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Inside the Drug Discount Program That Lets Big Hospitals Keep the Savings

Analysis by Dr. Joseph Mercola | November 24, 2026

STORY AT-A-GLANCE

- A federal program created in 1992 to help clinics serving poor and uninsured patients now moves $100 billion a year in discounted drugs, and nearly 4 out of every 5 of those dollars flow through one category of hospitals
- Hospitals buy drugs at steep discounts, bill insurers and patients the full price, and keep the difference, with no federal rule requiring them to report how much they make or how they spend it
- A new analysis of nearly 4,000 hospitals found that those in the program spend a smaller share of their budgets on charity care than hospitals outside it, while 2026 studies link the program to bigger markups, more drug use and hospital consolidation
- Hospital groups counter that charity care is too narrow a yardstick and that the discounts fund services in struggling communities, and some of the strongest critics are funded by the drug companies that pay for those discounts
- You can check whether your hospital is in the program, use its required financial assistance policy, and ask where an infused drug will cost you least before treatment starts

As reported by Sylvia Xu and Lawrence Wilson in The Epoch Times, hospitals that use a little-known federal drug discount program spend less on charity care than hospitals that don't.[1] That finding comes from a new analysis of 3,999 hospitals, and it lands just as Washington moves to rein in a program that has grown into a $244 billion business.[2,3]

The program is called 340B, after the section of federal law that created it. Most people have never heard of it. Yet, if you or someone you love has received an expensive infusion at a large hospital, especially cancer treatment, you may well have helped pay for it.

A Program Built for the Poor

Congress created 340B in 1992 for a narrow purpose. Clinics funded by federal grants, and public hospitals, were required to treat patients whether or not they could pay. A new Medicaid rebate law had just driven up their drug costs, and Congress stepped in so they could keep serving those patients. A 1992 House committee report described the goal as letting them "stretch scarce Federal resources," though, as the Milbank authors note, that language does not appear in the law itself.[4,5]

A 2026 legislative history in The Milbank Quarterly, drawn from 175 internal documents and interviews with people involved in creating the law, found that the hospital eligibility cutoff was chosen as a political compromise to qualify two specific hospitals.[6] The authors concluded that the program's current scope "exceeds Congress's original intent." Today it includes two-thirds of all nonprofit hospitals in the country.[7]

Here is how it works. Drug makers must sell outpatient drugs to participating hospitals and clinics at deep discounts. The hospital then bills insurers and patients the normal price and keeps the difference. The law does not say how that money must be spent.[8]

The 2010 Affordable Care Act opened the program to many more hospitals, and the same year federal guidance let each one sign up an unlimited number of outside pharmacies.[9,10] Growth took off. In 2025, participants bought $100 billion worth of drugs at discounted prices, up from $81.4 billion in 2024 and $16.2 billion in 2016.[11,12]

Hospitals that qualify by serving many low-income patients accounted for $79.2 billion of that 2025 total.[13] The number of participating hospitals and clinics rose 174% between 2013 and 2023, and by April 2026 there were 15,249 of them operating 49,214 sites.[14]

