# ACTION BRIEF

*Employer Strategies that Drive Health, Equity and Value*

National Alliance of Healthcare Purchaser Coalitions
Driving Health, Equity and Value

NCBCH
NC BUSINESS COALITION ON HEALTH

# EMPLOYERS BEWARE

## 340B PROGRAM SHARED SAVINGS MODELS REQUIRE SCRUTINY

The 340B Drug Pricing Program was established over three decades ago as a targeted, narrow program to help safety-net providers serve America's most vulnerable patients. Today, it has become a multi-billion-dollar revenue stream for large health systems, for-profit pharmacies, and middle men who purchase medicines at steep discounts, turn around and bill plan sponsors at full commercial rates with markups for those same medications, and pocket the spread — inflating costs while delivering little benefit to the program's intended beneficiaries.

The program rewards hospitals that capture as many eligible 340B "patients" and prescriptions as possible, especially those with commercial insurance as a primary payer. Health systems are increasingly partnering with third-party vendors that promote "shared savings models" to employers. In these models, plan sponsors designate their employees as "patients" of 340B hospitals, thereby increasing 340B patient volume and generating greater revenue for the hospitals, a portion of which is then shared with the employers.

With drug spending identified as a leading concern for plan sponsors and continuing to climb each year, vendors often market themselves as "anti-PBMs" in an attempt to appeal to employers frustrated with the opaque pricing, high costs, and limited transparency they get from traditional pharmacy benefit managers (PBMs). However, the "shared savings" these vendors promise come from bringing similar opacity, markups, and distortions to a drug discount program designed for low income patients and underserved communities – making employers complicit in the growth of the commercial market distortions caused by the 340B program.

## ACTION STEPS FOR EMPLOYERS

1. **Understand the 340B program and its impact on employers.**
2. **Be aware of "shared savings" vendor motives.**
3. **Evaluate the implications as a plan sponsor.**
4. **Consider alternatives to control health costs.**

## ACTION STEP 1

### Understand the 340B Program and its Impact on Employers

The 340B program allows eligible hospitals and clinics to purchase prescription drugs at steep discounts — often 30-50% below list price, and in some cases as low as one penny. When Congress established the program in 1992, it applied to fewer than 100 core safety-net providers who would use revenues to expand access and support care for vulnerable patients.

However, the program's inherent profit opportunity and relatively low threshold for qualification have attracted some of the nation's largest and most profitable health systems, such as Cedars Sinai, the Cleveland Clinic, and NY Presbyterian. Hospitals dispense 340B drugs to virtually any "patient" of theirs, bill payers at the prevailing rate — often several times the acquisition cost — and pocket the difference.

The 340B program has expanded dramatically over the years to become the nation's second-largest federal drug program. Participating hospitals face no federal requirements to demonstrate how revenues from the program are being used, nor to limit participation to particularly vulnerable patients, creating a strong incentive for health systems to expand their pool of 340B-eligible "patients," especially commercially insured ones, as widely as possible.

Hospital systems pursue this goal in several ways, including purchasing independent outpatient physician offices in wealthy areas and converting them to 340B "child sites." Increasingly, they also enlist plan sponsors as unwitting partners and their employees as "patients" – with the help of a new cottage industry of vendors.

## ACTION STEP 2

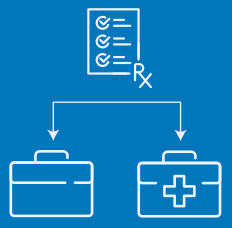
### Be Aware of "Shared Savings" Vendor Motives

Many of these vendors are brazen about the purpose of their company, openly marketing the 340B program as a profit engine for hospitals and a loophole for payers to exploit, rather than the safety-net lifeline it was intended to be. One vendor promises to "use pharmacy as a growth center," citing a case study where filling just four more prescriptions per day generated $10 million in revenue for the health system. Another touts an "average of $8,000 in free cash flow annually per patient through your pharmacy." However, others may frame their services more discreetly, with one publicly marketing its "virtual pharmacy platform" and "prescription delivery service," while offering more details behind closed doors.

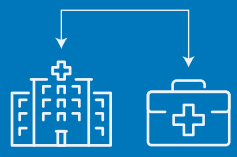
### The 340B Program "Patient Definition"

The federal statute doesn't clearly spell out who is considered a "patient" of a covered entity, and therefore, what prescriptions qualify for 340B pricing. While 1996 guidance from the government asserts that a patient must have an established, consistent relationship with the provider for their prescription to qualify for 340B pricing, a recent court decision (*Genesis Health Care Inc. v. Becerra*) ruled that the government could not require that a patient's prescription originate from a service provided by Genesis. While the *Genesis* ruling is limited to Genesis, today, covered entities and third-party vendors have used the Genesis ruling to broaden who they consider consider their 340B-eligible "patient."

