



BUCKEYE POLICY BRIEF

THE 340B FIX FEDERAL BIPARTISAN EFFORT BEST PATH TO REFORM

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Introduction

In 1992, Congress enacted the 340B program to deliver financial and medical assistance to low-income and uninsured patients through need-based facilities like federally qualified health centers (FQHCs), FQHC look-alikes, disproportionate share hospitals, and Ryan White HIV/AIDS centers. Although the program is described as voluntary, drug manufacturers are required to sell discounted prescription drugs to these entities if they want their drugs to be covered by Medicaid and Medicare. By restricting the number of eligible entities and contract pharmacies, the 340B program ran relatively inexpensively. But when the Affordable Care Act (ACA) expanded eligibility to a vast array of hospitals, and the Health Resources and Services Administration (HRSA) allowed covered entities to contract with multiple pharmacies, program costs and abuses quickly escalated.

Artificial price controls, perverse incentives, and virtually no reporting transparency have all contributed to unintended consequences and a program that largely neglects its well-intended goals. Understandably, state policymakers have proposed various ways to improve program outcomes, but a wiser course would be to encourage Congress to pursue extensive 340B reforms. U.S. Senator Bill Cassidy's investigative report¹ and President Donald Trump's executive orders regarding 340B² have opened the door for necessary change. Ohio and other states should raise their concerns about the costs and misuses of the disappointing 340B program, while encouraging Congress to increase programmatic transparency with a renewed effort to help low-income patients—not hospitals and pharmacy giants.

¹ Majority Staff Report, **Congress Must Act to Bring Needed Reforms to the 340B Drug Pricing Program**, U.S. Senate Committee on Health, Education, Labor, and Pensions, April 2025.

² **Executive Order 14,273**, The White House, April 15, 2025.

History of the 340B Program

Attaining affordable healthcare has been a festering problem for patients in Ohio for far too long. In 1992, Congress passed the 340B Drug Pricing Program, which allowed qualifying hospitals and health centers to purchase discounted prescription drugs from drug manufacturers. In theory, the program would give low-income and uninsured patients access to inexpensive medication. But in practice, recent investigations³ show that hospitals and contract pharmacies have been the greatest beneficiaries of the program, while many low-income patients have received little savings on their healthcare expenses.

Under the 340B program, participating drug manufacturers must sell their prescription drugs at a steep government-mandated discount, known as the ceiling price. These manufacturers sell to “covered entities,” eligible hospitals and health centers that predominantly care for poor and uninsured patients. Covered entities use either an on-site or a contract pharmacy (i.e., a local drugstore) to dispense medications to patients. In 1996, a covered entity could only use one contract pharmacy. The Affordable Care Act made new categories of hospitals eligible, and the HRSA permitted covered entities to use multiple pharmacies. According to the Congressional Budget Office (CBO),⁴ the number of contract pharmacies rose from about 2,000 in 2010 to almost 130,000 in 2021—75 percent of which are now owned by five major chains: CVS Health, Walmart, UnitedHealth Group, Cigna, and Walgreens.⁵

These changes coincided with rampant spending growth by covered entities. In 2010, covered entities spent \$6.6 billion on prescription drugs. By 2021, they spent \$43.9 billion. The ACA’s contract pharmacy expansion explains a significant portion of the meteoric rise in spending. Eligible hospitals accounted for 87 percent of this spending, despite making up only 61 percent of the 340B covered entity population. Unlike FQHCs, the newly eligible hospitals do not have to pass along their savings to patients, which can lead to wasteful spending habits, such as prescribing higher quantities of drugs or more expensive ones.

In 2024, Dan Crippen, a former CBO director, noted⁶ that lost Medicaid rebates could cost state and local governments \$3.5 billion per year. He also noted that over the next 10 years, federal corporate tax revenue could possibly decline by \$200 billion, with covered entities being tax-exempt institutions. With the recent proliferation of covered entities, state governments will need to explore alternative avenues to offset the loss in tax revenue.