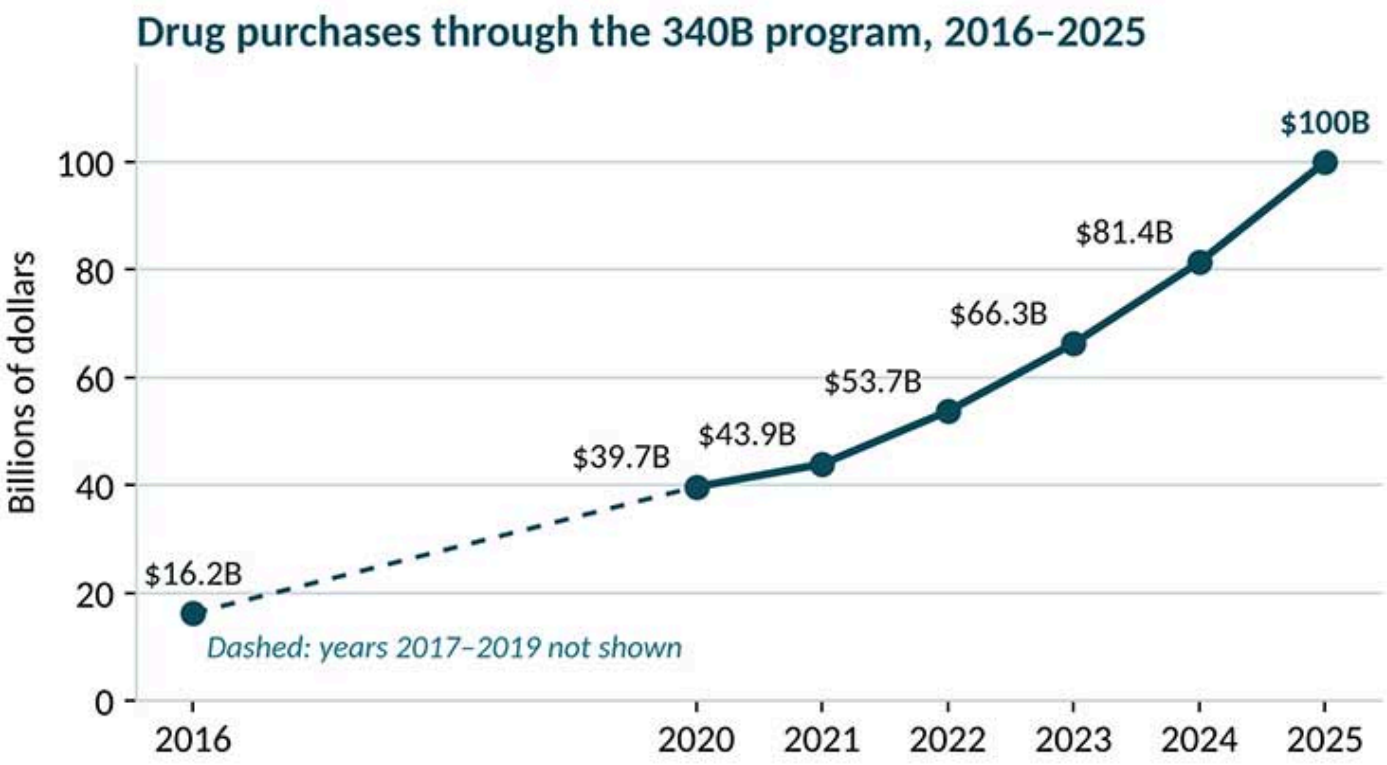

Figure 1. Purchases of outpatient drugs at discounted 340B prices. Data from the Health Resources and Services Administration for 2022 to 2025, from Fierce Healthcare's reporting of agency figures for 2016 and 2021, and from Berkeley Research Group's citation of agency figures for 2020.[15,16,17,18]

Where the Money Goes

The discounted purchase price is only half the story. A Berkeley Research Group analysis estimated that patients and payers spent $244.3 billion on drugs bought through the program in 2025.[19] The hospitals and clinics paid $102.1 billion for those drugs. The remaining $142.2 billion, the margin, stayed with them and their business partners, more than double the margin of 2021.[20] On average the discounted prices were 57% below list price, and some products cost as little as one cent.[21]

That analysis was paid for by the drug industry's trade group, which has an obvious stake in shrinking the program, so read its totals with that in mind. But independent, peer-reviewed research points the same way.

