May 2025 Special Report:

CBO Data Review Reveals Dramatic Increase In 340B Drug Pricing Program

HEALTH EQUITY COLLABORATIVE

Special Report

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The Health Equity Collaborative

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HEALTH EQUITY COLLABORATIVE

About the Author

The Health Equity Collaborative (HEC) is a diverse community comprised of dozens of national, public health, patient advocacy, and multicultural organizations that are committed to supporting equity and combating disparities experienced by underserved populations. HEC is a project of MANA Action, a 501c4 not-for-profit organization.

Introduction

This special report explores the dramatic rise in 340B program spending, its unintended consequences, and the growing misuse by healthcare entities. As the program has expanded, concerns over its transparency, integrity, and accountability have intensified. Originally designed to make medications more affordable for low-income and vulnerable populations, the program has increasingly failed to direct its benefits where they are most needed. Despite its original mission, the 340B program has evolved into a financial boon for large hospitals and pharmacy benefit managers (PBMs), raising questions about how its resources are being used. This report highlights data from the Congressional Budget Office (CBO) and other sources to expose these alarming trends. It also provides recommendations for legislative reforms aimed at restoring the program's original purpose and ensuring its benefits reach the populations it was designed to help.

SECTION ONE

A Well-Intentioned Drug Discount

The 340B Drug Pricing Program was established with a clear and noble purpose: to provide healthcare providers serving low-income and vulnerable populations with access to outpatient medications at significantly discounted prices.

> **THIS LACK OF OVERSIGHT HAS LED TO MOUNTING CONCERNS ABOUT THE ABSENCE OF CLEAR ACCOUNTABILITY, WITH HOSPITALS PROFITING AT THE EXPENSE OF PATIENT TAXPAYERS**

The 340B Drug Pricing Program was established with a clear and noble purpose: to provide healthcare providers serving low-income and vulnerable populations with access to outpatient medications at significantly discounted prices.

When functioning as intended, the program has the potential to make healthcare more affordable and accessible for those who might otherwise go without essential medications.

In its original form, the 340B program empowered hospitals and clinics in underserved areas such as rural hospitals, community health centers, and Ryan White HIV/AIDS clinics, to stretch limited resources. These savings were used to fund other essential services, including preventive care, primary care, and mental health services, which helped provide comprehensive care for those most in need.

However, over time, the program has deviated from its original mission. Instead of exclusively benefiting low-income patients, it has become a lucrative profit center for large hospitals and PBMs. [1]

The 340B program is now a hospital mark-up operation, where hospitals acquire drugs at steep discounts and then re-sell them at marked-up prices with little to no transparency. [2]

This lack of oversight has led to mounting concerns about the absence of clear accountability, with hospitals profiting at the expense of patients and taxpayers.

If the 340B program is to continue serving its intended purpose, significant reform is necessary. Legislation is needed to ensure hospitals are transparent about their pricing practices and that the program is refocused on improving access to affordable medications for the populations who need it most.

The 340B program is administered by the Health Resources and Services Administration (HRSA) under the Department of Health and Human Services (HHS).

SECTION TWO

Program Spending Growth

The growth of the 340B program has been substantial over the past several decades.

This dramatic increase in spending reflects both the expansion of participating hospitals and the rising number of drugs eligible for 340B pricing.

“SPENDING ON CANCER DRUGS, ANTI-INFECTIVE AGENTS, AND IMMUNOSUPPRESSANTS COMPROMISED 70% OF TOTAL 340B SPENDING IN 2021, UP FROM 58% IN 2010”

The program has seen a significant rise in participation among large, often for-profit, hospital systems, which now account for a growing portion of the program's beneficiaries. As hospitals expand their 340B participation, many are consolidating smaller community hospitals or acquiring outpatient facilities to further capitalize on the program’s benefits.

This trend has contributed to the closure of smaller, rural hospitals, which struggle to compete with the financial advantages that larger, more resource-rich hospitals gain from the 340B program.

From the first quarter of 2016 through the first quarter of 2022, 340B facilities were responsible for roughly 75% of hospital acquisitions. [3]

Several investigative reports show that hospital chains have been slashing services at their facilities in poorer, predominantly minority areas while investing in wealthier, white neighborhoods.

