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The Impact of 340B on the Federal Budget

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The 340B Drug Pricing Program was created with a noble goal: to help safety-net health care providers expand their services for vulnerable patients. Today, however, the program has drastically expanded and is not accountable for serving vulnerable patients. What began as targeted support for underserved communities has become a large, opaque system that pushes up drug costs, rewards hospital consolidation, and increases federal spending.

Although some have claimed that 340B doesn't cost taxpayers a penny, the Congressional Budget Office has proven that is not true. [1] The program drives up spending in Medicare and Medicaid, raises costs for employers and patients, and allows hospitals to profit from discounted drugs without any requirement to pass savings on to the people 340B was meant to help.

In this report, we examine how the current structure of the 340B program increases federal health care spending and undermines affordability. We also outline policy reforms Congress can adopt to realign 340B with its original mission—ensuring the program benefits patients rather than hospital balance sheets, while reducing its growing cost to taxpayers.

This report is part of a series called Fixing America's Broken Hospitals, which seeks to explore and modernize a foundation of our health care system. A raft of structural issues, including lack of competition, misaligned incentives, and outdated safety net policies, have led to unsustainable practices. The result is too many instances of hospitals charging unchecked prices, using questionable billing and aggressive debt collection practices, abusing public programs, and failing to identify and serve community needs. Our work sheds light on issues facing hospitals and advances proposals so hospitals can have a financially and socially sustainable future. [2]

What is 340B?

The 340B Drug Pricing Program, created in 1992, requires drug manufacturers participating in Medicaid and Medicare Part B to provide discounted drugs to eligible 340B health care providers. It is intended to help safety-net providers (such as community health centers and certain hospitals) stretch federal resources and expand services for the patients and communities they serve. Providers supply the discounted drugs to patients and then bill public and private health plans at a higher price, using the profit for health care services. The program has grown rapidly from $44 billion in 2021 to $81 billion in 2024.

How 340B Affects Federal Spending

The 340B program was intended to have no cost to the federal government, helping a small number of hospitals and other eligible providers. [3] Unfortunately, that's not the case as 340B has ripple effects across Medicare, Medicaid, employer-sponsored insurance, and drug pricing overall. Specifically, the 340B program increases federal spending in five different ways:

1. Bigger Medicare Payments

The 340B model incentivizes participating hospitals to maximize their use of discounted drugs, which in turn increases Medicare reimbursements. According to the Government Accountability Office, spending on drugs in Medicare Part B is "substantially higher" at 340B disproportionate share hospitals than non-340B hospitals. [4] One reason is that 340B hospitals prescribe higher-cost drugs, which give them higher profits. They also prescribe a higher quantity of drugs.

In 2019, the federal government sought to reduce Medicare Part B's reimbursement for 340B drugs from the average sales price plus 6% to the average sales price minus 22.5%. [5] This was to ensure Medicare wasn't overpaying 340B hospitals for discounted medicines and lower those drug prices for seniors. However, hospitals sued, and the Supreme Court overturned this policy because the Administration neglected to follow its own Executive Order to conduct a survey before making the changes. [6]

2. Lost Rebates in Medicaid

Congress created a separate program, the Medicaid Drug Rebate Program, in 1990 to lower prescription drug costs and ensure manufacturers contribute to the sustainability of Medicaid. It requires manufacturers to pay rebates to Medicaid for covered outpatient drugs dispensed to beneficiaries, with the savings divided between the federal government and states. When Medicaid pays for a drug purchased under 340B, it loses out on the Medicaid rebate that it normally receives.

The result is a systemic loophole that drains billions from Medicaid budgets: an estimated $2 billion in annual losses that are felt by state and federal governments. [7] This funding loss has two sources. First, although federal law prohibits "duplicate discounts" from 340B and the Medicaid rebate for the same drug, hospitals have lobbied states to let them keep the 340B rebate instead of the state getting the Medicaid rebate. [8] Second, managed care plans, which provide health care coverage for most people with Medicaid, can't use the Medicaid discount when a provider chooses to use the 340B program. [9]

3. Higher Premiums for Employers and Private Coverage

Spending on drugs for private coverage also increases as the 340B program leads providers to prescribe more higher-cost drugs and charge higher prices for drugs. [10] Providers using 340B can also bypass the rebates that employers receive from pharmacy benefit managers. One estimate puts the annual cost to employers who self-insure at $5.2 billion. [11] To compensate for increased spending, insurers raise annual premiums for patients and employers with private insurance, including plans purchased through the Affordable Care Act Marketplaces. [12]

The impact on the federal budget is twofold. First, the cost to the government for the Advance Premium Tax Credits (those that remain after the enhanced credits expired in December 2025) will be more as private plans increase their premiums. Second, the portion of premiums that employers pay is tax exempt, which means that higher premiums lead to more tax exemptions and less paid in federal taxes. [13]