- **The cancer drug example —** A 2026 study published in Health Affairs analyzed Blue Cross Blue Shield insurance claims for 59,717 commercially insured patients who received Keytruda, the top-selling drug in the 340B program, at 5,008 hospitals and physician practices.[22,23]

  Hospitals eligible for 340B discounts billed private insurers an average markup of 173% over what they paid — a figure the researchers calculated from a standard estimate of the 340B discount because the prices individual hospitals actually pay were not available. Hospitals not eligible marked it up 78%. Community physician practices marked it up 16%.[24]

  Each Keytruda patient was associated with $102,680 a year in additional revenue from the markup at an eligible hospital, compared with $67,825 at a hospital not eligible for the program and $3,094 at a physician practice, a figure that was not statistically significant.[25]

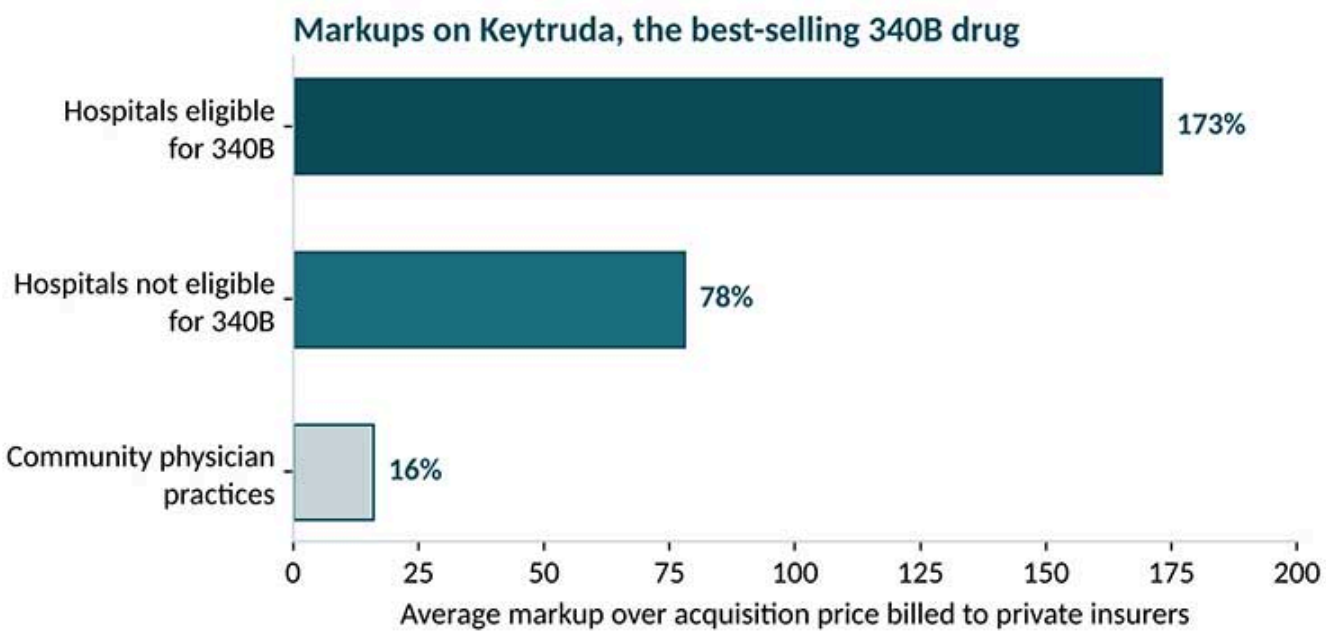

Figure 2. Average markup on Keytruda, the ratio of the price billed to private insurers over the price the provider paid. Data from Robinson and colleagues, Health Affairs, 2026.[26]

- **More treatment where the margin is —** A 2026 study of 2013 to 2018 Medicare claims for 35,334 lung cancer patients and 83,721 breast cancer patients found that exposure to the 340B program was associated with a 10.8 percentage point higher

chance of receiving Medicare Part B cancer drugs, the kind given in a clinic or infusion center, for lung cancer and 14.8 points for breast cancer.[27]

Medicare spent $9,592 more per lung cancer patient and $7,598 more per breast cancer patient among those exposed to the program than among those who were not.[28] The authors said the findings are "consistent with the financial incentives of the 340B program."[29]

Patients feel this directly. When the Centers for Medicare & Medicaid Services surveyed hospital drug costs in early 2026, it found cases where a Medicare patient's 20% coinsurance was more than the entire price the hospital had paid for the drug.[30]