A Wall Street Journal investigation found that:

“Overall, nonprofits are less generous in providing aid than their for-profit rivals. When patients do qualify for aid, nonprofits often put up obstacles. And many deploy a lucrative drug discount more often in wealthier communities, where the discounts can mean higher margins, over the low-income communities the program was meant to benefit.” [4]

One of the largest newspapers in the United States, The New York Times, writes,

"Many of these hospitals ... borrowing tricks from business consultants, have trained staff to squeeze payments from poor patients who should be eligible for free care." [3]

And a Richmond Times Dispatch commentary reveals,

“What started out as an obscure drug discount program to help the nation’s most needy has morphed into a massive profit generator for hospitals, pharmacies, and PBMs. This reality is leading to poorer health outcomes, less charity care for those in need, and higher health care costs for patients, taxpayers, employers, insurers and the government, creating significant market distortions in the health care industry. Hospitals and clinics are incentivized to consolidate to capture deeper discounts from the program, raising costs, creating fewer options for care, and leading to less market competition.” [6]

The Congressional Budget Office gathered data from the Health Resources and Services Administration to analyze expenditures in the 340B Drug Pricing Program from 2010 to 2021 and examine factors influencing spending changes over time.

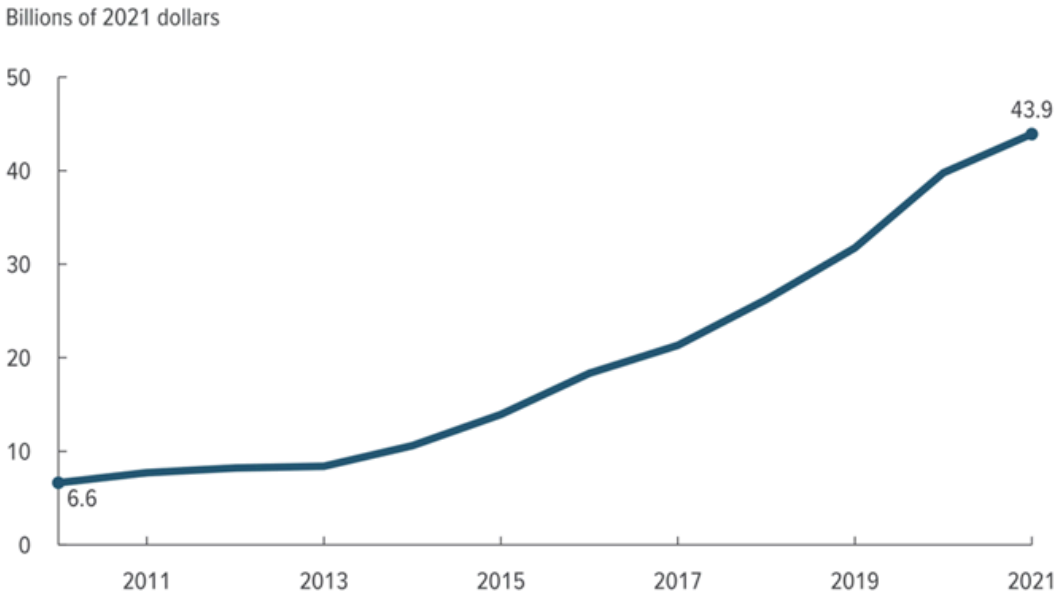
This data tracks 340B program spending by National Drug Code, the type of facility where prescriptions were written, and whether drugs were provided through a contract pharmacy.

“THE CBO ANALYSTS REVEALED A DRAMATIC INCREASE IN SPENDING ON THE 340B DRUG PRICING PROGRAM”

340B Drug Pricing Program by the numbers:

- From 2010 to 2021, 340B spending grew 19% annually, rising to 43.9 billion dollars in US spending.
- Spending on cancer drugs, anti-infective agents, and immunosuppressants comprised 70% of total 340 B spending in 2021, up from 58% in 2010.
- In 2021, 47% of 340B spending at hospital-based facilities was on cancer agents.
- 88% of the growth in 340 B spending from 2010 to 2021 can be attributed to spending on drugs prescribed by hospitals and their affiliated off-site clinics.

