POLICY BRIEF

Temple University
Beasley School of Law

Center for
Public Health Law
Research

Patient Affordability and Debt Collection Policies at 340B Program Hospitals

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Executive Summary

The 340B Drug Pricing Program provides participating hospitals with access to steep discounts on outpatient medicines, but hospitals are not required to report how those savings are used or whether they directly reduce costs for patients. To better understand patient affordability protections at participating hospitals, researchers at the Center for Public Health Law Research at Temple University Beasley School of Law analyzed financial assistance policies (FAPs) and debt collection policies from a national sample of 75 high revenue-generating 340B hospitals as of July 1, 2026.

Key findings:

- **Free-care eligibility varies widely.** More than half of all 340B hospitals (46) in the sample limited free care to patients below 300% of the federal poverty guidelines (FPGs).
- **Financial assistance can be difficult to access.** Thirty-one hospitals explicitly required asset tests to establish eligibility.
- **Hospital policies often allow the use of aggressive debt collection measures.** Among hospitals with available policies, 53% did not specify any limits on the use of extraordinary collection actions (ECAs) such as liens, lawsuits, foreclosures, or reporting debt to collection agencies, and only 13 hospitals explicitly prohibited the use of ECAs.
- **Most hospitals do not publicly describe prescription drug affordability assistance and some refer patients to manufacturer assistance.** Despite participating in the 340B program, which provides discounts on outpatient medicines, 83% of hospitals did not include information about prescription drug assistance in their financial assistance policies. Of the 13 hospitals that provided any details, five hospitals specifically reference helping patients utilize manufacturer-provided copay assistance programs pay for their medicines.

The analysis found substantial variation in affordability protections, debt collection practices, and prescription drug assistance among large 340B hospitals, highlighting the need for greater transparency and patient-centered accountability in the 340B program.

Introduction

Affordability of health care continues to be a major issue for patients in the United States as they seek to access care amid continuing economic uncertainty and structural challenges. The high cost of health care in the United States often leads people to forgo that care and their medicines.[1] With continuing financial barriers preventing access to care, it remains essential to better understand the mechanisms that may support cost reductions for patients. This policy brief updates our previous report from May 2022[2] with new cross-sectional data, including elements of 75 U.S.-based 340B hospitals' patient FAPs and related debt collection policies as of July 1, 2026.

Section 340B of the Public Health Service Act establishes a drug pricing program that requires pharmaceutical manufacturers to offer qualifying hospitals and clinics covered outpatient drugs at or below a statutorily-set ceiling price.[3,4] The program was intended to help certain hospitals and clinics access discounted medicines to treat low-income or otherwise underserved communities.[5] Participating hospitals acquire drugs at discounted prices while receiving reimbursement from public and private insurers, as well as cash-pay patients, at rates that usually exceed the hospitals' acquisition costs, generating substantial financial benefits. Under the 340B program, hospitals may use these benefits to expand their existing services for patients with low income by allowing the hospital to pass along cost savings on pharmaceuticals to patients, among other service expansions.[6] However, there is no specific requirement in the law that hospitals' savings from the discount program be passed along to patients or reinvested in providing more free or discounted care, often referred to as charity care, or otherwise expanding access for low-income patients. Free care is defined as a 100% discount on services, while discounted care refers to a partial discount on services.[7]

340B program participation for certain private, non-profit hospitals is partly contingent on those hospitals contracting with state or local governments to provide health care services to people with low income who are not eligible for Medicare or Medicaid. However, those contracts are not consistently submitted to the Health Resources and Services Administration (HRSA), and are often unclear or missing, according to a December 2019 report by the US Government Accountability Office (GAO).[8] Further, an October 2021 study suggests that hospitals participating in the 340B program have not increased their charity care offerings compared to non-340B hospitals, due in part to a lack of specific incentives to do so.[9] An October 2025 GAO report on the 340B program described persistent issues with HRSA oversight, including weaknesses in the oversight of hospital eligibility that "may allow noneligible hospitals to participate in the 340B Program."[10] These gaps highlight a need for objective analysis to determine how effectively hospitals' 340B program savings are benefitting or actually being passed on to patients.