### Background



Employer and vendor develop list of ~500 high-margin drugs



Vendor establishes partnerships with 340B covered entity hospitals

### Illustrative Example

Patient goes to fill **existing prescription** at retail pharmacy

**Claim is flagged** by vendor software as one of 500 drugs on list

Prescription is **put on hold** while vendor determines lowest net cost for drug — typically 340B

Patient recieves call from vendor's concierge service. Concierge explains that **patients have 2 options**:

Patient maintains existing provider pharmacy relationships — but is responsible for a **higher level of cost-sharing** to disincentivize

1. Patient schedules and completes **telehealth visit** with vendor's hospital partner.
2. Employee is now a **"patient" of the 340B hospital** for the purposes of that prescription, which is now 340B-eligible.
3. Concierge team **transfers patient's care and prescription** to the hospital; drug is dispensed — shipped to patient's home or hospital's pharmacy — typically with $0 copay.

## ACTION STEP 3

### Evaluate the Implications as a Plan Sponsor

Plan sponsors considering participation in such arrangements must examine the trade-offs implicit in their business models.

In addition to these risks, many contracts with shared savings vendors require a blind commitment to hospital networks, providing employers with limited visibility into which providers are included and who is ultimately responsible for their employees' care. That lack of transparency goes hand in hand with how these arrangements are structured; they are designed less around patient relationships and more around building business relationships to expand 340B eligibility. As a result, care often becomes transactional and impersonal. For example, prescriptions are often funneled through telehealth "concierge teams" who lack any established relationship with the patient, jeopardizing continuity, quality, and accountability for employees' care.

By participating in this model, plan sponsors may be inadvertently aiding and abetting the profiteering of large hospital systems while **contributing to the expansion of a flawed program** that raises healthcare costs for working families due to:

- Exacerbation of hospital system consolidation
- Incentives to prescribe more, and higher-cost, drugs
- Erosion of existing drug price transparency efforts
- Shifts in the site of care, often to higher-cost settings

### 1. Unclear Financial Impact Given Trade-Offs

Employers should scrutinize — and if possible, verify — the potential savings, especially any "guarantees" that shared savings vendors offer. While these vendors advertise significant savings across the board, every plan sponsor's membership and costs look different; the potential for any such savings to both the plan and the member must be evaluated on a case-by-case basis and consider several factors, including:

- Further, reduced volume being processed by the PBM may jeopardize rebate guarantees, potentially increasing net costs for other drugs purchased through the PBM.
- Whether the 340B prescriptions in question are paid via the pharmacy or the medical benefit.
- The costs associated with the telehealth visit (and any other coordination) required for an employee to be 340B-eligible.
- Member benefit design, including cost-sharing and utilization management requirements.

In addition, there are broader trade-offs to consider related to these agreements due to the market distortions caused by the 340B program. Cost increases stemmed from site of care shifts to 340B hospitals, lost rebates, other indirect costs, and potentially less favorable terms for employers in PBM contracting.

**For Example**

A recent IQVIA study estimated that revenue-sharing agreements **increase self-insured employers' healthcare costs** by an average of 14%, **even when 100% of the incremental 340B revenue was shared with the employer**.

### 2. Profiteering

While vendors that contract with employers to expand the use of 340B drug pricing may promise cost savings in the short term, these arrangements risk exacerbating the existing market distortions caused by the 340B program.

Research shows that the 340B program already inflates costs for employers and working families. The growth of the 340B program has been linked to over $22 billion a year in premium increases — an extra $137 per employee (single) or $415 (family). It also accelerates hospital consolidation; studies show that 340B hospitals are more likely than non-340B hospitals to acquire independent physician practices, reclassifying them as offsite outpatient sites to capture discounts and maximize reimbursement at the expense of lower-cost community providers. Furthermore, large 340B hospitals charge significantly higher prices — nearly 7% more for common procedures and 20% more for outpatient care — resulting in $36 billion in excess spending annually for working families.

So-called "shared savings" models may amplify these trends, funneling more "patients" and revenue into a program that rewards high-cost care and hospital profits at the expense of patients and employers — reducing provider choice, eroding transparency, and driving overprescribing.

### 3. Barriers and Possible Disruptions to Patient Care

Shared savings arrangements require steering each high-profit prescription through the vendor's and hospital's channels to make it 340B-eligible, which can complicate a patient's established relationship with their providers.

In some cases, the processing of a prescription is put on hold until the vendor can call the patient to enroll them in the 340B system, resulting in delays that risk creating confusion and leading to missed doses or non-adherence.

And while these vendors typically market to plan sponsors as "zero-copay" models, they sometimes feature what one vendor calls a "carrot-flavored stick" to patients: a choice between a relatively large copay to receive the medication immediately at their existing pharmacy, or enrollment in the vendor's program for access to the drugs at no cost. This approach often entails a telehealth visit to reclassify the employee as a "patient" of a 340B hospital. Although these cursory telehealth visits are presented as a chance for efficiency, integration, and care coordination, they can fragment patient oversight, shifting responsibility to providers who lack prior knowledge of the patients' medical history - undermining continuity and accountability.

