dialogue around the 340B program, and we encourage advocates and policymakers to join us in promoting greater transparency. A clearer understanding of the program's downstream impacts across the healthcare system will help inform policy solutions that ensure 340B works more effectively for all of us.

REFERENCES

[i] https://www.hrsa.gov/opa/updates/2023-340b-covered-entity-purchases; DSH hospitals accounted for $51.9B and CAH hospitals accounted for $955M out of $66.3B in 340B revenue in 2023.
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