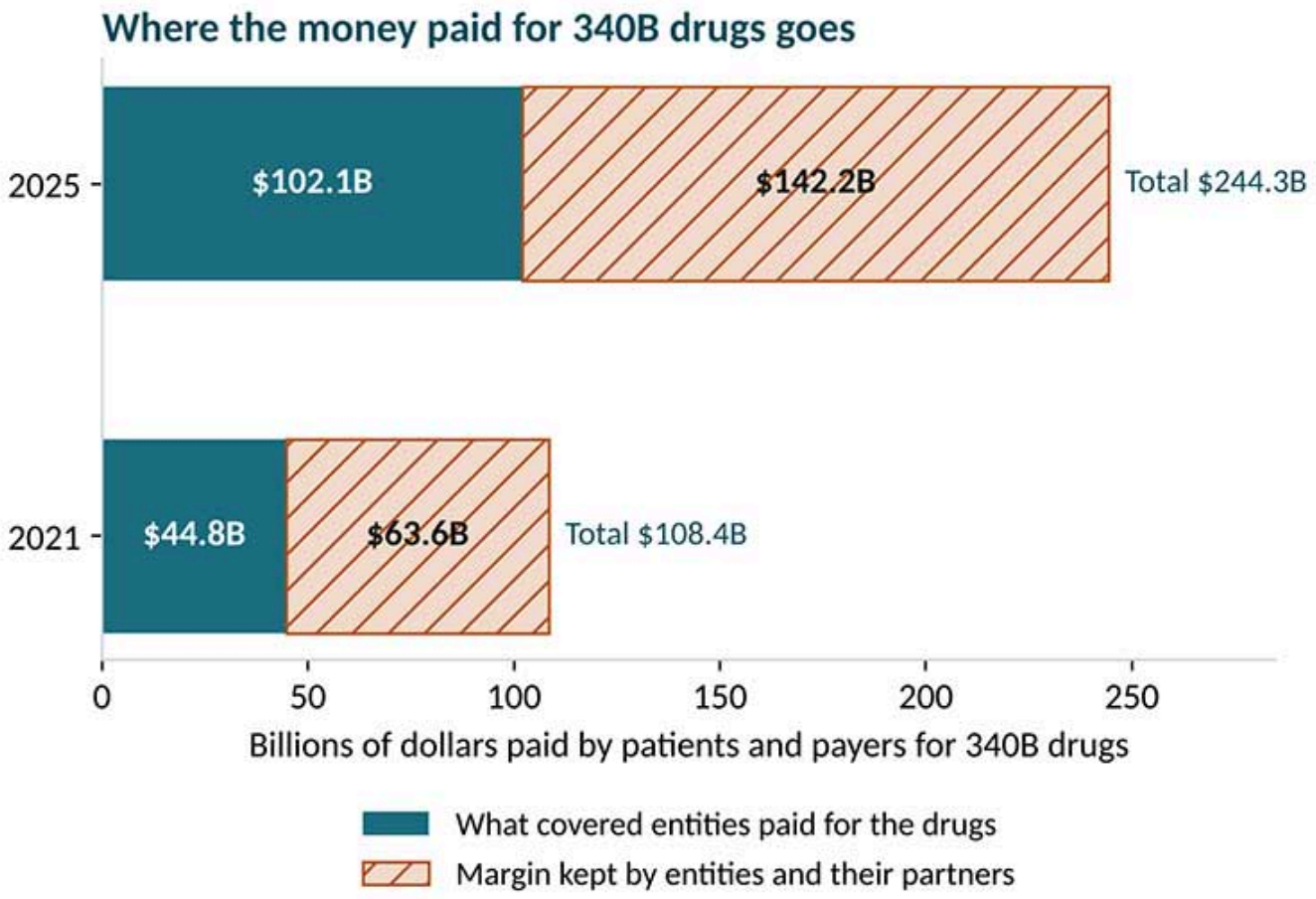

Figure 3. Estimated spending by patients and payers on drugs bought through the 340B program, split into what covered entities paid and the margin kept by them and their partners. Data from Berkeley Research Group, a study funded by the Pharmaceutical Research and Manufacturers of America.[31]

Less Charity, More Expansion

Nonprofit hospitals pay no federal income tax in exchange for benefiting their communities, including free and discounted care for people who can't pay. That makes charity care a fair place to look for where the 340B money goes.