Spending in the 340B Program, 2010 to 2021

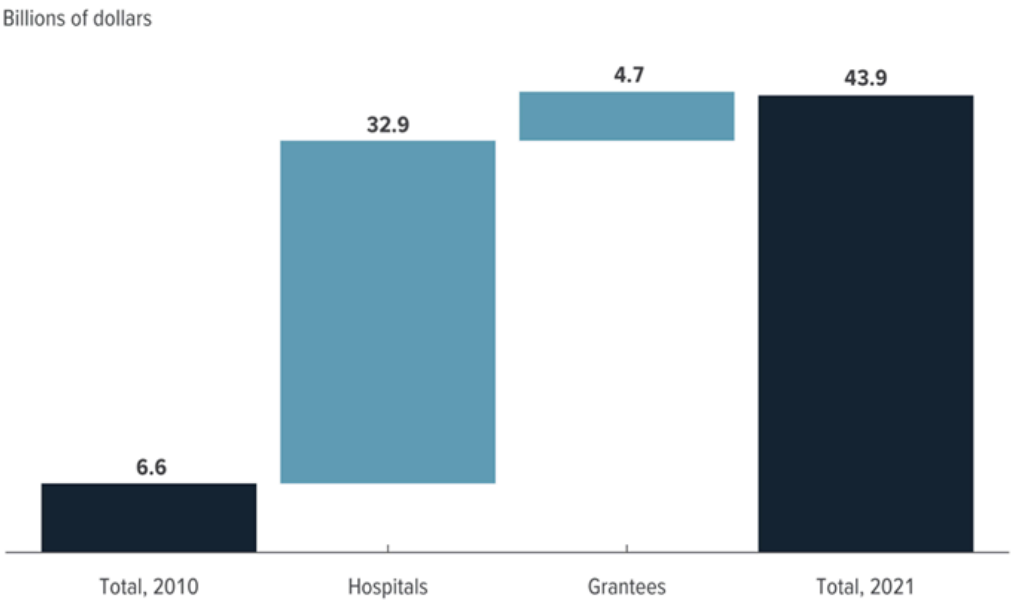


From 2010 to 2021, 340B spending grew 19 percent annually.

340B spending represents the total dollar value of purchases of drugs at the discounted 340B price across all facilities participating in the 340B Prime Vendor Program.

Spending amounts are adjusted for inflation using the consumer price index for all urban consumers (CPI-U) and are expressed in 2021 dollars.

Growth in Spending, by Facility Type, 2010 to 2021



Eighty-eight percent of the growth in 340B spending from 2010 to 2021 can be attributed to spending on drugs prescribed by hospitals and their affiliated off-site clinics.

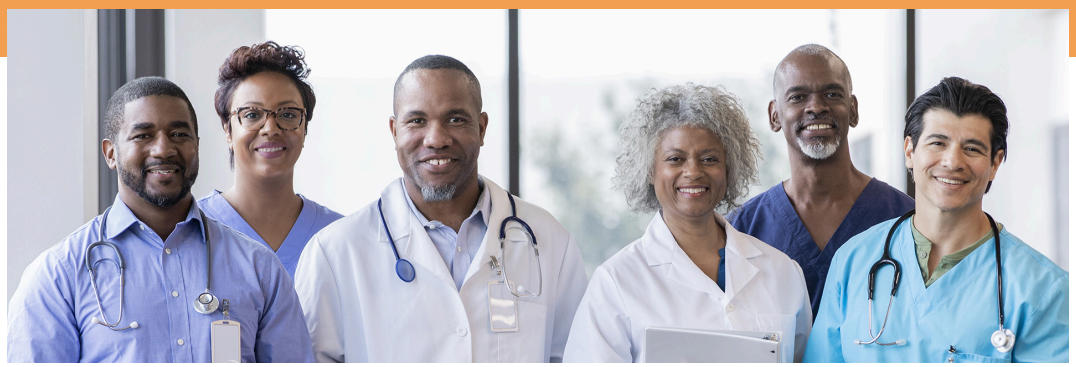
2010 spending is adjusted for inflation using the CPI-U and expressed in 2021 dollars. Numbers do not sum to the total for 2021 because $0.3 billion of spending in 2010 was not assigned to a facility type.

The analysts maintained that several factors likely contributed to the growth in spending. They pointed to the integration of hospitals and clinics, expanded facility participation due to the Affordable Care Act, and expanded use of “off-site” contract pharmacies. [8]

The numbers show the reality. The 340B program was intended to help safety-net hospitals provide services to underserved communities, but it has increasingly become a tool for larger hospital systems to increase their profit margins. There is little evidence that the program consistently provides patients with affordable access to medications.

SECTION THREE

Program Integrity Concerns: Hospital and Insurer-PBM Firms Abuse is on the Rise



As the 340B program has expanded, many hospitals have exploited loopholes to maximize their financial gain, often at the expense of patients.

Large hospital systems are increasingly using the program not to benefit underserved populations, but to boost their own bottom lines.

