



Reforming the 340B Drug Pricing Program

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The 340B drug pricing program has become a drug arbitrage program that acts as a revenue stream for large hospital systems. It has many unintended consequences, such as hospital consolidation, higher drug spending, and increased costs for both private and public insurance. If hospitals truly need a subsidy for treating low-income patients, then Congress should reform the 340B program to become a direct subsidy instead of a complex drug arbitrage program.

HOW 340B WORKS

In 1992, Congress created the 340B drug pricing program. This requires drug manufacturers that want to participate in Medicaid and Medicare Part B to sell covered outpatient drugs to 340B covered entities (CEs) at a steep discount tied to the Medicaid rebate formula.¹

Facilities that can qualify as CEs generally fall into one of two categories: federal grantees and hospitals. This brief focuses on hospitals because of their outsized contribution to purchases under the program. To qualify, a hospital generally must have a Medicare Disproportionate Share Hospital (DSH) adjustment percentage greater than

11.75 percent. That figure is calculated based on inpatient days for Medicare patients who receive Supplemental Security Income and Medicaid patients who are not entitled to Medicare Part A. Once a hospital qualifies, the benefit can extend to eligible outpatient departments within the hospital and to off-site clinics that appear on its Medicare cost report and are separately registered with the Health Resources and Services Administration (HRSA).²

A hospital generates net 340B revenue when the reimbursement for medications exceeds the discounted acquisition price. These medications can be distributed through in-house pharmacies or contract pharmacies or be administered by physicians on an outpatient basis. For Medicare, most separately payable Part B drugs administered through hospital outpatient departments are paid at 106 percent of average sales price (ASP). Medicaid fee-for-service generally pays near acquisition cost, while private contracts—including Medicare Advantage and Medicaid managed care—vary widely. The 340B statute does not require that hospitals pass the discount on to the patient (or even give them a discount on their copayment). Nor does it require that the revenue be spent on low-income services. There is also no reporting requirement for how the revenue is used.³

UNINTENDED CONSEQUENCES OF 340B

The HRSA reports that covered entities purchased \$100.01 billion in discounted 340B drugs in 2025, of which hospitals accounted for \$87.12 billion. In 2021, the Congressional Budget Office (CBO) counted 2,530 participating hospitals and found that hospital-based facilities accounted for 87 percent of purchases reported through the Prime Vendor Program.⁴

This financing structure creates predictable incentives. When payment is not tied to acquisition cost, the potential dollar margin rises with drug price and volume. The CBO concludes that 340B may encourage the use of more or costlier drugs. Additionally, because independent physicians are not eligible for 340B, the program promotes acquisition of those practices; there is a financial arbitrage opportunity for hospitals when they acquire independent physician offices and extend the 340B discount there. This has increased the tendency toward vertical integration of hospitals. In a 2018 quasi-experimental study of hospitals near the DSH threshold, 340B eligibility was associated with 2.3 additional hematologist-oncologists practicing in hospital-owned facilities. The Government Accountability Office (GAO) has also found substantially higher Part B drug spending per beneficiary at 340B DSH hospitals than at non-340B hospitals.⁵

Recent site-neutral evidence points in the same direction. In a 20 percent Medicare sample covering 2,550 hospitals from 2016 through 2022, the off-campus share of outpatient claims rose from 18.2 to 24.1 percent at 340B hospitals, compared with 16.6 to 18.3 percent at potentially eligible non-340B hospitals. At newly established or relocated off-campus departments subject to site-neutral payment, services accounted for 5.8 percent of all outpatient claims at 340B hospitals versus 2.2 percent at potentially eligible non-340B hospitals. Off-campus departments can reflect physician practices that hospitals

have acquired or integrated, so growth in their claims is a useful indicator of vertical integration.⁶

The eligibility metric is also poorly matched to the subsidy. A DSH's qualifying percentage is derived from inpatient-day shares, while 340B applies to outpatient drugs.⁷ It does not directly measure low-income outpatient access, which is arguably more under the control of hospital systems than how many patients come through the emergency room and end up utilizing inpatient beds. Hospitals certainly show strategic behavior in meeting the DSH threshold to qualify for 340B. Researchers found 41 percent more hospitals just above than just below the 11.75 percent threshold in 2014–2016, a pattern consistent with some hospitals adjusting their reported DSH measure. Once they meet that measure, there is little incentive to expand services beyond the threshold.⁸ Medicaid reimbursement for medications is much lower than reimbursement by private insurance, so the program perversely disincentivizes further care of low-income patients. There is, in fact, substantial evidence that 340B hospital-affiliated clinics expand into wealthier, better-insured areas after 340B qualification and that newly registered child sites have shifted toward less socially deprived areas over time.⁹ Contract pharmacy growth has likewise concentrated in more affluent neighborhoods.¹⁰