The analysis behind The Epoch Times report, led by researchers at the Pioneer Institute and funded by the patient charity CancerCare, used federal hospital cost report data for 3,999 hospitals.[32] Hospitals in the program spent 2.16% of their operating expenses on charity care, compared with 2.82% at hospitals outside it. For uninsured patients the figures were 1.60% and 2.26%, about 29% lower.[33] Medicaid patients did account for a larger share of hospital days at program hospitals — 19.69% compared with 17.76%.[34]

Two caveats matter. The featured study is a preprint that has not been peer- reviewed, and it compares hospitals at one point in time, so it cannot show that joining the program causes hospitals to give less charity care — something the authors say so themselves.[35,36]

An older federal review of 2016 data found similar charity care, and higher uncompensated care, at program hospitals compared with nonprogram hospitals.[37] What the new data do suggest is that the discount does not consistently translate into more free care for patients who can't pay.

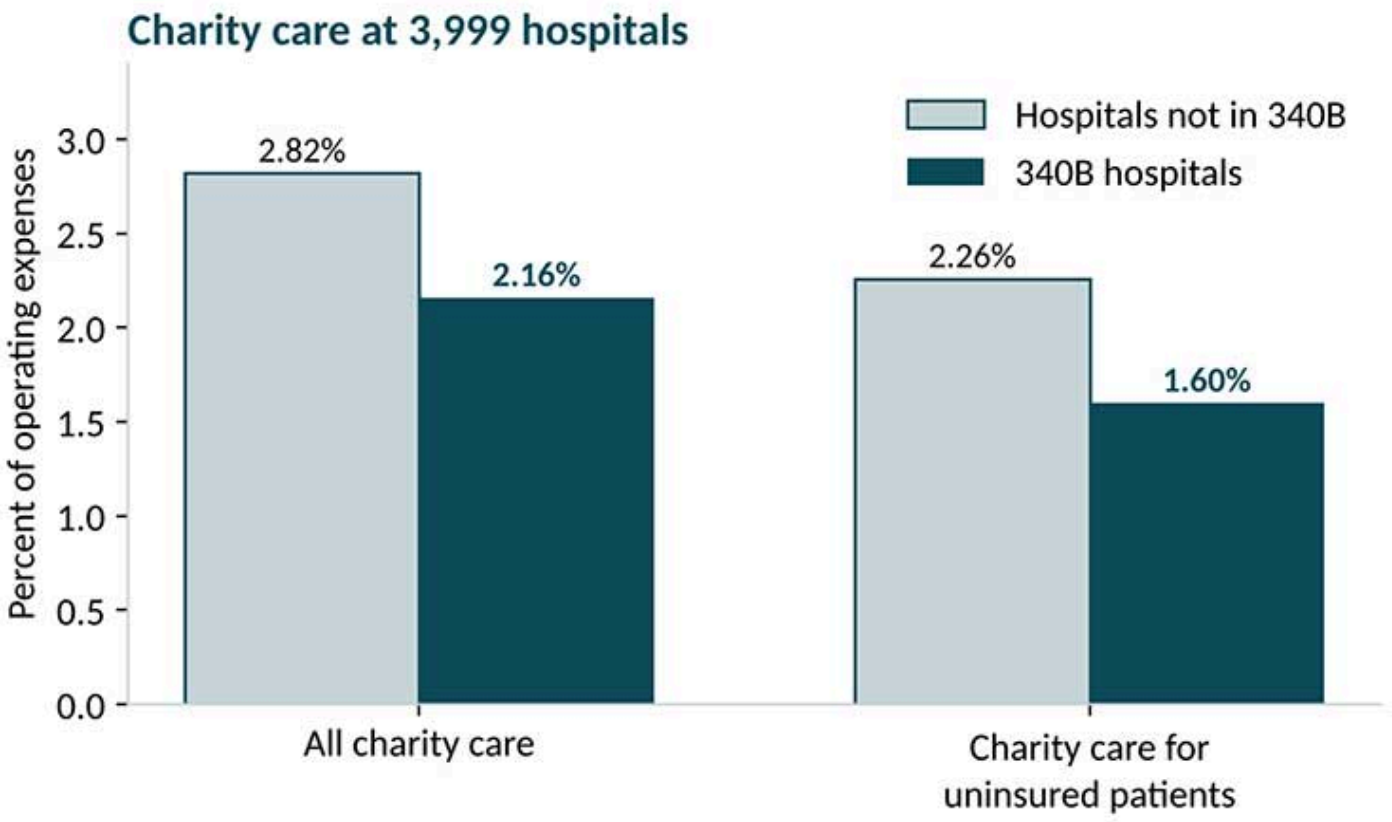

Figure 4. Charity care as a share of operating expenses at hospitals in and outside the 340B program. Data from Popovian and colleagues, a preprint not yet peer reviewed.[38]

So, where does the money go? Hospitals often say it simply becomes revenue. Responding to a Senate inquiry, Bon Secours Mercy Health wrote, "Revenue is revenue." The Cleveland Clinic reported $933.7 million in 340B benefit between 2020 and 2023 and noted that "there is no dollar-for-dollar 'pass on' requirement to patients."[39,40] Several 2026 studies link the program to growth:

