Children’s Hospitals Depend on the 340B Drug Pricing Program to Provide Needed Services to Vulnerable Patients

- The 340B Drug Pricing Program (340B program) supports safety net providers, such as children’s hospitals, in their mission to serve low-income, uninsured and under-insured patients while reducing federal and state health care expenditures. There are 51 freestanding children’s hospitals currently enrolled in the program.

- By providing outpatient pharmaceuticals at discounted rates, the 340B program enables enrolled hospitals to: provide reduced-price drugs to patients, expand comprehensive health services — many of which, including child life specialists and tutors, hospitals provide without compensation — and offset losses from low Medicaid reimbursements, the major payer for most children’s hospitals.

- On average, more than half of all patients treated at children’s hospitals are covered by Medicaid, which pays approximately 30 percent less compared to Medicare for the same procedures and considerably less than typical private insurance. Children’s hospitals depend on support from programs like the 340B program to provide the necessary care its patients need and to expand vital services to the communities we serve.

- Children’s hospitals became eligible for the program in 2006 and officially participated starting in 2009. Children’s hospitals remain fully committed to improving program integrity, and support the administration’s ongoing audits and annual recertification process.

- The 340B program accounts for an extremely small proportion of total pharmaceutical sales at approximately 3 percent of the U.S. drug market and the discounts the manufacturers provide are a fraction of that amount. Pharmaceutical manufacturers often allege that the size of the 340B program is unsustainable, but they neglect to explain that program size is not the same as the discount they provide. The discount provided by manufacturers is set by statute as a percentage of a drug’s average manufacturer price, which is established by the manufacturers themselves.
Children’s Hospitals Support:

- **Measures that promote program integrity for both manufacturers and covered entities.** Children’s hospitals support efforts to enhance 340B program integrity. Any proposal should take into consideration current hospital reporting requirements, as children’s hospitals are already subject to examination by multiple government entities. In addition to the annual recertification and ongoing audits by the Health Resources and Services Administration (HRSA), children’s hospitals also annually submit cost reports to Medicaid agencies and report financial assistance and community benefits to the Internal Revenue Service.

- **Measures that allow for flexibility in the usage of program savings.** The current program gives children’s hospitals the flexibility to stretch scarce resources and respond to the varying needs of local communities. This flexibility should remain. Children’s hospitals treat children regardless of their ability to pay and provide support beyond clinical services. This involves services that are non-reimbursable including population health, public health, tutoring, transportation assistance and the utilization of child life specialists.

Children’s Hospitals Oppose:

- **Proposals that tie the mission of the 340B program exclusively to charity care.** Due to Medicaid and the Children’s Health Insurance Program (CHIP), the nation has the highest rate of insured children in history with most children’s hospital patients covered by Medicaid/CHIP and commercial insurance. Proposals for charity care — particularly charity care for only the uninsured as versus the underinsured — unfairly punish children’s hospitals for popular, bipartisan policies like CHIP. Charity care requirements do not fully capture the benefits children’s hospitals provide to the communities they serve, nor do they account for the significant shortfall between the cost of care and Medicaid payments.

- **Proposals that do not account for new payment models.** Not all outpatient drugs have separately identifiable reimbursement amounts. As payers move away from fee-for-service, reimbursement models like bundled payments provide one inclusive payment that encompasses all necessary services and drugs, and no longer accounts for each individual item. Requiring gross reimbursement reporting for drugs when payers do not pay for drugs separately would only lead to inaccurate estimates that do not reflect actual hospital operations or the direction of alternative payment models.

- **Proposals that indiscriminately impose Medicare requirements.** On average, more than half of children’s hospitals’ patients are covered by Medicaid, while less than 1 percent are covered by Medicare. Proposals should not subject 340B hospital entities to Medicare requirements without considering their applicability to children’s hospitals.