340B hospitals' FAPs provide a lens to evaluate patient affordability.[11] FAPs generally describe hospital financial assistance for eligible healthcare services and may or may not address assistance with prescription medicines or other pharmaceutical costs. While FAPs do not capture every mechanism through which hospitals may support patient affordability, they provide one of the few publicly available sources for evaluating the affordability protections 340B hospitals provide to their patients. FAPs are meant to increase transparency for patients seeking financial assistance, and related debt collection policies are meant to explain protections for patients unable to afford their medical care at hospitals. All non-profit hospitals, including 340B hospitals, are required under the Affordable Care Act to maintain and publicize written FAPs, including records of the actions the hospital may take if a patient is unable to pay for care. The elements in these policies, referred to in Internal Revenue Service (IRS) regulations,[12,13] provide a framework for analysis:

1. Indication of which providers, products, and services the FAP applies to in relevant hospital facilities
2. Eligibility criteria for financial assistance and whether such assistance includes free or discounted care
3. Method for applying for financial assistance
4. Basis for calculating amounts charged to patients that qualify for financial assistance
5. In the absence of a separate billing and collections policy, the actions that may be taken in the event of patient nonpayment

Each element can impact a patient's experience navigating financial assistance. The specifics of these elements may differ from state to state, as the federal standards, while providing a baseline, are silent on certain finer details (e.g., a lack of a mandatory minimum for eligibility criteria). States can, and have in numerous instances, passed laws filling in some of those gaps in the federal regulation, mandating stronger FAP and related debt collection protections than those set at the federal level.

For example, New Jersey and Rhode Island mandate that a 100% discount be provided for residents at or below 200% of federal poverty guidelines (FPG).[14,15] As of 2026, FPG is $15,960 for a single individual and $33,000 for a family of four. California enacted even stronger requirements in 2025, mandating hospitals provide charity care to, at a minimum, patients at or below 400% FPG.[16] Hospitals may choose to provide more generous charity care than the federal- or state-defined minimums.

Researchers at CPHLR collected FAPs and related debt collection policies from a national sample of the 75 highest revenue generating 340B hospitals.[17] The first 51 hospitals in this sample were the largest 340B hospitals by patient revenue in the 50 states and the District of Columbia for the 2022 fiscal year. The remaining 24 hospitals were the next largest 340B hospitals by patient revenue in the nation. Reviewers systematically reviewed and analyzed the policies to assess 340B hospitals' approaches to financial assistance and debt collection practices. Findings from this analysis of policies as of July 1, 2026, are compared, where applicable, with findings from the May 2022 report, which is valid through October 1, 2021, to assess changes in these policies over time.

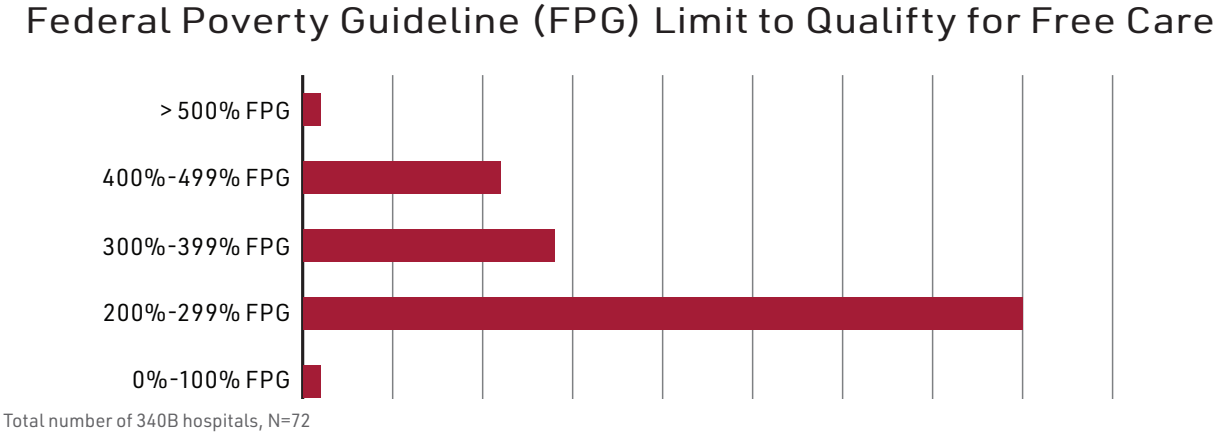
Current Policy Landscape

Using scientific legal mapping methods, CPHLR researchers identified FAPs, valid through July 1, 2026, for all 75 sample hospitals. The sample of 340B hospitals changed between May 2022 and July 2026 based on hospital revenue. Sixty of the hospitals overlap between the samples. Sixty-six hospitals published information on their debt collection policies, either in the FAPs or a separate debt collection policy, compared to 64 in 2022. Several policy features explored in this dataset are specifically examined below: (1) publicity around FAPs, (2) income levels required for financial assistance eligibility, (3) logistics to access financial assistance, (4) limits on hospital debt collection actions, and (5) discussion of whether FAPs explicitly address pharmaceutical assistance. Additional findings are available with the full data published on LawAtlas.org and the findings below are derived from that data.