- **Consolidation —** An analysis of 2,226 hospitals linked 340B participation to higher hospital market share and recent mergers. Participation was associated with operating margins 1.1 to 3.0 percentage points higher in hospitals that had not merged, and 5.2 to 7.0 points higher in merged hospitals.[41]

- **Off-campus sites —** Medicare claims from 2016 to 2022 showed 340B hospitals delivering a higher and growing share of outpatient care at off-campus sites, which often include physician practices that hospitals have bought and converted.[42]

- **Assets and salaries —** In 2023 cost report data, 340B hospitals had 47.5% greater total assets than comparable non-340B hospitals and spent more on administrative salaries.[43] A federal health department brief put the difference at about $7 million more on average in administrative salaries in 2023 for the largest category of participating hospitals, compared with similar hospitals outside the program.[44]

  Note that some of these studies were funded by Johnson & Johnson or by the National Pharmaceutical Council, which is a drug-industry-supported research group, as their disclosures show.[45,46]

  An independent scoping review found the same pattern in older research: Some studies found hospitals using the revenue to expand care for low-income patients, while others found them buying physician practices and opening sites in wealthier neighborhoods, and poor reporting made it hard to tell which was which.[47]

The Corner Drugstore Cut

In 2010 about 1,300 pharmacies dispensed 340B drugs under contract. By mid-2026 the figure was more than 31,000.[48] Five companies, CVS Health, Walgreens, Walmart, Cigna, and UnitedHealth Group, account for 77% of these contract pharmacies.[49]

