



ISSUE BRIEF

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ESI Payments to 340B Hospitals are Multiples Higher than Their Estimated Acquisition Costs

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An HCCI analysis [found a growing proportion of drug administrations were provided in 340B participating hospital outpatient departments between 2018 and 2022](#). This pattern was accompanied by a declining proportion of drug administration provided in physician offices. The analysis found that, among people with employer-sponsored insurance, 340B hospitals received higher reimbursement for blood-cancer oncology drugs than non-340B hospitals and physician offices. At the same time, the 340B Drug Pricing Program offers those hospitals lower drug-acquisition costs.

Because drug-acquisition costs by hospitals are not publicly available, it is difficult to quantify the difference between reimbursed amounts and prices paid to purchase the drug. That gap substantially affects the financial incentives associated with the 340B program. Therefore, this brief compares reimbursement amounts to estimated drug-acquisition costs.

To begin to assess this difference, we estimated the acquisition costs for three drugs: 1) Darzalex® (generic name: daratumumab), 2) Neulasta® (generic name: pegfilgrastim), and 3) Remicade® (generic name: infliximab) based on median billed units in Medicare FFS data and information from a [Department of Health and Human Services Office of Inspector General report](#). In estimating the acquisition cost, we did not explicitly account for the [Medicare Part B drug reimbursement policy of 106% of Average Sales Price \(ASP\)](#) because ESI reimbursement does not necessarily follow CMS reimbursement policy. This analysis is limited to 340B-hospital participants and excludes 340B federal grantee participants, such as Ryan White HIV/AIDS Program grantees or federally qualified health centers (FQHCs).

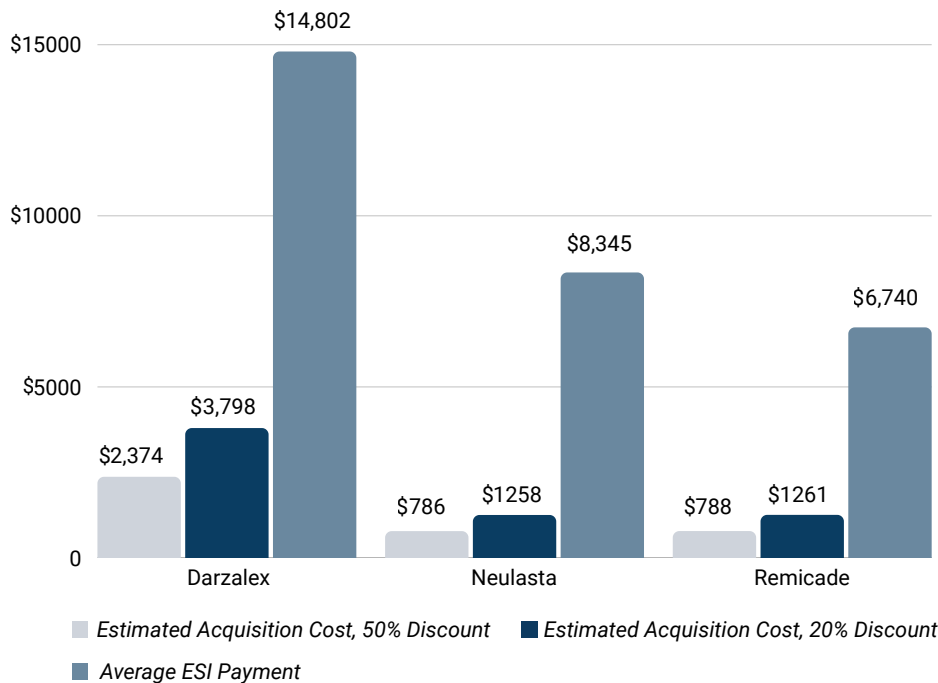
As shown in Figure 1, we estimate that ESI payments to 340B hospitals for Darzalex® administration ranged between 3.9 and 6.2 times what they paid to purchase the drug. We estimated that 340B hospitals paid between \$2,374 and \$3,798 for an average administered dose of Darzalex®. In 2022, 340B hospitals received an average ESI payment of \$14,802. Average Medicare FFS reimbursement for Darzalex® ranged between 1.9 and 2.9 times the estimated acquisition costs.

We estimate that ESI payments to 340B hospitals for Neulasta® are between 6.6 times and 10.6 times the estimated acquisition costs. Specifically, we estimate that 340B hospitals paid between \$786 and \$1,258 for an average administered dose of Neulasta®.

In 2022, ESI payment to 340B hospitals for an average administered dose averaged \$8,345. Non-340B hospitals, in contrast, paid more to acquire Neulasta® and received lower reimbursement. We estimate payments to non-340B hospitals were nearly 5 times the estimated acquisition cost. Medicare FFS reimbursement to 340B hospitals was substantially closer to estimated acquisition costs (between 1.6 and 2.6 times).

For Remicade®, we estimate 340B hospitals receive between 5.4 and 8.6 times what they paid to purchase the drug. We estimate that 340B hospitals paid between \$788 and \$1,261 for an average administered dose of Remicade®. In 2022, those hospitals received ESI payment of \$6,740, on average. Payments to non-340B hospitals for Remicade® were approximately 4 times estimated acquisition costs. As with Neulasta®, Medicare FFS payments were between 1.9 and 3 times estimated acquisition costs.

Figure 1: 340B ESI Payments Compared to Estimated Acquisition Cost



The growing share of drug administration at hospital outpatient departments, especially among 340B hospitals, is contributing to higher health care spending and health insurance premiums. Higher reimbursement prices at hospital outpatient departments also have a direct and growing impact on patients through cost sharing. A [recent CBO report](#) found that financial incentives, including the difference between reimbursement and acquisition cost, attributed to 340B program is one of many factors that can incentivize vertical integrations of health systems. Proposals, such as site neutral payment, which reimburses providers at the same rate regardless of site of care, can address the out-of-pocket burdens and shift financial incentives away from greater concentration in outpatient services and consolidation.

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ABOUT HCCI

The Health Care Cost Institute is an independent, non-profit research institute. HCCI's mission is to get to the heart of the key issues impacting the U.S. health care system by using the best data to get the best answers. HCCI stands for truth and consensus around the most important trends in health care, particularly those economic issues that are critical to a sustainable, high-performing health system. Our values are simple: health care claims data should be accessible to all those who have important questions to ask of it. Health care information should be transparent and easy to understand. All stakeholders in the health care system can drive improvements in quality and value with robust analytics.