# THE 340B PROGRAM'S VITAL ROLE in Oncology Care


## ABSTRACT

The little-known 340B drug discount program plays a key role in helping hospitals that treat high numbers of underserved and rural oncology patients. From the inner city of Detroit to the small towns of Michigan and Kentucky, the program provides an invaluable mechanism for the delivery of quality cancer care as well as discounted medicines and free clinical services. For many hospitals, the savings afforded by 340B are essential to keeping oncology programs running – and their doors open. The drug industry is eager to scale back the program. Some private oncologists have attacked 340B and blame it for driving hospital purchases of their practices as well as higher prices. In reality, hospital/private-practice mergers of all kinds are driven by economic forces associated with the changing health-care landscape – particularly low insurance reimbursements. Private practitioners also have the luxury of sending their poorest patients to safety-net providers for treatment.



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**Every day across America, the 340B drug discount program helps safety-net hospitals and clinics care for cancer patients. In rural and urban settings alike, the program has an enormous impact as patients receive quality attention close to home and at a reasonable cost – in many cases for free.**

Savings achieved through 340B are also critical to enabling health-care facilities that serve high volumes of indigent care to provide other vital services such as diabetes, HIV, and transplant care. This is exactly what Congress intended when it created the program in 1992 and reaffirmed its purpose last year.[1]

There has been considerable controversy about the 340B drug discount program in the media lately, largely driven by the pharmaceutical industry which is eager to see it scaled back – or dismantled. Some private-practice oncologists have also criticized 340B, convinced the program is driving practitioners into the arms of hospitals or somehow degrading the quality of patient care. From our vantage point in the trenches, we see nothing to validate these charges.

Here is how the program works. Under federal law, pharmaceutical companies are required to provide drug discounts of between 20 and 50% to health-care providers that serve large numbers of poor people. Hospitals, in turn, pass on those savings to uninsured patients. They also provide the discounted medicines to insured patients and are reimbursed by insurance companies at negotiated rates. Hospitals use their savings to fund clinics and services to help vulnerable populations.

## THE PICTURE AT RURAL HOSPITALS

Aspirus Ontonagon Hospital is a 25-bed facility near the Lake Superior shore. The facility was struggling and nearly closed due to steady financial losses. It enrolled in 340B in 2010, the first year it was eligible, and in early 2012, contracted with the town's only retail pharmacy to sell drugs purchased at 340B discounts to outpatients at insured rates. The arrangement allowed Aspirus Ontonagon to accrue much-needed savings.

This model is exactly what Congress wanted when it created the 340B program. For Aspirus Ontonagon, 340B was not only critical to saving the facility but it also enabled the Critical Access Hospital to provide cancer care in the community. In late 2012, the hospital was able to open a clinic staffed by a full-time oncology certified nurse and a part-time oncologist. Its existence means patients no longer have to travel up to 150 miles away, or even out of state, for cancer treatment.

Aspirus Ontonagon is also using its 340B savings to ensure that cancer patients in the community are able to pay for their medications. Those who are insured get help understanding their coverage and those who are not find out if they qualify for free or reduced cost services. In one recent example, an uninsured patient saved more than $36,000 over the course of her cancer regimen, thanks to help from the hospital.

## Take away points:

The 340B drug discount program is vital for hospital-based oncology programs that treat underserved and rural populations:

- It funds discounted meds and services for poor patients
- It helps rural providers treat patients close to home
- It allows rural hospitals to stay open
- 340B is not to blame for hospital/private-practice oncology consolidation.

Taken together, the benefits created by 340B savings add up to improved outcomes through earlier diagnosis, earlier identification of therapy-related problems, and better opportunities for personal bonding among patients. No one should face cancer alone. The citizens of Ontonagon no longer have to.

## MAKING A DIFFERENCE IN KENTUCKY

A 57-year-old man with lung cancer lost his job as a minister when he became too sick to work. Ineligible for COBRA, he also lost his health insurance. The man's three cancer drugs cost more than his monthly Social Security benefit of $680. Things looked up when he became a patient at KentuckyOne Health System in Louisville. It runs 10 statewide oncology clinics that are the funded by 340B savings.

Kathy Anderson, manager of the specialty pharmacy at Jewish Hospital, part of KentuckyOne, made it her business to get the patient chemotherapy at an affordable price. Ultimately, two of the medications were free; a third cost $40 a month from the hospital's retail pharmacy. A big-box chain would have charged $286.

Kentucky leads the nation in lung cancer, and most patients are diagnosed in advanced stages of the disease. Many come to this safety-net hospital system because other providers – including private oncologists – have turned them away.

KentuckyOne has also applied some of its 340B savings to hiring six pharmacy coordinators dedicated to oncology. Three of these clinics are in Louisville and three are in rural areas. Four of the pharmacy coordinators work face to face, two of them via telephone. Their goal: tap available resources – such as the system's charity care program; Pharmacy Plus, its retail pharmacy; and manufacturers' assistance programs – so that patients who cannot afford treatment do not miss a dose.

The 340B program is not just about pills. It is about vital services that make medicines accessible to uninsured, underinsured, and other needy patients.

## THE URBAN VIEW

The Henry Ford Hospital in Detroit, MI, is an 802-bed facility that serves a high percentage of uninsured and underinsured patients. It provides more than $200 million in charity and uncompensated care annually. It is a front-line hospital for cancer care and treats 14,000 oncology patients each year.

The hospital takes pride in the fact that its doctors are blind to a patient's economic circumstances. That is thanks in large part to 340B savings that help fund oncology clinics and related services in Detroit and surrounding townships.

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, pediatric, perinatal, family planning, counseling, and pharmacy services.

Hennepin County Medical Center in Minneapolis treats more than 500,000 patients each year. It serves a large immigrant community of Hmong, Somali, and Hispanic individuals who make up 40% of the hospital's patient base – and most are either on Medicaid, Medicare, or uninsured. The facility is the largest safety-net provider in the region:

*"Without the program, I don't know how we would function,"* said oncologist Andres Wiernik. *"It is critically important for us to have access to discount 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 surgery to chemotherapy and radiation. These services are provided regardless of patients' ability to pay.

The Queens 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 2700 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 330 units of Neulasta at a cost of $726,000 – instead of the $2,529,073 retail price. The center spent $549,438 on Herceptin, a considerable break from the retail price of $2,092,489. 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 this 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. Underinsured and uninsured patients do not fit the business model and so they are referred to the nearest safety-net hospital. To meet 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 Medicaid, according to a 2012 biopharmaceutical consulting report.[2] Another study indicates that, of the patients referred by community oncologists to outside practices, 15% are uninsured and 26% are Medicaid.[2] 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.[3] 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. Scuttling 340B will not solve their problems and will only result in hurting needy patients as they seek affordable health care from safety-net providers.

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**AUTHORS' DISCLOSURES OF POTENTIAL CONFLICTS OF INTEREST**

**The authors indicated no potential conflicts of interest.**