Income Eligibility Thresholds for Financial Assistance Vary Across 340B Hospitals

While many hospitals have a sliding-scale fee schedules to determine cost sharing on health services provided to lower income patients, many hospitals also offer care with no out of pocket cost to patients with incomes below a certain threshold, often referred to as free care (a 100% discount on services) in FAPs. These policies generally apply to hospital-provided health care services and may not include cost sharing associated with prescription medicines. However, eligibility for free care varied widely: For one hospital, it was limited to patients below 100% of FPG, while five hospitals limited free care at or below 199% FPG. On the other end of the spectrum, one hospital's' policies set the eligibility threshold for free

Figure 1. In the CPHLR sample of 75 340B hospitals as of July 1, 2026, more than half had a Federal Poverty Guidelines (FPG) below 300 percent for free care. Three hospitals did not indicate their FPG limit for free care. Except for 500%, all FPG upper limits are at or below that number, for example 101%-199% FPG, the maximum is at or below 199%.



Total number of 340B hospitals, N=72

care above 500% FPG. This variability in eligibility may lead to disparities in patient cost burden based on their income. Patients with similar income may face substantially different access to charity care depending on which 340B hospital provides their treatment.

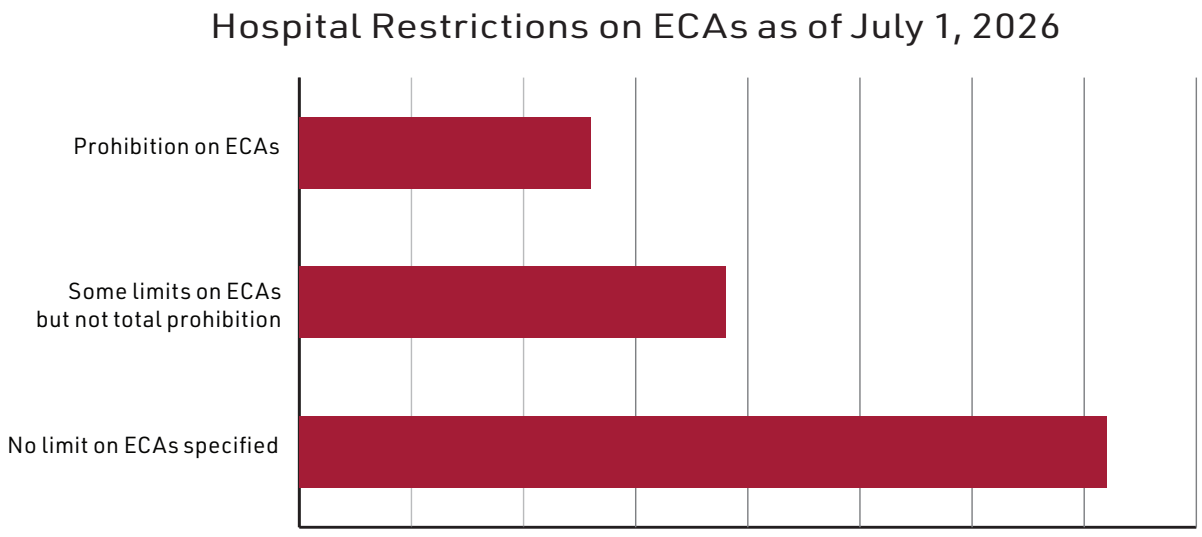
Application and Administrative Processes May Create Barriers for Patients Seeking Financial Assistance at 340B Hospitals

The process for accessing financial assistance varies widely: 31 hospitals explicitly stated they required an asset test to access financial assistance, which could include documentation of savings and other property beyond income. Forty-four hospitals detailed their appeals process in the FAP if patients are initially denied financial assistance, while 31 hospitals did not. Where appeals processes are not clearly stated or absent, patients may have more difficulty navigating a denial of financial assistance, potentially preventing access to assistance, which could lead to debt collection actions. The duration of approved assistance also varied: three hospitals provided assistance for three months, 17 hospitals for six months, two hospitals for nine months, and 32 hospitals for 12 months; 21 hospitals did not specify a duration. Variation in length of approved financial assistance suggests potential logistical burdens for patients needing to reapply for assistance more often at some hospitals than others.