Although vendors pitch "savings," any disruptions to care can have consequences for employees and may ultimately translate into lost productivity, poorer workforce health, and higher downstream spending for employers. If prescriptions are delayed; rerouted to providers unfamiliar with their medical history; or require additional, burdensome telehealth visits, employees may be forced to spend more time managing their conditions, including during the workday. These barriers could result in increased absenteeism, reduced presenteeism, additional sick days, and diminished ability to retain talent over time.

### 4. Potential Legal, Regulatory, and Compliance Risks

Plan sponsors must also consider that 340B shared savings arrangements represent risks given **statutory ambiguity, regulatory uncertainty, and active litigation around several elements of the 340B program**. In addition, discussions around legislative reform are active at both the state and federal levels, which could also impact the legality of these models.

Before entering into any arrangements that rely on using 340B pricing to generate revenue, employers should be aware of several potential risk areas, including:

- The **statutory prohibition** in the original 340B program guidance against the "diversion" of 340B drugs to ineligible patients – especially given the lack of clarity and litigation related to the definition of a covered entity patient (*Genesis v. Becerra*).
- **Regular audits** are conducted by the federal government around patient definition and diversion.
- **Heightened scrutiny from government watchdogs** (Government Accountability Office, Department of Health and Human Services Office of the Inspector General, Congressional inquiries, and state 340B reporting requirements).
- Potential risks or liability related to the federal **Anti-Kickback Statute and False Claims Act liability and similar state laws**.

### 5. Fiduciary Implications

When entering into these arrangements, employers are effectively outsourcing, or assigning, fiduciary responsibility to third parties whose systems and resources may not meet the standards of the Employee Retirement Income Security Act (ERISA), namely, to act solely in the best interest of employee benefit plan participants. This could create additional exposure for employers if vendors cannot demonstrate appropriate stewardship of employees' healthcare.

## ACTION STEP 4

### Consider Alternatives to Control Health Costs

Rather than facing the complexity and risk that come with 340B shared savings vendors, employers should consider alternative strategies to reduce prescription drug and overall healthcare costs by strengthening fiduciary oversight, increasing transparency, and improving care management.

Effective strategies include:

- Ensure fiduciary alignment with PBMs to confirm that incentives are structured in the best interests of plan members and the employer, and eliminate indirect revenue streams for PBMs that obscure true costs.
- Prioritize contract transparency and accountability with PBMs, including detailed reporting on pricing, rebates, and spread, and owning and analyzing claims data to gain a full, independent understanding of cost drivers and usage trends.
- Avoid PBM spread pricing and instead adopt pass-through pricing models, requiring that PBMs pass through 100% of rebates and discounts, and require PBMs to establish an independent pharmacy & therapeutics committee to ensure formulary decisions are evidence-based.
- Mitigate and prevent the magnitude of high-cost claims by identifying drivers of spending and ensuring they are clinically warranted.
- Invest in early diagnosis and intervention programs to prevent disease progression and reduce downstream costs.

## CONCLUSION

The 340B program is overdue for reform. Arrangements that enlist plan sponsors as allies of hospitals and vendors in the program's expansion only further highlight its shortcomings, which inflate costs for a range of stakeholders and limit the program's ability to fulfill its intended purpose of serving vulnerable patients. Before entering into any agreements with third-party vendors, plan sponsors, as fiduciaries, must fully understand not only the mechanics of the 340B program, but also the potential downstream consequences of participating in models that exploit its loopholes. What may appear as short-term savings can drive higher costs across the system, undermine continuity of care for employees, and expose employers to reputational, regulatory, and even legal risks.

By prioritizing profits over patient well-being, these arrangements deepen the very market distortions that policymakers are struggling to correct. Employers should think twice before enabling a model that ultimately shifts costs, erodes trust, and threatens the long-term sustainability of care delivery.

## RESOURCES

### National Alliance Resources to Help Employers Manage Healthcare Costs

- New Directions to Better Manage High-Cost Claims
- Rethinking How Employers Address High-Cost Claims
- PBM Misalignment Initiative: Final Report

### National Alliance Resources to Help Employers Understand the Impact of 340B

- 340B Overview
- 340B By the Numbers
- The 340B Premium: New Data Shows Program Inflates Prices for Working Families

NCBCH
NC BUSINESS COALITION ON HEALTH
10130 Mallard Creek Rd, Suite 300 · Charlotte, NC 28262
704-944-3135 · ncbch.net
www.linkedin.com/company/north-carolina-business-coalition-on-health

National Alliance
of Healthcare Purchaser Coalitions
Driving Health, Equity and Value
1015 18th Street, NW, Suite 705 · Washington, DC 20036
(202) 775-9300 (phone) · nationalalliancehealth.org
https://www.linkedin.com/company/national-alliance/



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