



**TESTIMONY**

# **Growth in the 340B Drug Pricing Program and Its Implications for the Federal Budget**

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Health, Education, Labor, and Pensions

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Chairman Cassidy, Ranking Member Sanders, and Members of the Committee, thank you for inviting me to testify today. My remarks summarize the Congressional Budget Office’s recent report about the 340B Drug Pricing Program.<sup>1</sup> That report examines trends in drug purchases through the program from 2010 to 2021, the factors driving those trends, and the implications for the federal budget.

## What the 340B Program Does

The 340B program requires pharmaceutical manufacturers to sell outpatient drugs at discounted prices to eligible health care facilities. Those facilities include hospitals that treat a large share of patients with low income and federally supported clinics and specialized programs.

Participating facilities buy drugs at discounted prices but typically receive larger reimbursements from public and private insurers. The resulting difference generates net revenues. Facilities may use those revenues to expand services, but the program statute does not specify how 340B revenues must be used—for example, it does not restrict their use to services for patients with low income.

The Health Resources and Services Administration (HRSA) administers the 340B program. In 2021, roughly 50,000 facilities participated. HRSA also contracts with a “prime vendor” to manage distribution, negotiate discounts, and support participating facilities. About 90 percent of facilities that participated in the 340B program also participated in HRSA’s Prime Vendor Program.

## Growth in 340B Spending

In 2021 dollars, facilities participating in the Prime Vendor Program spent \$43.9 billion in 2021, up from \$6.6 billion in 2010. That represents an average annual growth rate of 19 percent. By contrast, marketwide spending on brand-name drugs grew by about 4 percent per year during the same period.

In 2021, spending through the 340B Prime Vendor Program accounted for 11 percent of all net drug spending nationwide. Hospitals and their affiliated outpatient clinics represented 87 percent of 340B spending that year. Federally qualified health centers, Ryan White HIV/AIDS clinics, and specialized clinics accounted for the remaining 13 percent.

Drug purchases were concentrated in a few therapeutic areas. Cancer drugs made up the largest share—41 percent of all 340B purchases in 2021. Anti-infective drugs, including treatments for HIV and hepatitis C, and immunosuppressants accounted for most of the remainder.

## Factors That Contributed to Growth in the 340B Program Over the 2010–2021 Period

CBO estimates that about one-third of the increase in 340B spending from 2010 to 2021 reflects overall growth in prescription drug spending, particularly in classes such as cancer and anti-infective drugs.

CBO examined three factors that contributed to the remaining two-thirds of the increase in spending through the 340B program. First, the integration of hospitals and off-site clinics (known as vertical integration) from 2010 to 2021 led to more facilities becoming eligible. Second, the enactment of the Affordable Care Act expanded facility participation. Third, a 2010 change in program guidance allowed hospitals to contract with multiple off-site (or contract) pharmacies, enabling participating facilities to increase the share of prescriptions for which they receive a 340B discount.

CBO does not have sufficient data to quantify the effects of those factors. In the agency’s assessment, however, the integration of hospitals with off-site outpatient clinics is the factor that contributed the most to the growth in 340B drug purchases.

## Implications for the Federal Budget

In CBO’s assessment, the 340B program encourages behaviors that tend to increase federal spending, although the magnitude of their effects is uncertain. (CBO has not estimated how legislation affecting those behaviors would alter federal spending.) The behaviors include the following:

- **Prescribing More and Higher-Priced Drugs.** Facilities have financial incentives to prescribe more drugs and to shift prescriptions to drugs for which the difference between insurance reimbursement and the 340B discounted price is large. Increasing prescription volume results in higher spending on drugs by federal insurers and in larger federal subsidies for insurance premiums. To the extent to which drugs that generate greater net revenues are also more expensive, shifting prescription volume to those drugs also results in higher federal spending.

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1. Congressional Budget Office, *Growth in the 340B Drug Pricing Program* (September 2025), [www.cbo.gov/publication/60661](http://www.cbo.gov/publication/60661).

- **Reducing Manufacturer Rebates to Insurers.** For drugs that are purchased at 340B prices, manufacturers may limit rebates offered to Medicare Part D, Medicare Advantage, or commercial plans. That dynamic raises costs for insurers and, in turn, the federal government through larger subsidies for insurer premiums and larger federal outlays for Medicaid and Medicare.
- **Expanding Services.** Facilities may use revenues generated by the program to establish new clinics or offer more comprehensive care, some of which is reimbursable by federal programs.
- **Increasing Vertical Integration.** Vertical integration of hospitals and off-site clinics generally increases the prices that commercial insurers and Medicare pay. In CBO's assessment, the 340B program is one of several factors that incentivize the integration of hospitals and off-site clinics. To the extent that the program amplifies those incentives, it increases federal spending.

In some cases, insurers may reduce their reimbursement rates for drugs purchased through the program. Lower rates reduce federal spending, but the effects of any such reductions are probably small and only partially offset the effects that increase federal spending.

In keeping with the Congressional Budget Office's mandate to provide objective, impartial analysis, this testimony makes no recommendations.

Aditi Sen prepared the testimony with guidance from Tamara Hayford and Chapin White. Ravza Aykan fact-checked the testimony.

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