An obscure drug discount program stifles use of federal lifeline by rural hospitals

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Facing ongoing concerns about rural hospital closures, Capitol Hill lawmakers have introduced a spate of proposals to fix a federal program created to keep lifesaving services in small towns nationwide.

In Anamosa, Iowa—a town of fewer than 6,000 residents located more

than 900 miles from the nation's capital—rural hospital leader Eric Briesemeister is watching for Congress' next move. The 22-bed hospital Briesemeister runs averages about seven inpatients each night, and its most recent federal filings show it earned just $95,445 in annual net income from serving patients.

Yet Briesemeister isn't interested in converting the facility into a rural emergency hospital, which would mean getting millions of extra dollars each year from federal payments. In exchange for that financial support, hospitals that join the program keep their emergency departments open and give up inpatient beds.

"It wasn't for us," said Briesemeister, chief executive of UnityPoint Health-Jones Regional Medical Center. "I think that program is a little bit more designed for hospitals that might not be around without it."

Nationwide, only about two dozen of the more than 1,500 eligible hospitals have become rural emergency hospitals since the program launched last year. At the same time, rural hospitals continue to close—10 since the fix became available.

Federal lawmakers have introduced a handful of legislative solutions since March. In one bill, senators from Kansas and Minnesota list a myriad of tactics, including allowing older closed facilities to reopen.

Another proposal introduced in the House by two Michigan lawmakers is the Rural 340B Access Act. It would allow rural emergency hospitals to use the 340B federal drug discount program, which Congress created in 1992.

The 340B program, named after its federal statute, lets eligible hospitals and clinics buy drugs at a discount and then bill insurance companies, Medicare, or Medicaid at market rates. Hospitals get to keep the money

they make from the difference.

Congress approved 340B as an indirect aid package to help struggling hospitals stay afloat. Many larger hospitals say the cash is used for community benefits and charity care, while many small hospitals depend on the drug discounts to help cover staffing and operational shortfalls.

Currently, emergency hospitals are not eligible for 340B discounts. According to a release from U.S. Rep. Jack Bergman, R-Mich., the House proposal would "correct this oversight." Backers of the House bill include the American Hospital Association and the National Rural Health Association.

In Iowa, Briesemeister said the 340B federal drug discount program "can be used for tremendous good." The small-town hospital uses money it makes from 340B to subsidize emergency services and uninsured and underinsured patients who frequent the emergency department, he said.

Chuck Grassley, Iowa's longtime Republican senator, shepherded the Rural Emergency Hospital program into law. His spokesperson, Gillie Maddox, did not respond directly to questions about why the federal law creating rural emergency hospitals omitted the 340B program. Instead, Maddox said the designation was a "product of bipartisan negotiations."

A survey conducted by the health analytics and consulting firm Chartis, along with the National Rural Health Association, found that nearly 80% of rural hospitals had participated in 340B and nearly 40% said they reaped $750,000 or more annually from the program.

Sanford Health, a largely rural health system headquartered in Sioux Falls, South Dakota, considered converting a handful of smaller critical access hospitals into rural emergency hospitals.

Martha Leclerc, vice president of corporate contracting for Sanford, said the system analyzed how much revenue would be lost by closing inpatient beds, which is also a requirement of the emergency hospital program, and by being unable to file for drug discounts.

In the end, she said, switching did not "make a lot of sense."

While many rural hospitals are clamoring for the 340B provision to be added to the rural emergency hospital program, opponents have said 340B can be a cash cow for hospitals that don't serve enough vulnerable patients.

Nicole Longo is deputy vice president of public affairs for the Pharmaceutical Research and Manufacturers of America, the nation's largest, most influential pharmaceutical lobbying group. She wrote in a recent blog post that hospital systems and chain pharmacies are "exploiting the program" and said patients have not benefited from the growth in the program.

In an interview, Longo said PhRMA supports rural emergency hospitals being able to access 340B because they are treating "vulnerable patients in underserved communities" and are "true safety net providers."

PhRMA, she said, wants to encourage a thoughtful conversation about "which types of hospitals should be in the program." Last year, PhRMA formed an unlikely pact with community health centers to create the Alliance to Save America's 340B Program, or ASAP 340B.

Vacheria Keys, associate vice president of policy and regulatory affairs at the National Association of Community Health Centers, said, "There is a new day of openness, from all parties."

Use of the drug discount program skyrocketed after provisions in the

Patient Protection and Affordable Care Act, passed in 2010, increased the number of hospitals and clinics allowed to contract with an unlimited number of retail pharmacies, such as Walgreens and CVS, which are paid a fee to dispense the discounted drugs.

Adam J. Fein, president of the industry research organization Drug Channels Institute, reports that the 340B program is the second-largest federal drug program, trailing Medicare Part D. The flow of drugs purchased under the 340B program reached $53.7 billion in 2022, about $9.8 billion more than in 2021.

In response to the exploding use of contract pharmacies, pharmaceutical manufacturers have restricted the drugs they offer at a discount through the pharmacies. That throttling is affecting rural hospitals like Labette Health, a Kansas hospital whose president asked President Joe Biden for help in dealing with the pharmaceutical companies.

Rena Conti, an associate professor of markets, public policy, and law at Boston University's Questrom School of Business, has studied the drug discounts for years and said she has "significant worries about expanding" the 340B program.

"There is a lot of money being generated in this program that we really can't understand exactly how much that really is and exactly who it is benefiting," Conti said.

At the same time, said Conti, a health care economist, giving rural hospitals access to the federal drug discounts "makes sense because they are hospitals that are serving particularly vulnerable patient populations."

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