Regrettably, the 340B program has deviated from its original purpose. Covered entities purchase drugs at a discounted price and then bill health insurance companies for them at a higher price. The price difference is referred to as “savings.” The program originally intended for covered entities to use the savings to provide more medical access to vulnerable patients. But the supposed

³ Rory Martin and Kepler Illich, *Are Discounts in the 340B Drug Discount Program Being Shared with Patients at Contract Pharmacies?*, IQVIA, September 27, 2022.

⁴ *Growth in the 340B Drug Pricing Program*, Congressional Budget Office, September 2025.

⁵ Adam J. Fein, *Exclusive: For 2023, Five For-Profit Companies Dominate the Drug Channel’s Flow of Money*, DrugChannels.net, July 24, 2023.

⁶ Dan Crippen, *340B Impact on the Federal Budget*, AIR340B, October 2024.

savings have been obscured, and the program’s good intentions have gone unfulfilled in part because it does not require all covered entities to report their savings or how they use them.

The consulting firm Magnolia Market Access found⁷ that much of the 340B savings are used for financial portfolios, and U.S. Senator Bill Cassidy (Louisiana) discovered significant programmatic abuse.⁸ Ohio-based hospitals, Bon Secours Mercy Health and Cleveland Clinic, for example, have accumulated hundreds of millions of dollars in 340B revenue but have never delivered any of the 340B discounts directly to their patients. Senator Cassidy’s report led U.S. Senator Jon Husted (Ohio) to hold an investigative hearing⁹ in the Senate Health, Education, Labor, and Pensions Committee during which Senator Cassidy lamented that “the significant growth of the 340B program has become a means for some to pad bottom lines, but with little focus on affordability for the family, or for the employer who is helping to pay for their insurance.”¹⁰ Senator Husted expressed optimism for reform during the hearing: “So what I hope we’ll be able to accomplish with this conversation is targeting the savings that come out of 340B toward the places that are most in need...”¹¹ Minnesota quantified¹² how much 340B revenue covered entities generate, reporting that they raised approximately \$630 million in net revenue, with hospitals contributing 80 percent. Tellingly, safety-net grantees—the program’s intended beneficiaries—generated the least revenue. Furthermore, the top 10 percent of them lost more than their gross revenue due to excessive operating costs imposed by contract pharmacies and administrators.

In light of these glaring failures, President Trump issued an executive order in April 2025¹³ to demand more transparency from the 340B program and combat the anti-competitive corporate practices that have prioritized hospitals and pharmacy chains over low-income patients at taxpayer expense.

Perverse Incentives and Their Consequences

The 340B program incentivizes physicians to prescribe patients more drugs or more expensive drugs to maximize their “savings.” But those supposed savings quickly become profits for the physicians, hospitals, and pharmacy chains. Dr. Ge Bai, a Johns Hopkins health policy professor, warned in her congressional testimony that a lack of competition, coupled with predatory

⁷ **How 340B Disproportionate Share Hospitals (DSH) Are Failing to Reinvest in Patient Care**, Magnolia Market Access, Inc., 2025.

⁸ Majority Staff Report, **Congress Must Act to Bring Needed Reforms to the 340B Drug Pricing Program**, U.S. Senate Committee on Health, Education, Labor, and Pensions, April 2025.

⁹ U.S. Senate Committee on Health, Education, Labor, and Pensions, **Senate HELP Committee to Hold Hearing on 340B Drug Program, Impact on American Patients**, October 16, 2025.

¹⁰ **Chair Cassidy Delivers Remarks During Hearing on 340B Drug Program, Impact on American Patients**, U.S. Senate Committee on Health, Education, Labor, and Pensions, October 23, 2025.

¹¹ Dave Muoio, **Senators Open to Calls for Greater 340B Oversight, Spending Requirements-but Remain Wary of New Provider Burdens**, Fierce Healthcare, October 23, 2025.

¹² Minnesota Department of Health, **340B Covered Entity Report to the Minnesota Legislature**, 2024.

