Milliman, 12/2019

1. on average, insurers reimburse hospitals for brand drugs used in outpatient settings or retail pharmacy at 247% of the hospitals' cost to stock the drug
2. for 340B hospitals, insurers reimburse brand drugs used in outpatient and retail pharmacy at  294% of the hospitals' cost to stock the drug
3. for non-340B hospitals, insurers reimburse 170% of the hospitals' cost to stock the brand drug used in hospital retail pharmacy or outpatient clinics

Drug Channels 6/2020

1. 340B program was worth $30B in 2019 -- about 8% of all US drug sales
2. Hospitals comprise most of the 340B sales (relative to FQHCs etc)
3. 340B sales are almost as great as drug expenditures in the Medicaid program

Drug Channels 8/2019

1. Hospital ownership of specialty pharmacy grew from **9% in 2016 to 20% in 2018** (even more today in 2021)
2. This maximizes 340B profits since hospitals do not have to share savings with 340B pharmacies.
3. Drugs like Humira ([list price $9000](https://www.goodrx.com/humira)/mo) is available in 340B for $.01 (a penny) but those savings are not shared with patients or payers.  This is the problem.

So, I think using this information can help get the hospitals to discuss their real issues ---

1. Reduced profit margin on drugs that would have a UPL applied (but in the case of Humira for example -- there still will be good profit margins, perhaps not amazing profit margins).
2. Somehow manufacturers will not stock the hospital specialty pharmacy because they will be mad.  My read of the 340B law is that manufacturers have NO discretion to deny stocking any 340B entity. This idea of 'punishment' is not relevant to a 340B hospital.  For a non-340B hospital, a UPL could really help them on the inpatient side and for their employee health benefit plan.  [I suspect the profit on 340B outpatient drugs will exceed the savings a UPL will provide on the inpatient side or in the employee benefit plan.