Debt Collection Policies in 340B Hospitals FAPs Often Lack Clear Limits on Extraordinary Collection Actions

Just 13 hospitals specifically prohibited the use of extraordinary collections actions (ECAs).[16] Figure 2 details treatment of ECAs based on hospital FAPs and related debt collection policies. ECAs are specific actions a hospital may take to collect payment when a patient does not meet payment obligations for hospital care. These actions may include reporting adverse information to credit agencies, deferring, denying, or otherwise requiring payment before rendering medically necessary care, selling debt to collection agencies, or taking legal actions like liens, foreclosure, or civil actions. The IRS provides certain protections to FAP-eligible patients from being subject to ECAs, like requiring hospitals to take reasonable efforts to determine a patient's eligibility for financial assistance.[12] Thirty-six hospitals did not specify any limitations on the use of ECAs. Forty-six hospitals required specific notice (i.e., official communication from the hospital to the patient) before commencing a debt collection action. At the 22 hospitals that did not indicate providing advance notice in their FAPs, patients may not receive notice of a pending debt collection action before it occurs.

Figure 2. In the CPHLR sample of 68 340B hospitals in 2026, 53% did not specify any limitations on the use of ECAs. Debt collection policies could not be located for seven of the 75 hospitals in the overall sample.



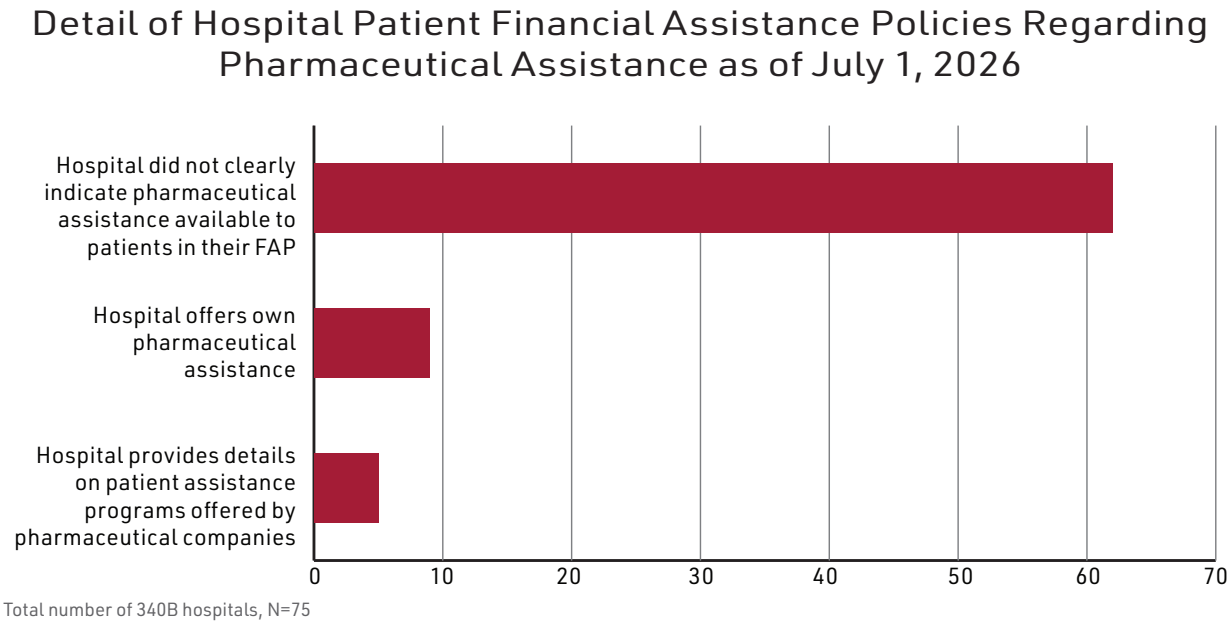
Total number of 340B hospitals, N=68

Prescription Drug Assistance is Rarely Described in 340B Hospital FAPs

Because the 340B program provides participating hospitals with access to discounted outpatient drugs, the availability of medication-related financial assistance is particularly relevant. Yet only six of the 75 hospitals (8%) detail their own pharmaceutical assistance programs in their FAPs, with three of those detailing their own pharmaceutical programs while referencing 340B and three not referencing 340B. One explained provision of financial assistance for outpatient prescriptions to patients who cannot afford them at hospital retail pharmacies but did not detail a pharmaceutical assistance program further. There were also two hospitals (3%) that referenced their own pharmaceutical assistance programs that are detailed in separate policies. Further, five (7%) specifically reference helping patients utilize manufacturer-provided copay assistance programs pay for their medicines. Overall, only 13 hospitals (17%) included any details for pharmaceutical assistance in their FAPs, meaning that most hospitals in the sample (83%) did not clearly indicate pharmaceutical assistance available to patients in their FAPs or how patients may receive discounts on needed medicines. Hospitals with details about their pharmaceutical assistance in their FAPs are detailed in Figure 3 below. As 340B participation is tied specifically to outpatient drug discounts, the limited availability of pharmaceutical assistance included in FAPs is notable.

Moreover, the limited reporting of prescription drug affordability assistance should be considered alongside the findings on debt collection practices. Despite receiving substantial discounts on outpatient medicines through the 340B program, only a small minority of hospitals in this sample publicly described how patients may access assistance with prescription drug costs. At the same time, more than half of hospitals with available debt collection policies did not specify any limitations on extraordinary collection actions (ECAs). This results in limited visibility into whether 340B savings are improving medication affordability, even as some patients may remain vulnerable to debt collection actions.