¹³ **Executive Order 14,273**, The White House, April 15, 2025.

behavior, has distorted a “buy-low sell-low” program into a “buy-low sell-high” version.¹⁴ Not surprisingly, the unlimited expansion of eligible 340B pharmacies has made prescriptions for patients with private insurance more attractive than prescriptions for uninsured patients or those on Medicaid and Medicare. A *New England Journal of Medicine* article¹⁵ revealed that the reimbursement prices charged to insurers by 340B entities were higher than those of non-340B establishments.

Government-mandated price controls have likely had another effect: less research and innovation. According to an investigative working paper,¹⁶ program-participating manufacturers selling their drugs at a deep discount lose significant revenue that then cannot help pay for research or developing new drugs. The authors found that a 19 percent to 39 percent decrease in revenue tends to reduce research and development by 29 percent to 60 percent; and they expect between 167 and 342 fewer drugs to reach the market. Consistent with those findings, another working paper showed that regulated Medicare price reductions for medical devices have resulted in a 75 percent drop in patent applications, signaling a de-emphasis on innovative medical technology.¹⁷

Cost to Ohio

In addition to lost research and innovation, the 340B program also imposes costs on states, employees, and employers. IQVIA, a healthcare data solutions company, conducted extensive research on program costs for each state¹⁸ and concluded that Ohio employees and employers pay an extra \$275 million per year due to lost rebates. State Medicaid offices cannot request rebates from manufacturers for claims dispensed at 340B prices in order to avoid what is known as “duplicate discounting.” IQVIA estimates that costs may reach \$326 million if Ohio initiates a mandate for contract pharmacies.

The Pioneer Institute reported that 340B entities are neglecting to care for Ohio’s low-income patients. A majority (55 percent) of the contract pharmacies intended to serve low-income households sit in relatively affluent districts.¹⁹ Also, hospitals, such as Cleveland Clinic, deliver an

¹⁴ Ge Bai, PhD, CPA Professor of Accounting, Carey Business School Professor of Health Policy & Management (Joint), Bloomberg School of Public Health Johns Hopkins University, Testimony submitted to the U.S. House Committee on Ways and Means, Subcommittee on Oversight, **Tax-Exempt Hospitals and the Community Benefit Standard**, April 24, 2023.

¹⁵ James C. Robinson, Christopher Whaley, and Sanket S. Dhruva, **“Hospital Prices for Physician-Administered Drugs for Patients with Private Insurance,”** *New England Journal of Medicine*, Volume 390, No. 4 (January 2024) p. 338-345.

¹⁶ Philipson, Tomas J., and Troy Durie, **The Evidence Base on the Impact of Price Controls on Medical Innovation**, working paper No. 2021-108, University of Chicago, September 14, 2021.

¹⁷ Yunan Ji and Parker Rogers, **The Long-Run Impacts of Regulated Price Cuts: Evidence from Medicare**, working paper No. w33083, National Bureau of Economic Research, October 29, 2024.

¹⁸ Chuan Sun, Shanyue Zeng, and Rory Martin, **The Cost of the 340B Program to States**, IQVIA, 2025.

¹⁹ **340B in Ohio**, Pioneer Institute, 2025.

abysmal rate of charity care at less than two percent of their revenue,²⁰ which helps explain why Ohio 340B hospitals are providing charity care below the national average.

Legislative Reform Efforts

Several bills in the Ohio General Assembly and in Congress propose reforms related to the 340B program.

Two companion bills, House Bill 276 and Senate Bill 198 would prevent drug manufacturers from denying FQHCs and other non-hospital grantees access to discounted drugs, and it prohibits them from demanding claims or utilization data from these covered entities. The legislation promises that drug manufacturers will supply covered entities with 340B eligible drugs at a discounted price, which would seemingly allow uninsured and low-income patients access to more affordable medication. But nothing in the draft legislation requires medical providers to pass this discount directly to the appropriate patients—a flaw in the 340B program. Nor does the legislation make 340B savings more transparent. Under the program, medical providers generally do not have to divulge savings figures if they have been reinvested toward providing care for patients. Cleveland Clinic, for example, reported allocating program savings toward vague projects such as “community benefit programs” and “capital improvement projects.”²¹ And nothing in these bills addresses such opacity.

