

# Concentration of 340B Program Expansion Among Hospitals of Varying Size: A Retrospective Analysis, 2017-2023

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## Background

- The 340B Drug Pricing Program (340B) allows eligible hospitals and clinics to purchase outpatient drugs at deeply discounted prices<sup>1</sup>
- Established in 1992, 340B was intended to help a narrow set of safety-net providers improve access to medications for uninsured and indigent patients, but has since transformed into the second-largest federal drug program, with 2024 340B purchases reaching \$147.8 billion at list price (up from \$53.8 billion in 2018)<sup>2</sup>
- Two major structural dynamics have led to substantial 340B growth in recent years<sup>3</sup>:

1. Hospitals' 340B expansion through child sites	Hospitals integrate off-campus outpatient facilities that are registered under a hospital's 340B identifier (such as satellite oncology clinics, urgent care centers, orthopedic clinics, etc.)
2. Hospitals' 340B expansion through contract pharmacies (CPs)	Hospitals contract with third-party off-site pharmacies (mostly for-profit national chains) <sup>4</sup> which can then apply 340B pricing to eligible prescriptions filled at that pharmacy

- While 340B provides participating hospitals with substantial margin opportunities, how (and whether) these advantages translate into meaningful patient or population health benefits is uncertain and actively contested in 340B policy discussions<sup>5-7</sup>
- Prior research suggests that the program raises overall healthcare costs, in part by incentivizing hospital consolidation,<sup>1,3</sup> and that expansion via satellites/CPs has largely been driven by profit opportunities, often concentrating growth in more affluent, healthier neighborhoods rather than lower-income communities with greater healthcare needs<sup>8,9</sup>
- Against the backdrop of calls for 340B reform, it is important to ask which hospital types are most engaged in the program's structural growth and how participation patterns have evolved in recent years

## Research Objective

- To quantify how 340B's structural expansion has been concentrated across hospital types by measuring growth in child sites and contract pharmacy (CP) relationships, stratified by hospital size and teaching status

## Methods

### Study Design and Data Source

- Retrospective observational analysis using the Health Resources and Services Administration's Office of Pharmacy Affairs Information System (OPAIS), with quarterly extracts from Q4 2017 through Q4 2023<sup>10</sup>
- Data included all 340B hospitals, including those continuously active throughout 2017 to 2023, as well as 340B hospitals that entered the program during 2017 to 2023
- Hospitals were classified by size and teaching status using Medicare cost reports
  - Size was defined using quartiles based on 2023 hospital bed counts within the analytic sample: Q1 represents the smallest 25% of hospitals by bed count and Q4 represents the largest 25% (top quartile); Q2 and Q3 represent the middle two quartiles (25th-50th and 50th-75th percentiles)
  - "Major teaching" hospitals were identified as a distinct category using the Medicare designation; notably, most major teaching hospitals are academic medical centers (AMCs) and almost all AMCs fall within the major teaching category<sup>11</sup>

### Key Measures

- Structural 340B expansion was captured using hospital (covered-entity)-level counts of child sites and active CP relationships
- Hospital growth was defined as the change in the number of child sites and active CP relationships from Q4 2017 to Q4 2023
- Changes were summarized and compared across bed size quartiles and teaching status

### Limitations

- Child site and CP relationship counts captured structural drivers of hospitals' 340B growth; this study did not measure changes in 340B sales volume or drug mix
- OPAIS records may be inaccurate, outdated, or subject to timing lags, which creates residual misclassification risk even after cleaning
- Misclassification risk can be higher for teaching hospitals due to provider-based reclassifications; rotating resident clinics; research/mixed-use settings; Medicaid/CP carve-in/carve-out controls; and lags between operations, cost reporting, and OPAIS updates that can mask true eligibility

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## Results

### Hospitals Participating in 340B (2017-2023)

- Among continuously participating 340B hospitals between 2017 and 2023 (n = 1844), 44% were in the smallest bed size quartile (Q1; 818 hospitals; mean, 22 beds), 9% in Q2 (169; mean, 46 beds), 13% in Q3 (244; mean, 120 beds), and 33% were in the largest quartile (Q4; 613; mean, 448 beds)
- 340B hospitals expanded child sites and CP relationships across all size cohorts, adding ~4 child sites on average (11.0-15.3; ~38% growth) and ~22 active CP relationships (13.7-35.8; ~162% growth) during the study period (Figure 1)
- The largest hospitals (Q4; top 25% by bed count) added ~10 child sites on average (from 25.1-35.4) and nearly ~40 active CP relationships (from 29.1-69.0)
- Accounting for only one-third of participating hospitals, the largest hospitals drove a disproportionate share of 340B expansions and were responsible for 81% of added child sites and 60% of added CP relationships (Figure 2)