Minnesota has a unique transparency requirement that provides a useful glimpse into otherwise opaque 340B finances (although the Minnesota Department of Health cautions that the report may undercount because of incomplete reporting). The latest report estimated roughly \$1.34 billion in statewide net 340B revenue for calendar year 2024. Twenty-three general acute-care DSHs accounted for more than 80 percent of the total (\$1.08 billion). Also, a substantial amount goes to administrative overhead, as covered entities reported nearly \$10 in payments to external organizations for every \$100 of gross 340B revenue. It also estimated approximately \$261 million in net

340B revenue from low-income Minnesota Health Care Programs, which includes revenue from Medicaid and MinnesotaCare.¹¹

These figures illustrate that 340B is not a program whose costs come solely from the pharmaceutical industry. Aside from higher drug costs as manufacturers price the discount into list prices, there are the costs that come with vertical integration and hospital consolidation. Then there are those direct costs to commercial plans, Medicare, and Medicaid as shown in the Minnesota report. IQVIA estimated that lost manufacturer rebates increased drug costs for self-insured employers and workers by 4.2 percent, or \$5.2 billion, in 2021.¹² Another analysis estimated that prices for commercially insured patients were nearly 20 percent higher at large 340B hospitals, producing \$36 billion in additional annual spending.¹³ A Berkeley Research Group model estimated that 340B made \$6.5 billion in Medicaid managed-care rebates ineligible in 2024. This cost \$2.3 billion that would otherwise have accrued to state budgets.¹⁴ There is no official estimate of 340B's total incremental cost to Medicare, but the CBO has estimated that paying ASP rather than ASP plus 6 percent for 340B-acquired Part B drugs would reduce federal outlays by \$15.4 billion over 2025–2034; paying ASP minus 22.5 percent would reduce outlays by \$73.5 billion.¹⁵

INCREMENTAL REFORMS

CMS has proposed a 2027 outpatient payment policy that would pay most 340B-acquired drugs at ASP minus 33.4 percent. The full proposed rule estimates a \$4.85 billion reduction in Outpatient Prospective Payment System (OPPS) drug payments, offset dollar for dollar by an 8.44 percent increase in non-drug OPPS rates, representing redistribution within OPPS rather than net federal savings. However, CMS estimates that beneficiary coinsurance would fall by \$1.15 billion, because coinsurance is calculated based on Medicare's

payment amount rather than the hospital's acquisition cost.¹⁶ This proposal would also improve identification of 340B and non-340B claims. Better claim data are essential, as the Minnesota case shows.

HRSA has also reopened a revised 340B Rebate Model Pilot Program. Its August 2026 notice invites qualifying manufacturers to apply to participate with a January 1, 2027, start for selected Medicare-negotiated drugs. Instead of receiving an up-front discount, covered entities would purchase drugs at their wholesale acquisition cost, submit unit-level data, and receive a rebate within ten calendar days of a complete submission. The hope is that this pilot will reduce the risk of duplicate discounts and provide better accountability for purchases.¹⁷

Congress is also considering competing incremental approaches. As of August 14, 2026, a few bills had been introduced and referred to committee. H.R. 5256, the 340B ACCESS Act, is sponsored by Rep. Buddy Carter (R-GA) with Rep. Diana Harshbarger (R-TN) as a cosponsor. Introduced on September 10, 2025, it is pending before the House Energy and Commerce and Ways and Means Committees. It would define patient eligibility, tighten hospital child site and contract pharmacy rules, strengthen duplicate discount controls, require patient affordability and financial reporting, and add audits and penalties. On balance, it would constrain and more tightly target 340B.¹⁸

H.R. 4581 and S. 2372, the 340B PATIENTS Act, take the opposite approach. The House bill is sponsored by Rep. Doris Matsui (D-CA) and has sixteen Democratic cosponsors; the Senate bill is sponsored by Sen. Peter Welch (D-VT) with Sens. Jeff Merkley (D-OR) and Maria Cantwell (D-WA) as cosponsors. Both were introduced on July 22, 2025; the House measure is pending before Energy and Commerce, and the Senate measure is pending before the Health, Education, Labor, and Pensions Committee. They would codify

contract pharmacy access and restrict manufacturer conditions. These bills would expand and protect current 340B practice.¹⁹

FROM DRUG ARBITRAGE TO A CAPPED SAFETY NET SUBSIDY

The 340B program needs more than incremental reform. The simplest measure would be to eliminate the program altogether. There are multiple subsidies available to low-income hospitals. With the expansion of Medicaid and the Medicaid Drug Rebate Program (MDRP), few low-income beneficiaries lack access to medications. There is little need for this program anymore.

