Myth vs. Fact:

The 340B Drug Pricing Program

The federal 340B Drug Pricing Program allows covered entities, safety-net hospitals, FQHCs, and others to purchase prescription drugs from pharmaceutical manufacturers at their best price. The law is specifically designed to help the covered entities stretch scarce resources to ensure access to care. Covered entities employ the savings from paying the discounted price for very expensive drugs for numerous different programs and purposes depending on the needs within the community.

MYTH: **Taxpayers are spending a great deal of money on this program, and it is growing dramatically.**

FACT: **The 340B program is funded by big pharmaceutical companies, not taxpayers, as a result of federal law dating back to the 1990s. The pharmaceutical companies agreed to an expansion of the program as part of the Affordable Care Act. The cost of the program for the pharmaceutical companies has risen because of the agreed-upon expansion of the program, a continued shift from inpatient care to outpatient care that relies on 340B drugs, and a surge in the use of costly specialty drugs, among other factors.**

MYTH: **Patients are supposed to receive a discount for drugs they purchase because the covered entity receives a discount under the 340B program.**

FACT: Nothing in the law mandates patient discounts. **The law provides the covered entities with needed latitude in how the savings are used to stretch scarce resources. Hospitals and other covered entities use the savings from the 340B program for a wide range of patient care and assistance that includes: providing free or discounted drugs to patients who can't afford them; supporting money-losing programs such as oncology services, Hep-C clinics, behavioral health services, trauma care, and substance use disorder treatments; offsetting billions of dollars in underpayments by Medicaid and Medicare; upgrading medical**

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facilities and making other capital improvements; funding the salaries of specialized medical staff to maintain community care access; paying for patient transportation, translation, and other support services; and much more.

MYTH: Hospitals and other covered entities are not transparent about how they use savings from the 340B program.

FACT: Hospitals and other covered entities are and have always been subject to audit by HRSA, the federal agency charged with oversight of the program. HRSA audits 200 covered entities each year and has the authority to approve drug company audits. Hospitals also make no secret of how they employ savings from their purchase of discounted pharmaceuticals. They submit annual Medicare cost reports and IRS forms that detail the community benefits and charity care that they provide for patients.

MYTH: This is a federal issue and the state has no role to play in it.

FACT: States have the authority to oversee drug distribution within their borders. The pharmaceutical industry has filed lawsuits against Arkansas and other states that have already passed legislation to require the drug companies to deliver prescription medications to covered entities and their pharmacy partners in their states. Courts have ruled against the pharmaceutical companies in all but one case, and the U.S. Circuit Court of Appeals for the Eighth Circuit explicitly rejected the drug companies' argument that states could not act in this realm. Last month this same case was brought to the Supreme Court of the United States (SCOTUS) and SCOTUS declined to take up pharmaceutical manufacturers' challenge to Arkansas. Proposed legislation in Kentucky simply seeks equal treatment for hospitals and other covered entities here in Kentucky. If drugmakers must deliver discounted prescription drugs without conditions in other states such as Missouri, Arkansas, Maryland, Louisiana, and several others that have adopted laws compelling distribution at the federally agreed upon price, Kentucky's covered entities must receive the same price.

MYTH: The 340B program does not significantly benefit low-income patients, such as those on Medicaid.

FACT: The 340B program was created to support safety-net hospitals, health centers, and clinics that provide care to large numbers of low-income patients and those in rural communities. Research shows that 340B hospitals provide three-quarters (77%) of all hospital care for Medicaid patients. In Kentucky that figure is

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much higher at 88%. Medicaid revenue as a percent of total operating revenue is nearly twice as high at 340B disproportionate share hospitals compared to non-340B hospitals.[1, 2] Additionally, 340B hospitals provide two-thirds (67%) of uncompensated and unreimbursed care in the U.S., despite accounting for less than half (43%) of all hospitals.[3] These hospitals are essential for maintaining access to care for low-income patients, with 81% of critical access hospitals (CAHs) using 340B savings to increase access to care for low-income rural patients and 74% reporting needing 340B savings to keep their hospital doors open.[4]

