How CMS plans to fix a major flaw in the 340B drug discount program

The 340B program has exploded. We want to rein it in to help Medicare patients

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Some Medicare patients owe more in coinsurance than the hospital paid for their drug. That arithmetic sounds impossible. It is a consequence of the 340B drug discount program and Medicare's payment formula. Now the Department of Health and Human Services, where I work, is proposing to narrow that gap.

Congress created the 340B drug discount program in 1992 to financially support safety net hospitals that serve low-income patients. Drug manufacturers must give them steep discounts. But Medicare, Medicaid, and commercial insurers generally reimburse them at the full amount, allowing these hospitals to keep the spread above the discounted purchasing costs.

A new report from the Department of Health and Human Services shows other unintended consequences of this well-intended program. The spread grows with the price of the drug. It therefore rewards hospitals for using more and costlier drugs and makes physician practices and infusion clinics more valuable after a 340B hospital acquires them. The patient's treatment needn't change. The owner and billing site do.

The 340B program has exploded: Eligible drug purchases rose from $12 billion in 2015 to $81 billion in 2024, mostly at hospitals, as shown in the report. Those purchases are now larger than net Medicare Part B and Medicaid drug spending overall and, among public prescription drug programs, are smaller only than Medicare Part D.

A 340B hospital that buys another hospital or a physician practice can register more off-campus clinics and contract pharmacies and capture more spread. Hospital off-campus clinic sites grew from about 7,000 in 2013 to more than 34,000 in 2023, often in neighborhoods that are

wealthier and better-insured than that of the parent hospital. Contract pharmacies grew from roughly 1,300 in 2010 to more than 31,000 by mid-2026, dominated by the largest chains.

With greater bargaining power after acquisitions, hospital systems can negotiate higher commercial prices for health care services, which can in turn raise premiums. Newly acquired hospital outpatient sites can also add facility fees to non-drug services. The effects of 340B show up as larger, more expensive hospital systems and a bigger bill for patients, employers, and taxpayers. The program's ripple effects contribute to the broader problems facing the U.S. health care system.

Medicare payment for Part B drugs is typically based on average sales price (ASP). Beginning in 2018, the first Trump administration narrowed the spread in Medicare by paying hospitals for 340B drugs' ASP minus 22.5% rather than the usual statutory standard of ASP plus 6%, based on an earlier estimate of their average minimum discount.
Overall outpatient drug payments rose nearly 15% a year from 2015 through 2017. Once the lower rate was fully in effect, inflation-adjusted payments largely plateaued. Payments for the affected 340B drugs held near $7 billion from 2019 through 2021. It is clear that Medicare payment policy influences outpatient drug spending.

The Supreme Court ruled in 2022 that HHS couldn't vary payment rates by hospital group without first conducting the acquisition-cost survey required by statute. The court didn't find that hospitals were economically entitled to the markup. It found that HHS lacked a procedural prerequisite. After the lower rate ended and ASP plus 6% returned for these drugs, annual payments for the affected drugs rose from $7.1 billion in 2021 to $10.7 billion in 2023 — a $3.6 billion increase. Overall outpatient drug payments rose from $14.3 billion in 2021 to $17.6 billion in 2023.

Restoring the higher rate meant paying hospitals more for the same drugs. The $3.6 billion increase combines that direct payment effect with induced changes in hospitals' dispensing quantities and drug manufacturers' underlying prices. The larger spread also strengthens hospitals' incentive to choose costlier drugs and move treatment into 340B billing sites.

Off-campus hospital departments benefited too. From 2021 to 2023, payments for their affected 340B drugs rose about $800 million even as claims fell and the number of beneficiaries remained similar. Although these amounts do not tell us how many practices hospitals acquired because of the markup, they indicate the additional financial incentives for acquisitions.

On April 18, 2025, President Trump directed HHS to obtain the cost information the statute requires. CMS surveyed hospitals from January through April 2026 and has proposed paying for affected 340B drugs at ASP minus 33.4% in 2027. CMS estimates that Medicare drug payments would fall by $4.55 billion in the first year and beneficiary drug copayments by $1.15 billion.

For a drug with an ASP of $1,000, a beneficiary's standard 20% coinsurance would fall from $212 to $133.20. The prescription hasn't changed. The patient's share of the hospital's bill has. Narrowing the spread also weakens the incentive to steer patients toward costlier drugs and to acquire physician practices and infusion clinics — the very behaviors that have made care more expensive.

There's an important lesson here. A small, well-intended discount for safety net hospitals became a large institutional subsidy with expensive unintended consequences. Under the proposed rule, hospitals would still receive their 340B drug discounts. What would change is Medicare's payment for those drugs at affected hospitals. Congress provided for a survey of hospitals' acquisition costs, and CMS says its proposed rate would "more accurately align Medicare payments with hospital drug acquisition costs."

Medicare patients should not pay coinsurance as though the discount did not exist.

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