4. Incentives for Hospitals to Consolidate

Since the inception of the 340B program, the number of hospitals that qualify for the program's discounts has grown exponentially. [14] This growth has been driven in part by large hospital networks purchasing facilities in working-class and rural communities that qualify for the program. [15] Hospitals have also expanded their reach and increased profits by purchasing doctors′ offices, often in wealthy areas. [16]

Simply put: the 340B program incentivizes wealthy hospitals to purchase facilities in both underserved and wealthy communities. [17]

Consolidation of hospital markets is not only bad within the context of the 340B program—it also increases costs for other services as providers charge higher prices due to their outsized influence within the market. [18] This means Medicare and Medicaid spend more covering care for working-class and older Americans, and private insurers raise premiums to cover the cost of care for their patients. [19]

5. Higher list Prices for New Drugs

Since drug manufactures receive only a fraction of a drug's list price under 340B, some raise list prices on new drugs to recover lost revenue. [20] As a result, patients across all insurance types pay higher prices for lifesaving medications to offset losses created by the 340B program.

Solutions

Lawmakers need to ensure that 340B dollars benefit patients and meet the needs of vulnerable communities. Additionally, there needs to be a focus on reducing 340B's impact on the federal budget and lowering the cost of health care. Congress should consider a mix of both by doing the following:

Ensure 340B Dollars Meet Patient Needs

First, require basic reporting requirements to boost transparency. Hospitals should be required to report basic information to the federal government on what they are doing with 340B funds. [21] For example, the bipartisan Senate 340B working group published a discussion draft last Congress that would require hospitals to report on how much charity care they provide, the amount they receive in 340B discounts, and what those savings are used for. [22] States like Minnesota have taken the lead on 340B transparency and illustrate the kind of action needed. [23]

Second, establish a clear patient definition. There is no clear definition of an intended patient whose drugs are to be purchased through the 340B program. The current definition was issued by the Health Resources and Services Administration and is too wide and ill-defined to target benefits to working-class patients. [24] Instead of tying eligibility solely to covered entities, a definition should set patient eligibility by income level or insurance status.

Third, create minimum patient benefits. The savings that providers reap should be funneled back to vulnerable patients in the communities they serve. However, hospitals covered in 340B provide a lower proportion of their revenues towards charity care than non-340B nonprofit hospitals. [25] Lawmakers should set firm minimum standards for charity care to ensure that savings are going back to patients, not cushioning a wealthy hospital system's bottom line.

Fourth, ban aggressive medical debt collection. Hospitals receiving 340B benefits should be prohibited from aggressively going after patients for unpaid medical debt. This includes filing lawsuits against patients, denying non-emergent care, and sending debt to collection agencies.

Decrease 340B's Impact on The Budget

First, ensure seniors don't overpay for prescriptions. Medicare pays hospitals 106% of the average sales price for outpatient drugs through Medicare Part B—even for discounted medications under 340B. To lower seniors' costs, the Centers for Medicare and Medicaid Services attempted to reduce that reimbursement to 77.5%, which would've saved the Medicare program $1.6 billion a year until the Supreme Court overturned the change due to procedural issues. [26] Congress or the Administration could attempt to do so again but in a way that avoids legal issues.

Second, prioritize Medicaid rebates over 340B discounts. Congress should require all drugs reimbursed by Medicaid to use its drug rebate program first, not defer to 340B prices. This would give states and the federal government more room to negate the negative effects of the recent cuts to Medicaid and empower state Medicaid programs to direct funding towards the hospitals and providers that need it most, rather than the large tax-exempt hospital chains that take the bulk of 340B dollars.

Third, limit employer and ACA markups for 340B drugs. To ensure patients with employer and private insurance aren't paying excessive prices for discounted medications, Congress should prevent hospitals from overcharging discounted drugs to these patients. For example, Senator John Kennedy (R-LA) introduced the 340B Reporting and Accountability Act in 2023 to do just that. [27]

Fourth, prevent abuse of 340B child sites in wealthy areas. When 340B hospitals acquire physician practices, they can deem them "child sites," expanding their patient base for 340B discounts. This incentivizes hospital systems to grow their market power, especially in wealthier areas where they can access more patients with private insurance that pay higher prices than Medicare and Medicaid. [28] Child sites should be required to abide by the same eligibility requirements as their parent hospital to quality for 340B discounts, including providing care for large safety-net populations.

Conclusion

The 340B program remains an important tool to support access to prescription drugs for working-class patients and safety-net providers. However, the absence of guardrails has allowed billions in savings to flow to hospital systems without guaranteeing benefits for vulnerable patients. As the program's footprint continues to grow, so does its effect on federal spending—whether through higher Medicare reimbursements, lost Medicaid rebates, or higher costs for patients and taxpayers.

To safeguard both patients and the federal budget, lawmakers should adopt reforms that preserve the program's mission, ensure accountability and transparency, and maximize federal health care dollars.

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