Minnesota becomes first state to release report on 340B drug discount program for ‘safety-net’ hospitals

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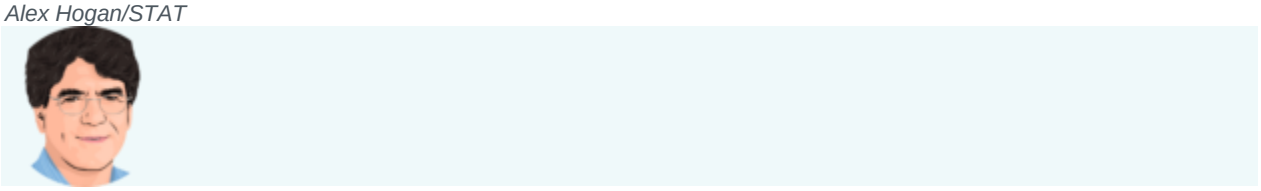

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Minnesota hospitals participating in a controversial U.S. drug discount program reaped at least $630 million in revenue last year, and the largest institutions were the biggest beneficiaries, according to a reportfrom the Minnesota Department of Health.

Specifically, hospitals received $1.5 billion in discounted medicines under the 340B Drug Discount program, but paid $734 million plus another $120 million to various parties for administration fees. Meanwhile, the largest hospitals received roughly $500 million, representing 80% of the total revenue collected. Yet these institutions accounted for only 13% of the total number of participating hospitals.

The report is the first ever compiled by a state in response to controversy over the 340B program, which was created three decades ago to help hospitals and clinics care for low-income and rural patients. Drug companies that want to participate in Medicare or Medicaid must offer their medicines at a discount — typically, 25% to 50%, but sometimes higher — to participating hospitals and clinics.

But the program has become a flash point in the debate in the U.S. over the rising cost of prescription medicines. Drugmakers argue that hospitals abuse the program and divert payments to other uses, such as fueling consolidation of health care systems that, in some cases, favor wealthy communities. As a result, the pharmaceutical and hospital industries have squared off over pricing, transparency, and billing.

In recent weeks, three of the largest drug companies — Johnson & Johnson, Eli Lilly, and Sanofi — have attempted to alter their payment plans to participating hospitals, arguing that the 340B program is rife with waste and abuse, and no longer fulfills its mission. J&J and Lilly, however, received pushback from the federal government and are now locked in litigation.

There is no dispute that the program has ballooned. There are now about 55,000 participating hospitals and clinics, which are known as covered entities. Prescription medicines purchased in the U.S. under the program amounted to $66.3 billion in 2023, a 23.4% increase from the previous year, according to data from the U.S. Health Resources and Services Administration, which oversees the program.

Consequently, more federal and state lawmakers want to know about the flow of money. Minnesota, however, is the first state to attempt to dive into the numbers with a law that requires participating hospitals and clinics to report discounts received, the fees paid to third-party administrators and contract pharmacies, and their net revenues, among other things.

“This is a huge step forward, because nobody has ever done this before and so until this moment, we’ve never had numbers like this to examine,” said Sayeh Nikpay, an associate professor of health policy and management at the University of Minnesota School of Public Health. “Until now, we’ve had no systematic view of how covered entities benefit from this program.”

For the moment, though, the picture is mixed, because the data are incomplete — and by a large amount.

Why? Most of the hospitals and clinics reported data only for medicines dispensed by retail pharmacies, but not those administered in physician offices due to ambiguity in state law. That was since clarified, but the report noted such medicines account for roughly 80% of all spending in the 340B program. As a result, there is a “significant underestimate” and half of all 340B revenue may have been missed.

Nonetheless, the data reveal some interesting details. For instance, hospitals and clinics paid third-party administrators and contract

pharmacies more than $120 million, which means that for every $100 of gross 340B revenue generated, these institutions paid approximately $16 to external parties to administrate and operate areas of their 340B programs. In fact, the top 10% of all hospitals and clinics lost about one-third of their gross 340B revenue to administrators and contract pharmacies.

The findings reflect what Nikpay called the "accumulating market power" in the opaque 340B world, where many smaller 340B hospitals and clinics do not operate their own contract pharmacies. Consequently, these institutions reach agreements with large players, such as CVS Health, that run a third-party administrator and specialty pharmacies that can charge large fees, she explained.

These third-party costs have also generated separate disputes.

Four years ago, many drugmakers began limiting some discounts when hospitals or clinics bought medicines and then shipped them to contracted retail or specialty pharmacies for patients to pick up or for delivery, instead of using their own in-house pharmacies. The drug companies alleged that using contract pharmacies led to abuses, such as duplicate billings, product diversions, and ineligible rebates.

The moves to curtail discounts or restrict use of contract pharmacies sparked an outcry among lawmakers, state attorneys general, and numerous patient groups that argued those steps violated federal law and hurt patient access. Some states passed laws to block drugmakers from restricting hospitals from using contract pharmacies, prompting some companies to file lawsuits.

Separately, various drugmakers have filed still other lawsuits against the U.S. Department of Human and Health Services, which oversees the HRSA, over a 2021 advisory opinion that maintained pharmaceutical companies should provide discounts, even if hospitals and clinics use contract pharmacies to deliver drugs.

The Minnesota report also found three drugs accounted for roughly 57% of 340B spending last year by hospitals and clinics — Trikafta, a cystic fibrosis medication that is sold by Vertex Pharmaceuticals; the Humira

treatment for rheumatoid arthritis that is sold by AbbVie; and Biktarvy, an HIV medicine marketed by Gilead Sciences. These drugs also appeared high on a similar list compiled by the HRSA.

As for revenue generated through the program, the list was topped by Humira at $12.2 million, or $3,405 per fill. This was followed by Trikafta at $9.7 million, or $3,950 per fill, and then Eliquis, a widely prescribed blood thinner, at $9.6 million, or $558 per fill. Ozempic, which is approved to treat diabetes but also prescribed for obesity, generated $6.3 million, or $569 per fill.

Based on the number of prescription fills, oxycodone was the most frequently filled drug for which 340B discounts were applied in hospitals. In total, there were over 80,000 fills of oxycodone, generating about $100,000 in net 340B revenue. Fentanyl was ninth, based on volume, with over 20,000 fills and net revenue of roughly $360,000. Opioids are the 10th most-filled therapeutic class of drugs in the state.

Nonetheless, state officials underscored that many questions remain unanswered.

These include understanding how 340B benefits patients; how hospitals use net 340B revenue and how this relates to other financing; how incentives shape prescription drug pricing and the broader health care system; the impact on net 340B revenue when office-administered drugs are included in future reports; and whether are there more efficient ways to administer 340B to reduce administrative costs.

As Brian Reid of Reid Strategic, who works with drug companies on pricing and access issues, noted in a blog post, the Minnesota report is a “milestone and it ought to be a guide to how the program is approached going forward.”