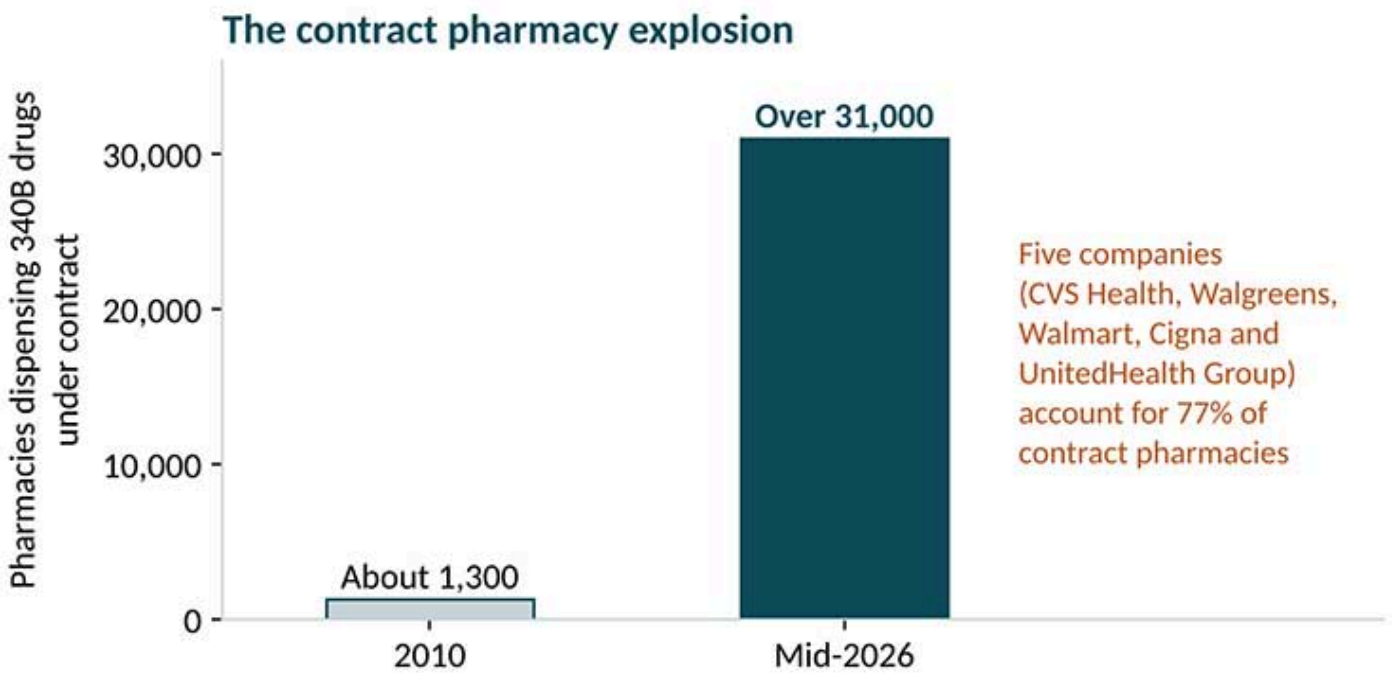

Figure 5. Pharmacies dispensing 340B drugs under contract with hospitals and clinics. Data from the Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, October 2026.[50]

These pharmacies are paid for their role. In contracts the Government Accountability Office reviewed, hospitals and clinics paid flat fees of $6 to $15 per prescription, and some also paid 12% to 20% of the revenue on insured patients' prescriptions.[51] Minnesota, the first state to collect this data, found that for every $100 of gross 340B revenue, about $10 went to outside companies, roughly $137 million in 2024, and that about 80% of net 340B revenue came from drugs paid for by commercial plans and Medicare.[52]

Contract pharmacies have not grown mainly where uninsured patients are. Between 2010 and 2021, the average share of a county's pharmacies dispensing 340B drugs rose from 1.5% to 43.7%, and that growth was higher in counties with more Medicare and Medicaid drug coverage and lower in counties with higher uninsured rates.[53]

Earlier work found hospital contract pharmacy growth was unrelated to local poverty or uninsured rates, while growth tied to safety-net clinics did follow poverty.[54] In Texas, contract pharmacies were located in significantly less vulnerable areas than the hospitals and clinics they worked for.[55]

What the Hospitals Say

The hospitals have a case, and it deserves a fair hearing. The American Hospital Association says 340B hospitals provided nearly $100 billion in community benefits in 2022, a broader measure that counts much more than charity care.[56] Its pharmaceutical policy director told The Epoch Times that charity care is only one way to measure what hospitals do for their communities.[57]

The association's former chief executive, Rick Pollack, has also argued that the program grows because drug makers keep raising prices: the higher the price, the bigger the discount.[58]