MYTH: **Undocumented immigrants are using 340B to receive free health care and the taxpayers are underwriting the expense.**

FACT: This accusation from a dark-money, anti-340B group is patently false. The care that hospitals provide the people in their communities using 340B funds comes from drug company discounts, not taxpayer dollars. As for the people we treat, we provide emergency care to all patients who enter our doors, regardless of their ability to pay. This is not just a core element of our patient care mission, it is also the law. Since President Reagan signed it in 1986, EMTALA requires that all hospitals with an emergency department, like ours, provide stabilizing care to all who need it.

MYTH: **340B is funding gender transitions for kids.**

FACT: This accusation from the same dark-money, anti-340B group is designed to inflame and grossly mislead lawmakers and the public about how 340B works and how hospitals use their savings. Nothing in the federal 340B statute overrides state laws governing the delivery of care. Kentucky is one of the states that currently bans gender transition therapies for minors, which includes puberty blockers, hormone therapies, and surgeries. Moreover, the focus on one extremely specific and controversial treatment is intended to obscure the wide range of care and support that hospitals can provide to all their patients because of 340B.

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1. 340B DSH Hospitals Serve Higher Share of Patients with Low Incomes, 2022 Dobson DaVanzo & Associates, LLC **https://www.340bhealth.org/files/340B_and_Low_Income_Populations_Report_2022_FINAL.pdf**
2. 340B DSH Hospitals Increased Uncompensated Care in 2020 Despite Significant Financial Stress, July 20, 2022. Steven Heath, Joan E. DaVanzo, Ph.D., M.S.W., Elaine Cheng, Seung Ouk Kim, Ph.D., Al Dobson, Ph.D. **https://www.340bhealth.org/files/Dobson_DaVanzo_Op_Margins_and_UC_FINAL.pdf**
3. Kentucky 340B Hospitals Serve More Patients with Low Incomes and Provide the Majority of Hospital Care to Medicaid Patients, Accessed Jan. 30, 2024. **https://www.340bhealth.org/files/KY-340B-Low-Income15015.pdf**
4. 2021 340B Health Annual Survey: 340B Continues to Support Essential Programs and Services in the Face of Significant Financial Stress on Hospitals, April 7, 2022. **https://www.340bhealth.org/files/340B_Health_Survey_Report_2021_FINAL.pdf**

Congress designed 340B so each hospital has the flexibility to reinvest its savings based on critical community care needs and in accordance with state health care delivery laws. Hospitals use their savings in myriad ways that include providing free and discounted drugs, offering services that they otherwise could not provide, covering underpayments from government programs, funding wraparound services for patients, and much more.

MYTH: **The 340B program is increasing the price of Pharmaceuticals.**

FACT: **The 340B program does not increase the price of medication, in fact, it significantly lowers the price of prescription drugs for qualifying covered entities, allowing them to purchase medications at a discounted rate to provide affordable care to low-income patients; essentially, drug manufacturers offer discounted prices to participating entities under the 340B program, which means the cost of medication does not go up for patients due to this program. In the US, the sticker price of medications is 100% controlled by manufacturers. According to HHS, in 2022, US prices across all drugs (brands and generics) were nearly 2.78 times as high as prices in the comparison countries. US prices for brand drugs were at least 3.22 times as high as prices in the comparison countries, even after adjustments for estimated US rebates. Most new drugs were available first in the US before being launched in other countries. The US spends a higher and growing share of total drug spending on new drugs compared to other countries.**[5]

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5. AMA Citation: U.S. Department of Health & Human Services, Assistant Secretary for Planning and Evaluation. Comparing Prescription Drugs. Published January 2024. **https://aspe.hhs.gov/reports/comparing-prescription-drugs**

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