Figure 1. Added Child Site and CP Relationships by Hospital Size for Continuous 340B Participants Between 2017-2023

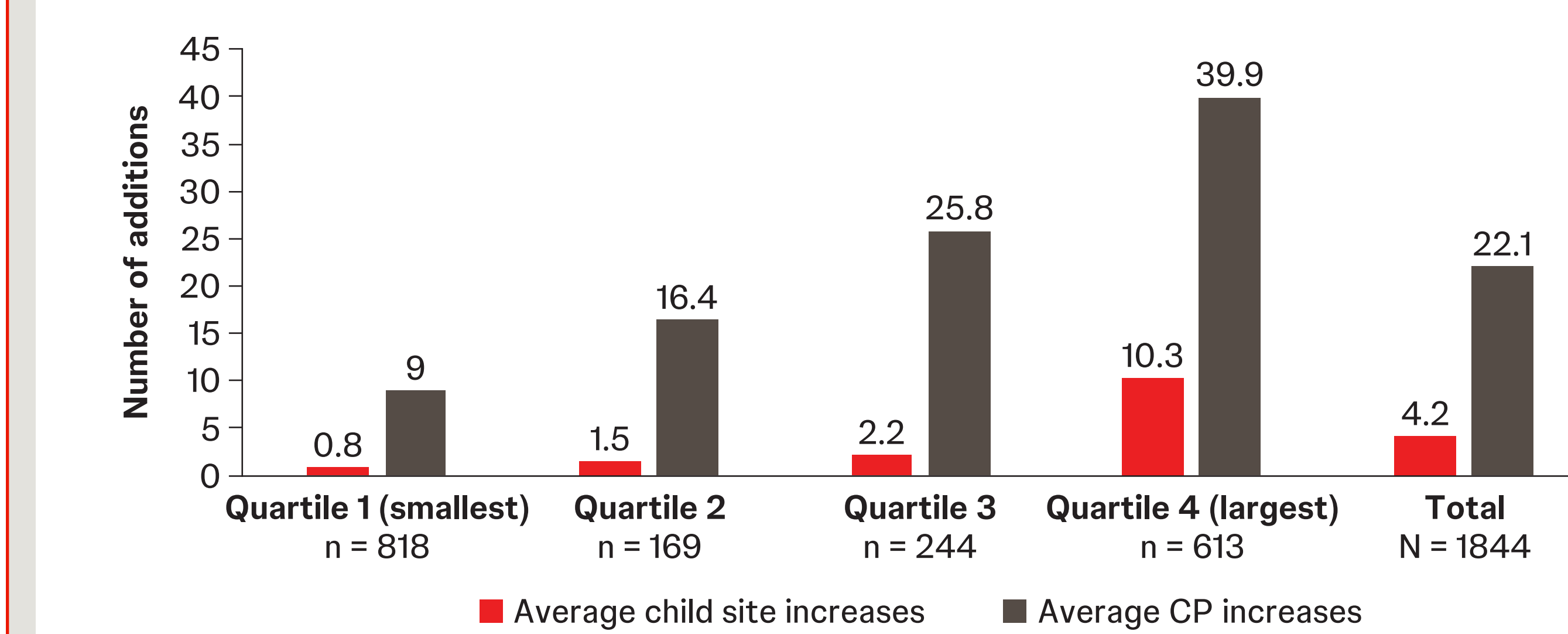
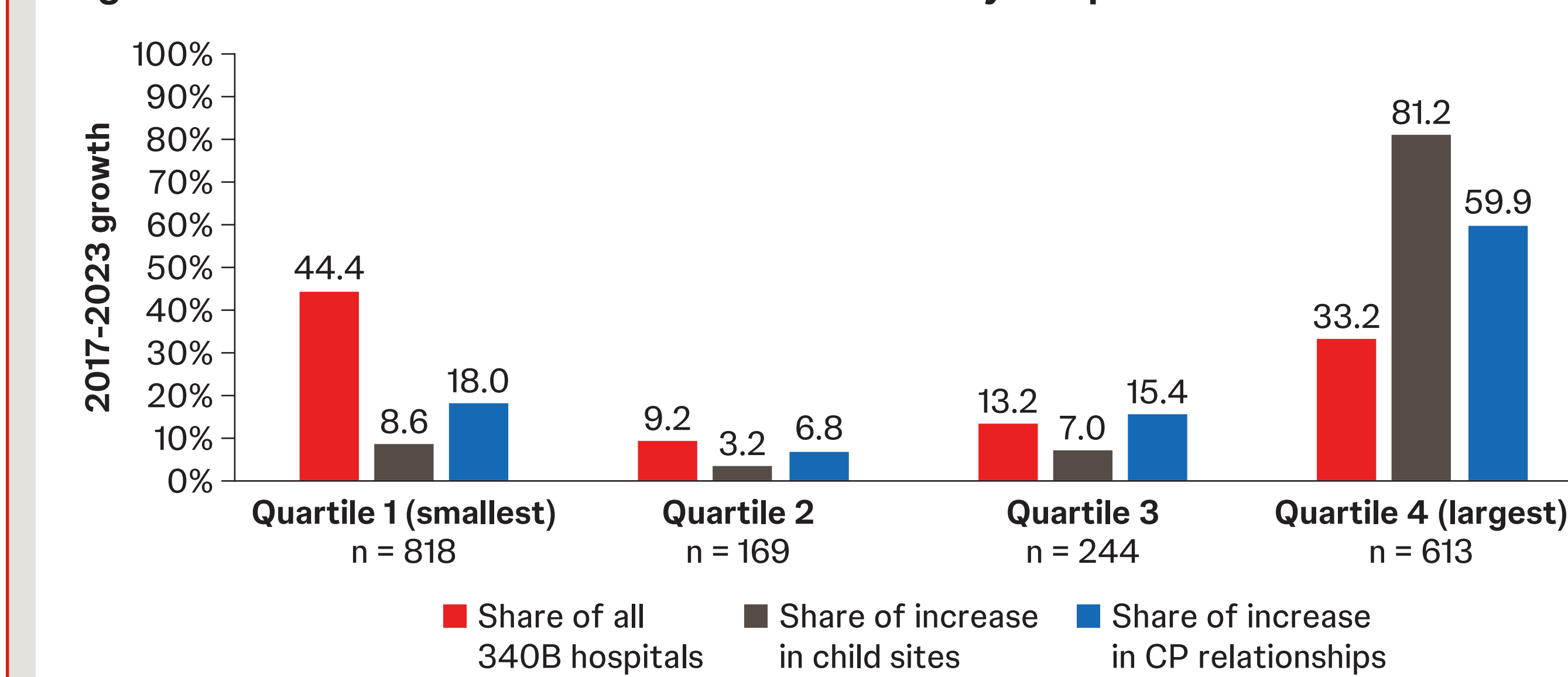