Defenders of 340B argue that hospitals need the drug arbitrage spread to subsidize the losses from treating low-income patients. However, if hospitals need yet another subsidy, they should not be using a complex drug arbitrage program with significant money going to third parties and administration. Hospitals and independent clinics should instead have access to a subsidy that follows low-income patients to the facilities and clinics they choose. Congress should replace hospital-based 340B discounts with a capped, manufacturer-financed safety net fund while ensuring that traditional grantees, such as federally qualified health centers and Ryan White clinics, remain in the traditional 340B program.²⁰

The first step is to establish the fund. The Department of Health and Human Services (HHS) and the GAO should calculate the actual value of hospital 340B revenue in a base year to use as the starting point and index it to inflation thereafter. The pharmaceutical industry can continue to fund the benefit by having most manufacturers pay a tiered assessment based on their share of relevant drug sales, while the smallest firms are excluded to incentivize innovation. Congress has used this basic approach before: The Affordable Care Act created a fixed annual branded-drug fee,

allocated across manufacturers according to their weighted sales to federal health programs. A 340B replacement fee should be more transparent and flexible, but the precedent exists.²¹

Congress will have to decide whether the assessment is based on gross sales, net revenue, or a combination of the two. Gross sales are easier to measure but do not account for discounts. Net revenue better reflects what a company actually collects but is harder to standardize. A tiered fee offers a reasonable compromise and can protect smaller biotechnology firms that take on high-risk development work.

SUBSIDIZE TRUE SAFETY NET CARE

CMS should distribute the fund as a capped, transparent, and publicly reported grant. The point is to subsidize institutions that actually provide outpatient access to low-income patients, offsetting the low reimbursement that comes with seeing those patients. This restores the link to patients: Funding would follow care delivered to low-income patients, not the arbitrage on an individual drug claim.

The fund should be distributed using an outpatient metric instead of an inpatient one. Low-income patients, especially those on Medicaid, face significant barriers in obtaining outpatient care.²² This leads to more emergency room utilization and higher overall costs to Medicaid, while research has shown that increasing clinic reimbursement rates for Medicaid patients improves access to appointments.²³

Thus, one option is to tie the fund to evaluation and management (E/M) billing, the core set of codes used for clinic care. Clinics that bill more outpatient E/M relative value units (RVUs) for Medicaid, dual-eligible, and uninsured patients would receive more funding. E/M RVUs are not a perfect measure of access, so CMS would need safeguards against coding games and a method

for counting care that does not generate ordinary claims. But the basic idea is simple: Reward clinics for creating outpatient appointment capacity and managing chronic disease for low-income patients.²⁴

Facilities would have to meet a minimum threshold to qualify. The grant could provide a base payment, followed by an additional allocation based on each facility's share of low-income outpatient volume. Large hospital systems should be required to direct funds to the clinics within the system that see the most low-income patients.

Independent and for-profit clinics should be eligible if they meet the same threshold. That may be controversial, but excluding independent clinics re-creates the current pro-consolidation incentives. If a direct grant is politically difficult, Congress could use a tax credit to for-profit clinics instead. Either way, eligibility should turn on patients served, not who owns the building.

This approach is still administratively complex, but it is simpler and more transparent than the current web of third-party administrators, pharmacy benefit managers, contract pharmacies, and validation companies. Congress could even reserve a portion of the fund for a cash-equivalent benefit (such as Health Savings Account seed funding), direct drug assistance, or premium support for low-income patients to purchase private insurance. If the goal is to help patients, policymakers should fund them directly.

High-priced miracle drugs would remain a problem. But 340B has never been the answer to that problem because the hospital discount does not necessarily reach the payer or the patient. Under the grant model, former hospital 340B Medicaid units could return to the MDRP rebate pool, subject to the rule against duplicate discounts.²⁵ States also have flexibility in Medicaid drug contracting. Louisiana offers one example: In 2019, the state entered a five-year "subscription"

or "Netflix-style" agreement with Asegua Therapeutics covering Medicaid beneficiaries and incarcerated people. Louisiana paid up to an annual expenditure cap for the authorized generic of Epclusa (sofosbuvir/velpatasvir); after the cap, supplemental rebates drove the state's net cost for additional treatment courses to zero.²⁶ Along with restored MDRP rebates, arrangements like this give states a more direct way to offset the cost of high-priced medicines.

AUTHORITY, TRANSITION, AND SCORING

This reform requires legislation. Congress would have to authorize the manufacturer fee and safety net grant, phase out the hospital discount, and set the basic eligibility and transparency rules. The Treasury and the IRS can collect the assessment; CMS and HRSA can distribute the money and publish the awards.²⁷

The transition should be gradual. Hospital discounts can phase down as grant payments ramp up, with temporary protection for rural and core safety net hospitals. That would give hospitals time to adjust without preserving the drug-spread model indefinitely.

No CBO or CMS actuary score exists for the capped-grant proposal. The CBO has separately estimated that lowering Medicare payment for 340B-acquired Part B drugs could reduce federal spending by \$15.4 billion to \$73.5 billion over 2025–2034, depending on the payment rate. Those are estimates for Medicare payment reform while hospitals still receive 340B discounts. They are not savings estimates for this grant and should not be added to it without a new score.²⁸

CONCLUSION

The current financial arbitrage model of 340B is fundamentally flawed. It acts as an inefficient, poorly targeted revenue stream for large hospital systems. Converting the program to a capped

safety net grant would simplify it, reduce its adverse effects on affordability and competition, and ensure that funds follow low-income patients.

Hospitals are indispensable, and true safety net functions deserve support. But if Congress wants a safety net subsidy, it should create one openly.

NOTES

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