A study published in the Journal of the American Medical Association concluded:

> **"...OUR WORK ADDS TO A GROWING BODY OF EVIDENCE QUESTIONING THE DEGREE TO WHICH 340B PROGRAM GROWTH SERVES VULNERABLE COMMUNITIES [9]"**

Findings in the New England Journal of Medicine are not any better. Its analysis found no evidence that hospitals invest their 340B profits into safety-net care. [10]

We, the Health Equity Collaborative, exposed that the 340B program currently permits covered entities to build large contract pharmacy networks without demonstrating access needs for vulnerable populations. This is incentivizing a steady, unchecked, expansion of the program. Between 2010 and 2022, the number of 340B-eligible pharmacies participating in contract arrangements grew from less than 1% to more than 40%. Today, the 340B program accounts for approximately 7% to 8% of the total U.S. drug market. This growth has been largely driven by a handful of for-profit, publicly traded pharmacy chains, including CVS Health, Walgreens, Cigna, and Walmart, some of which own or are affiliated with a pharmacy benefit manager (PBM). As the number of contract pharmacies has grown, more and more are being located in wealthier and less diverse areas—a direct contradiction to the intention of the program. [11]

The well-documented data on the growth and power of PBM's is staggering:

- **There are more than 33,000 distinct pharmacies participating in the program, and these pharmacies have become a major driver of 340B profits. [12]**
- **More than 50 cents of each $1in profits contract pharmacies receive through the 340B program go to the four biggest PBM and pharmacy companies. [13]**
- **Profits from 340B markups now account for nearly $65 billion – 10% of brand medicine spending – and continue to grow unchecked. [14]**
- **The exponential growth in contract pharmacies from 2011 to 2019 was concentrated in wealthy and predominately white communities and not in areas with high unmet need where expansion could help improve health equity. [15, 16]**

While the program was designed to make medications more affordable for low-income patients, these practices have instead led to increased costs for everyone else.

Employers who provide insurance are paying higher premiums, and taxpayers are footing the bill for the lost revenue. Meanwhile, patients, who are often unaware of these mark-ups, are left with higher out-of-pocket costs. [17, 18]

SECTION FOUR

Policy Reforms for Congress

To help reform the 340B program, Congress could consider several actions aimed at increasing transparency, ensuring accountability, and addressing concerns about its misuse.

1. Implement Stricter Oversight and Transparency: Congress could require hospitals and pharmacies participating in the 340B program to disclose how they are using the savings from the program. This would provide more accountability on whether the funds are being used to benefit patients, especially those who are low-income and uninsured.

2. Clarify Eligibility Requirements: Congress could make eligibility criteria more transparent, ensuring that only hospitals and pharmacies that truly serve underserved populations benefit from the program. This would prevent large, wealthier institutions from exploiting the program for profit.

3. Strengthen Compliance Enforcement: Congress could give federal agencies more power to enforce compliance with 340B requirements, ensuring that participating entities adhere to the rules, particularly regarding care for uninsured or low-income patients and avoiding aggressive debt collection tactics.

4. Ensure Patient Benefit: Congress could ensure that the 340B savings directly benefit patients, such as by requiring that hospitals and pharmacies reduce drug prices or provide more services to underserved populations, rather than simply using savings to boost their bottom lines.

5. Limit the Use of 340B by Certain Entities: Congress could place limits on which types of organizations can participate, possibly restricting the program to only hospitals that serve a certain percentage of low-income or uninsured patients, focusing on those most in need.

6. Increase Data Collection and Public Reporting: Mandating regular reporting and analysis of 340B program outcomes, including how funds are spent and the direct benefits to patients, could help identify areas for improvement and ensure that the program is meeting its goals.

Dr. Ge Bai, PhD, CPA at Johns Hopkins University is one of the leading experts working to emphasize the importance of accountability to ensure that the 340B program benefits those it was designed to serve. She says:

> **“The 340B program was created as a ‘buy-low-sell-low’ initiative. But over the years, it has evolved into a ‘buy-low-sell-high’ program. Hospitals can still buy drugs at a low price, but when they sell those drugs, they do so at full price—without any discount. This allows hospitals to reap substantial profits from the difference between the discounted purchase price and the high selling price.” [19]**

Reforming the 340B drug discount program is a key priority for Senate Health, Education, Labor, and Pensions (HELP) Committee Chair Bill Cassidy (R-LA). In February 2025 he announced plans to introduce legislation aimed at preserving the program's original mission, while addressing concerns about safety net hospitals misusing drug discounts. Cassidy also emphasized that the reforms are essential to help prevent rising drug prices. [20]

> *"The 340B Program is regularly reviewed by the Government Accountability Office (GAO) and the Department of Health and Human Service Office of the Inspector General (OIG), both of which have highlighted issues with the program's integrity."*

Cassidy recently expanded his 340B investigation to include the nation's two largest contract pharmacy companies. [21]

Conclusion

The 340B Drug Pricing Program, originally designed to support underserved populations by providing discounted medications, has grown into a complex system that, in many cases, fails to meet its intended purpose. The unchecked expansion of contract pharmacies, lack of sufficient oversight, and insufficient accountability mechanisms have allowed large, profit-driven institutions to exploit the program, often at the expense of the very populations it was meant to help. Despite the program's impressive growth in funding, there is little evidence that these funds are being used to directly benefit vulnerable communities.