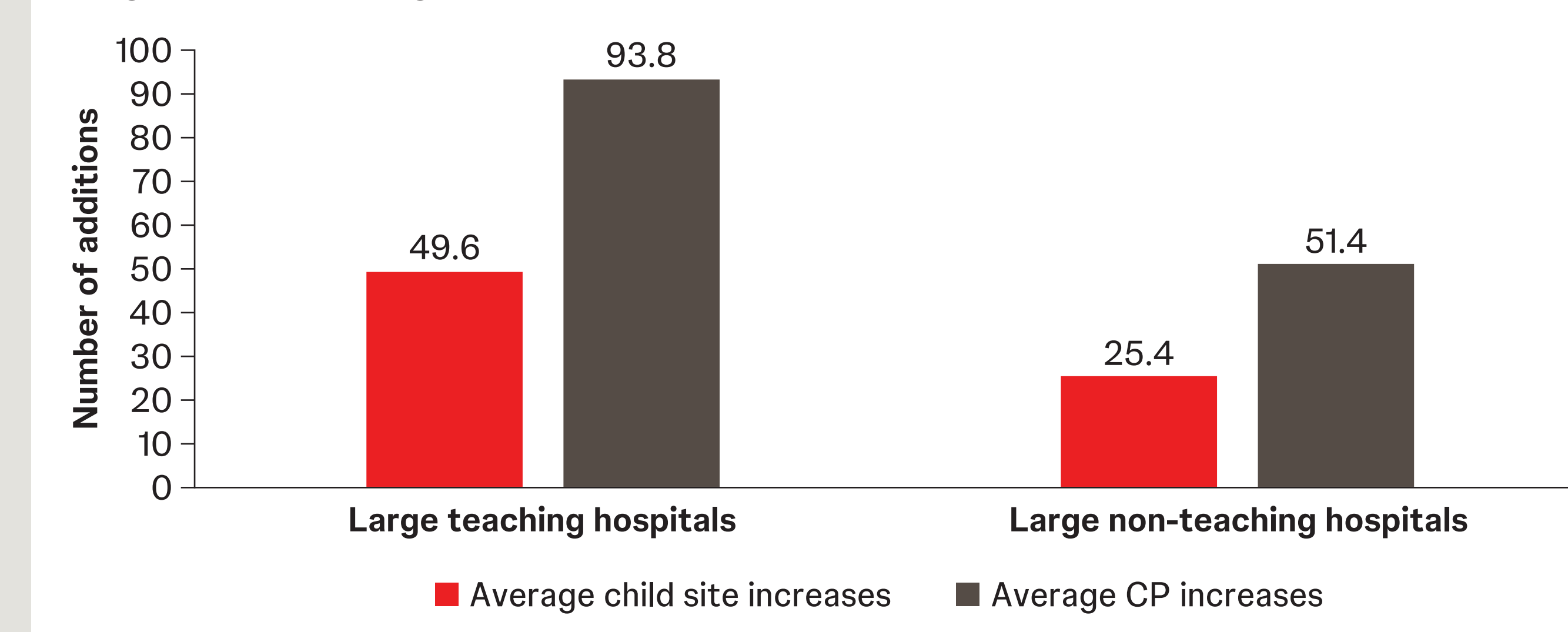
Figure 2. Relative Contribution to 340B Growth by Hospital Bed Size



