The 340B program also supports non-oncology patients in the Henry Ford Hospital system. It helps underwrite the Community Health and Social Services Center that provides Detroit’s large Latino and African-American communities with primary care, dental, pediatrics, perinatal, family planning, counseling, and pharmacy services. 340B savings add up to improved outcomes through earlier diagnosis, earlier identification of therapy-related savings, and underinsured patients. It provides more than 100,000 patients per year with medications free of charge and the center absorbs the full cost of any medications. Otherwise there would be no way we could afford the cost of drugs.”

For patients, the hospital’s 340B savings help cover every aspect of cancer care from diagnosis to chemotherapy and radiation. These services are provided regardless of patients’ ability to pay. The Queen’s Cancer Center in New York is the only comprehensive cancer center in the Health and Hospital Corporation system. Established in 2002, it treats more than 2,700 cancer patients per year regardless of income. Seventy-nine percent of the center’s patients are either uninsured or on Medicaid and many are undocumented.

Discounted 340B chemo drugs are absolutely vital to keeping the center open. In the past year, it has used $130 units of Neulasta at a cost of $2,726,000 – instead of the $2,329,075 retail price. The center spent $549,438 on Herceptin, a considerable break from the retail price of $2,692,489. The majority of the center’s patients receive all their chemo drugs free of charge and the center absorbs the full cost of preparing and administering the medication. “Without the program we couldn’t run the cancer center and give high-quality care,” said Director Mary Margaret Kemeny, MD.

PRIVATE VS. HOSPITAL ONCOLOGY

The Community Oncology Alliance, which represents private-practice oncologists, charges that treatment costs more in hospital settings and that 340B is somehow to blame. They conveniently overlook that fact that private oncologists treat very few poor patients. Much of a private oncologist’s profit is made marking up chemo drugs to fully insured customers. Uninsured and underinsured patients do not fit the business model and so they are referred to the nearest safety-net hospital. To many their missions, these providers must shoulder the enormous expense of treating all patients, regardless of ability to pay. 340B discounts help in this regard, but do not cover the full costs of uncompensated care.

Only 4% of patients treated by community oncologists are uninsured and the same percentage have Medicare, according to a 2012 biopharmaceutical consulting report. Another study indicates that, of the patients referred by community oncologists to outside practices, 15% are uninsured and 26% are Medicaid. In reality, these patients end up receiving cancer care from public and non-profit 340B hospitals.

Private oncologists also blame 340B for driving consolidation. But integration of community-based physician practices and institutional providers has a long history driven by fundamental changes in our nation’s health-care system. Managed care, integrated delivery systems, capitation, and, more recently, accountable care organizations have all created financial and clinical incentives for physicians and hospitals to work more closely together. The logical result of this 30-year trend is physician-hospital mergers. There is no credible evidence that 340B hospitals are buying up private oncology practices any faster than non-340B providers. Private oncologists are resentful over changes in the medical marketplace that threaten their independence and earning power. Scantling 340B will not solve their problems and will only result in barring needy patients as they seek affordable health care from safety-net providers.

REFERENCES

AUTHORS’ DISCLOSURES OF POTENTIAL CONFLICTS OF INTEREST
The authors indicated no potential conflicts of interest.