House Bill 276²² and Senate Bill 198 would also protect FQHCs and other non-hospital grantees from manufacturers demanding data as a condition of receiving 340B drugs. Commendably, the bills exclude hospitals that have largely exploited the federal program, but they, too, do not require transparent pricing or promote competition among medical providers. Their effort to protect contract pharmacies and other third parties falls short of improving care access for disadvantaged patients.

House Bill 96, signed in 2025, highlights the ambiguous data practices of covered entities by rightly requiring all covered entities to submit relevant data to the Ohio Department of Health (ODH).²³ All submitted data will now be publicly available on ODH’s website, including payments made to contract pharmacies and third-party administrators, the total number of contract pharmacies, and acquisition costs and payments for 340B program drugs. Unfortunately, Governor Mike DeWine line-item vetoed some useful transparency provisions in the original bill,²⁴ the most significant being a requirement that covered entities publish a comprehensive accounting of how they use their 340B savings. That vetoed information-sharing requirement would have provided more clarity to taxpayers and patients, which is the key to ensuring that the 340B program satisfies its purpose.

²⁰ Melanie Evans and Shane Shifflett, **How Hospitals Use a Federal Program for the Poor to Fund Expansion and Executive Pay**, *The Wall Street Journal*, December 20, 2022.

²¹ **S.B. 198**, 136th General Assembly (Ohio 2025).

²² **H.B. 276**, 136th General Assembly (Ohio 2025).

²³ **Ohio Revised Code 3701.88 (2025)**.

²⁴ Ohio General Assembly, **Disapproved Language Am. Sub. H.B. No. 96**, 136th General Assembly, June 30, 2025.

Finally, support for 340B reform is growing in Washington, and lawmakers seem eager to consider solutions. In September, Congress introduced the 340B ACCESS Act,²⁵ co-sponsored by U.S. representatives Earl Carter (Georgia) and Diana Harshbarger (Tennessee), which would return the 340B program to its original model by ensuring that grantees are truly safety net hospitals, defining “patient” to reach the bill’s intended group, and adopting patient affordability requirements. Additionally, the Centers for Medicare & Medicaid Services published suggestions for avoiding duplicate discounts that could further burden taxpayers,²⁶ and recommends that states provide drug manufacturers with claims-level data to provide more accurate information for reconciling rebate disputes. Although the 340B ACCESS Act was recently introduced, both Democrats and Republicans are justified in expressing support for amending this legislation to its original foundation, where transparency is practiced by all parties involved. Following Congressional support, it could help sway Governor DeWine and others to reconsider the line-item vetoed language in House Bill 96 and clarify how covered entities operate in Ohio. By doing so, Ohio policymakers would help ensure that these health centers provide for needy patients.

Conclusion

Ohio should investigate 340B program revenue across the state to reassure taxpayers and patients that the program “savings” are properly used. The state should have an accurate accounting of the program’s financial impact on Medicaid and hold all involved parties more accountable for any abuse of program funds. The General Assembly should favor transparency-legislation like House Bill 96 to reveal which entities pass down program discounts to patients and expose those that exploit the system. Ultimately, the 340B program requires federal reforms to fix the broken program and Ohio leaders should encourage that effort. State initiatives like House Bill 276 and Senate Bill 198, despite their good intentions, risk complicating and confusing genuine legislative solutions percolating in Washington.

²⁵ **H.R. 5256 - 119th Congress (2024-2025): 340B ACCESS Act**, Congress.gov, September 10, 2025.

²⁶ Calder Lynch, **Best Practices for Avoiding 340B Duplicate Discounts in Medicaid**, Centers for Medicare & Medicaid Services, January 8, 2020.

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