### Hospitals by Teaching Status

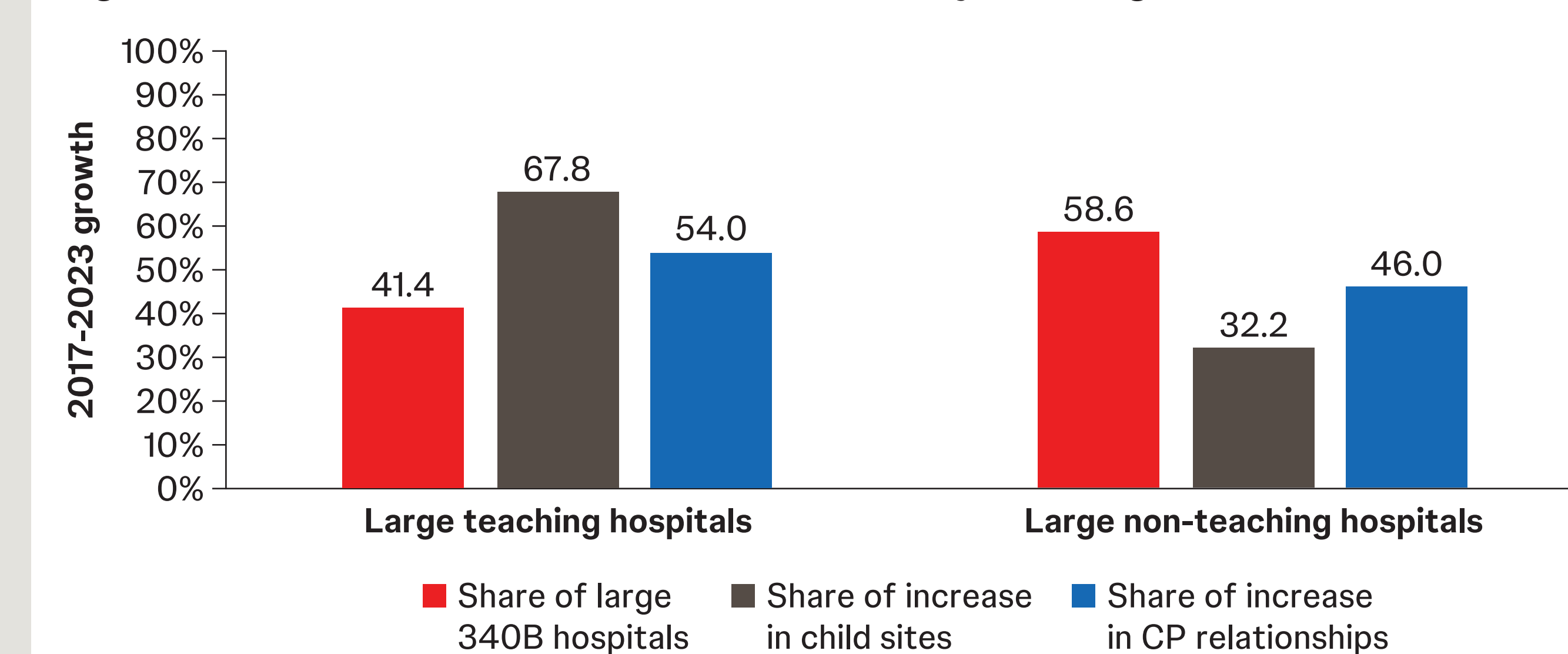
- As teaching hospitals are predominantly very large, teaching-status comparisons were restricted to 340B hospitals in the highest bed size quartile (Q4; n = 613), thus comparisons were made between major teaching hospitals (n = 254; mean, 532 beds) and large non-teaching hospitals (n = 359; mean, 388 beds)
- Major teaching hospitals started with higher baseline participation and experienced larger absolute growth from 2017 to 2023
  - Major teaching hospitals added 16.9 child sites on average (32.8-49.6; +51.5%) versus 5.7 among large non-teaching hospitals (19.7-25.4; +28.7%)
  - Major teaching hospitals added 51.9 active CP relationships on average (41.9-93.8; +124%) versus 31.3 among large non-teaching hospitals (20.1-51.4; +156%; Figure 3)
- Differences by teaching status exceeded what would be implied by bed size differences alone. By 2023, major teaching hospitals averaged nearly twice as many child sites (49.6 vs 25.4) and ~80% more CP relationships than large non-teaching hospitals (93.8 vs 51.4; Figure 3)
  - The child site disparity by teaching status also widened over time. Major teaching hospitals already averaged ~66% more child sites versus non-teaching hospitals in 2017, but the gap increased to ~95% by 2023

Figure 3. Added Child Site and CP Relationships for Large Teaching Hospitals and Large Non-Teaching Hospitals Between 2017-2023



- While major teaching hospitals represent ~41% of the largest hospital cohort, they contributed a disproportionate share of aggregate growth, with approximately 68% of total child-site additions and ~54% of total CP additions in that cohort (Figure 4)