To ensure the 340B program fulfills its original mission, comprehensive reform is needed. Congress has a critical role to play in restoring transparency, clarifying eligibility requirements, and ensuring that savings from the program are used to benefit patients rather than enrich large healthcare corporations. By addressing these gaps and ensuring stricter oversight, the program can return to its roots, supporting safety-net providers and improving access to essential medications for low-income, uninsured, and vulnerable populations.

Reforming the 340B program is not only essential for restoring integrity to this vital public health initiative but also for promoting equity in healthcare. Only with these changes can we ensure that the 340B program truly serves its intended purpose: to help those who need it most.

References

1. Know, R. (2023, November). Outcomes of the 340B Drug Pricing Program A Scoping Review. JAMA Network Open. [Link]

2. PhRMA. (2025). The 340B Hospital Markup Program. PhRMA. [Link]

3. Centers for Medicare & Medicaid Services. (2024). Centers for Medicare & Medicaid Services. [Link]

4. Evans, M. (2022, December). Big Nonprofit Hospitals Expand in Wealthier Areas, Shun Poorer Ones. WSJ. [Link]

5. Thomas, K. (2022, September). How a Hospital Chain Used a Poor Neighborhood to Turn Huge Profits. New York Times. [Link]

6. Newby, J. (2024, December). Commentary: Unchecked Growth of Federal Drug Program Hurts Virginia Patients. Richmond Times-Dispatch. [Link]

7. Sachs, R. (2024, June). Spending in the 340B Drug Pricing Program, 2010 to 2021. Congressional Budget Office. [Link]

8. Sachs, R. (2024, June). Spending in the 340B Drug Pricing Program, 2010 to 2021. Congressional Budget Office. [Link]

9. Lin, J. (2022, June). Assessment of US Pharmacies Contracted With Health Care Institutions Under the 340B Drug Pricing Program by Neighborhood Socioeconomic Characteristics. JAMA Network Open. [Link]

10. Desai, S. (2018, January). Consequences of the 340B Drug Pricing Program. The New England Journal of Medicine. [Link]

11. Health Equity Collaborative. (2024, October). The State of U.S. Charity Care: Solutions to Improve the Patient Experience and Achieve More Equitable Health Outcomes. Health Equity Collaborative. [Link]

12. PhRMA. (2025). The 340B Hospital Markup Program. PhRMA [Link]

13. Erb, K. (2020, October) For-Profit Pharmacy Participation in the 340B Program. [Link]

14. PhRMA. (2025). The 340B Hospital Markup Program. PhRMA. [Link]

15. Lin, J. (2022, June). Assessment of US Pharmacies Contracted With Health Care Institutions Under the 340B Drug Pricing Program by Neighborhood Socioeconomic Characteristics. JAMA Network Open. [Link]

16. Lin, J. (2022, June). Assessment of US Pharmacies Contracted With Health Care Institutions Under the 340B Drug Pricing Program by Neighborhood Socioeconomic Characteristics. JAMA Network Open. [Link]

17. National Alliance of Healthcare Purchaser Coalitions. (2025). The 340B Program's Impact on Employers. [Link]

18. Voytal, D. (2024, November). 340B Spending is Exploding, Forcing Prices Up for Patients, Employers and Government Programs. PhRMA. [Link]

19. Health Equity Collaborative. (2025). New HEC Community Member Podcast Highlights Why the 119th Congress Needs to Prioritize 340B and PBM Reforms. Health Equity Collaborative. [Link]

References

20. Mills-Gregg, D. (2025, February). Cassidy: Upcoming Bill Will Realign 340B Program To Mitigate Misuse. Inside Health Policy. [Link]

21. U.S. Senate Committee On Health, Education, Labor, and Pensions. (2023, November). Ranking Member Cassidy Requests Information from Community Health Centers as Part of Ongoing 340B Investigation. U.S. Senate Committee On Health, Education, Labor, and Pensions. [Link]