Independent researchers have found real benefits too. A 2026 study comparing hospitals just above and below the eligibility cutoff, using 2012 to 2014 data, found that eligibility lowered negotiated commercial drug prices by about 25% overall, an effect concentrated in competitive markets and not significant where one hospital system dominated.[59]

The American College of Physicians credits the program with expanding access for low-income and uninsured patients while calling for transparency about how the savings are spent.[60] And community health centers and HIV clinics, the program's original intended users, run on grant budgets that require them to treat patients whether or not they can pay.[61]

Both sides have a great deal of money riding on this fight. The drug companies pay for the discounts and want them smaller. The hospitals collect the margin and want it protected. Neither side's numbers should be taken at face value, which is exactly why reporting how the money is used matters so much.

Washington Is Finally Moving

In April 2025, the Senate health committee's majority staff concluded that Congress must act and recommended requiring covered entities to report how they use their 340B savings.[62] Two federal changes are aimed at January 1, 2027.

- **A Medicare payment cut —** The Centers for Medicare & Medicaid Services has proposed paying hospitals for 340B drugs at their average sales price minus 33.4%, down from the current average sales price plus 6%, based on its new survey of what hospitals actually pay.[63] The agency estimates this would cut Medicare drug payments by $4.55 billion and patients' out-of-pocket costs by $1.15 billion in the first year.[64]

  An earlier version of this cut was struck down by the Supreme Court in 2022 because the agency had not first surveyed costs.[65] Under budget rules, the savings would be redistributed to other outpatient services, so safety-net hospitals would

lose while some for-profit hospitals would gain.[66] The rule is not yet final.

- **A rebate pilot —** The Health Resources and Services Administration plans to make hospitals pay full price up front for certain drugs, then claim the discount as a rebate after submitting claims data.[67] A federal court in Maine blocked an earlier version in December 2025.[68] On October 9, 2026, the American Hospital Association, the Maine Hospital Association, and four safety-net hospitals sued to stop the new version, arguing that administrative costs alone could exceed $1 billion a year.[69]

How to Put This Together

You can't fix federal drug policy from your kitchen table, but you can protect yourself and your family.

- **Find out whether your hospital is in the program —** The government's public 340B database lets you search covered entities by name.[70]

- **Use the financial assistance policy —** Every tax-exempt hospital must have a written financial assistance policy covering emergency and medically necessary care, and must make it widely available, including on its website and in its emergency room and admissions areas.[71] If money is tight, ask for the application before you are billed, not after.

- **Ask where an infused drug will cost you least —** For Keytruda, the markup at community physician practices averaged 16%, compared with 173% at 340B-eligible hospitals.[72]

  If your plan charges coinsurance as a percentage, where you receive an infusion can change what you pay. Before treatment starts, ask your insurer to price the same drug at each available site, and ask your oncologist or care team whether a different site is appropriate for you.

- **Ask for an itemized bill —** Look closely at drug charges, and question anything you don't understand.
- **Tell your representatives you want reporting —** The simplest reform, supported by the Senate committee's report and by the American College of Physicians, is requiring hospitals to show how much they receive from the program and where it goes.[73,74]
- **Build the health you can control —** Nutritious food, daily movement such as an hour of walking, regular sun exposure, and restorative sleep support your overall health and may reduce how often you need costly medical care. These habits don't replace treatment when you need it, and they won't change what a hospital charges, but they are the part of your health you control most directly.

The Bottom Line

The 340B program began as a lifeline for clinics that treat people with nowhere else to go. It has become a $100 billion purchasing stream, with an estimated $142 billion margin, flowing mostly to hospitals, with a share going to pharmacy chains and other partners, and no federal rule requires anyone to show where the money ends up.[75,76]

Some hospitals use it well. Others use it to grow. Until hospitals have to report what they receive and how they spend it, patients have no way to tell the difference, and that is the reform that matters most.

This article is for informational purposes only and does not constitute medical advice. Consult a qualified health care provider before making changes to your health regimen.

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