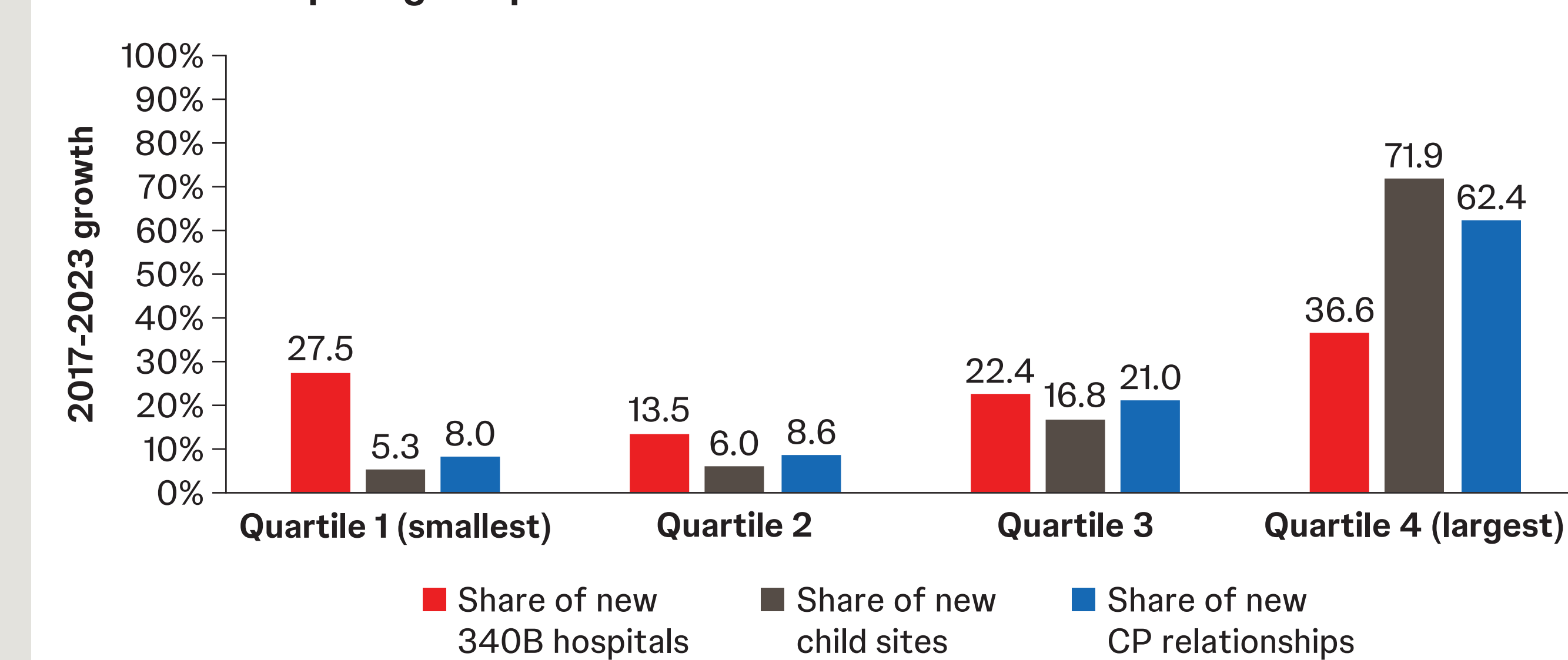
Figure 4. Relative Contribution to 340B Growth by Teaching Status From 2017-2023



### Newly Joined 340B Participants

- 340B has also continued to grow through new participants each year, with 415 hospital-covered entities joining the program between 2017 and 2023
- Among new entrants, the largest 340B hospitals dominated expansion via new child sites and CP relationships
  - Q4 hospitals (largest 25% by bed count) accounted for 72% of new child sites and 62% of new CP relationships despite representing only 37% of newly joined hospitals (Figure 5)
  - By contrast, Q1 hospitals (smallest 25% by bed count) represented 28% of newly joined hospitals but only 5% of new child sites and 8% of new CP relationships
  - Taken together, these patterns suggest that hospitals of all sizes enter 340B, but a minority of large entrants is responsible for the majority of the growth in child sites and CPs

Figure 5. Share of Hospitals, Child Sites, and CP Relationships for Newly Joined 340B-Participating Hospitals From 2017-2023



## Discussion

- The Congressional Budget Office recently linked 340B growth to hospital integration with offsite clinics, expanded facility participation, and increased CP use<sup>3</sup>
  - Our findings show that these trends are concentrated among large hospitals and disproportionately among large teaching institutions
- Dominance of large entities with superior resources may leave small rural hospitals and independent community health providers, who often operate on thin margins,<sup>12</sup> at a persistent disadvantage
  - With respect to CP relationships, this presents additional ramifications since prescription attribution is governed by opaque third-party administrator agreements rather than transparent standards. When patient definitions broaden without a clear care nexus, attribution may favor well-resourced systems (using superior data feeds, stronger information technology integration, and comprehensive prescriber-affiliation capture) at the expense of smaller providers

## Conclusions

While 340B reform debates often highlight concerns about small safety-net providers' access to discounted 340B pricing, much of the recent program growth that is drawing public scrutiny has been driven by large, generally well-resourced hospitals

This study supports prior research that concluded that stronger oversight and accountability are needed to realign 340B with its original mission to benefit vulnerable patients

Results raise the question whether, absent substantial reform, 340B growth will continue to concentrate among the largest systems and accelerate consolidation, with cost implications for public payers, employers, and patients

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