The 340B program is a US federal program that grants participating hospitals and clinics access to prescription drugs at substantial discounts. The 340B program was designed to enable participating institutions to pass the savings onto patients, or to use the savings from discounted drugs to provide safety-net care.1 A variety of institutions participate in the 340B program, from small federally funded outpatient clinics to large not-for-profit and public hospitals. In 2022, participants spent $53.7 billion on outpatient drugs under 340B, amounting to 9.5% of national spending on outpatient drugs.2,3

As the 340B program has grown, it has come under intense scrutiny from lawmakers and drug manufacturers, which are legally required to honor 340B discounts when selling drugs to Medicaid or Medicare enrollees. These parties are concerned that the 340B program has grown beyond its original intended size and—because there are no legal requirements on how participants use revenue—that the program is not being used as the US Congress originally intended.4 Numerous investigative reports and a growing body of academic literature document the tenuous relationship between 340B participation and increased access to safety-net services.5-7

In this issue of JAMA Health Forum, Owsley et al8 evaluate changes in typically unprofitable hospital services lines after hospitals initiated participation in 340B. These include important services such as in- and outpatient psychiatric treatment, burn care, obstetric units, and substance use treatment. They use a difference-in-differences design (in combination with adjusting for covariates that may indicate differential demand for unprofitable services) to isolate the variation in service provision that can be attributed to new 340B participation. By tracking service provision before and after hospital 340B participation and comparing changes with those made by nonparticipating hospitals over the same time period, this research design systematically addresses differences across hospitals, and secular trends that could drive changes in service lines. This allows Owsley et al8 to attribute the changes in unprofitable and profitable service line provision to 340B enrollment.

A study by Nikpay et al9 used the same design to assess how 340B participation was affecting low-profit service line provision and found little change in service line offerings after participation. The study by Owsley et al8 furthers this line of inquiry by highlighting an important difference between hospitals participating in this program: although most are nonprofit hospitals, 28% are publicly run hospitals. This latter category may be more safety net oriented than nonprofit hospitals because they face different constraints and may serve a higher proportion of uninsured and low-income patients. Owsley et al8 also considers a longer period of time, incorporating more new participants to the program, and ultimately, increasing the statistical power of the study.

Owsley et al8 find, similar to previous studies, that participation in 340B was largely not associated with increases in the number of unprofitable service offerings. However, when they estimated their results separately for nonprofit and public hospitals, an interesting finding emerges. After initiating participation, public hospitals increased the number of unprofitable services offered by more than 10%. Looking across unprofitable services, this change seems to be associated with an increased likelihood of offering inpatient psychiatric services and substance use care. Yet on average, overall, there was no change in unprofitable services after participating among nonprofit hospitals. In fact, there was actually a small increase in the likelihood of offering oncology services—a drug intensive, and thus, highly profitable service that often uses high-cost specialty drugs that allow 340B participants to maximize their savings.

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The study by Owsley et al.\(^8\) study adds important new findings to the current conversation on 340B. As policymakers consider options to reform (or reinforce) the 340B program, studies that differentiate 340B participants are needed. The current body of research largely shows that 340B participating entities at best use 340B savings to marginally increase safety-net care. Yet these studies largely focus on hospital participants, which are dominated by nonprofit hospitals. Owsley et al.\(^8\) offer a new and deeper level of understanding: there are different types of 340B participants that act in distinct ways. Not-for-profit hospitals do not make observable additions to access for safety net care for patients, whereas public hospitals do. Mounting discussions of the 340B program demand a better understanding of who benefits from the program and how. These findings may allow policymakers to maintain program eligibility for the hospitals that use 340B revenue to provide safety net care and scale back participation for those that do not.

As several states (eg, Maine, Minnesota) implement the nation’s first 340B reporting requirements, policymakers will be producing novel insights on the size of 340B savings or profits from billing insurers negotiated rates that do not reflect 340B discounts.\(^10\) The study by Owsley et al.\(^8\) suggests that policymakers in these states should consider analyses that stratify hospitals by ownership status.

Owsley et al.\(^8\) make an important contribution to the discussion on 340B by distinguishing and describing differences in safety net care provision among hospitals that participate in 340B. They provide robust evidence indicating that public hospitals increase the provision of unprofitable services after enrollment in 340B, whereas not-for-profit hospitals do not. This evidence will help policymakers make decisions about how to regulate the 340B program as it comes under scrutiny from lawmakers and drug manufacturers alike, enabling policymakers to protect eligibility for the subset of participating institutions that use the program as the Congress originally intended.

**ARTICLE INFORMATION**

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