Figure 3. Sixty-two 340B hospitals in 2026 did not clearly articulate pharmaceutical assistance in their FAPs, about 83% of the total sample of 75 340B hospitals. Five specifically referenced details on patient assistance programs offered by pharmaceutical companies. One of those hospitals, University of Arkansas Hospital, details their own specialty pharmacy financial assistance policy that specifically utilizes savings earned through participation in the Medicare 340B Drug Pricing Program for specific specialty drugs. It is therefore coded in the data as both "Hospital offers own pharmaceutical assistance" and "Hospital provides details of patient assistance programs offered by pharmaceutical companies." The coding response, "Hospital offers own pharmaceutical assistance," includes any hospital that included detail captured in Question 9.1 only once – full details are available in Question 9.1 of the dataset.



Evidence

Existing evidence from GAO and others points to gaps in accountability regarding how 340B drug savings benefit low-income patients.[18,19,20] Desai and McWilliams suggest that health insurance coverage expansions may have more efficient direct benefit to low-income patients than covered entity enrollment in the 340B program.[21]

Research from the National Consumer Law Center (NCLC) has highlighted the limitation of federal requirements for FAPs and related debt collection policies and the actions that states have taken to strengthen protections for low-income patients.[22] The pertinent gaps, reflected in CPHLR research, include no federal minimum standards for eligibility criteria for financial assistance. This lack of standards results in broad variation in patient access to financial assistance across nonprofit hospitals generally, including among hospitals participating in the 340B program — a program intended to support care for low-income and underserved populations.

With more than 2,500 340B hospitals nationwide, CPHLR's research has identified, collected, and analyzed a national sample of the highest revenue generating hospitals to provide insight into hospital provision of financial assistance in absence of other legally mandated transparency measures.[23] This analysis indicates many hospitals receiving discounted medicines under the 340B program may not offer low-income patients financial assistance to access those medicines and may use extraordinary collection actions, including but not limited to, liens, foreclosures, and civil actions when patients fail to pay bills.

Policy Recommendations

Overall, significant gaps and variability exist in 340B hospitals' FAPs and related debt collection policies. There is a clear opportunity for hospitals to review and be more transparent with their policies, especially those concerning 340B hospitals' financial assistance for pharmaceutical products. Considering the lack of statutory mandate to include such information and the evidence that an extremely low percentage of hospitals that include pharmaceutical discounts in FAPs, more transparency into these data elements is essential to ensure patients benefit from the significant discount hospitals receive to purchase medicines.

The findings also highlight the need for greater 340B transparency and patient-centered accountability. Because hospitals are not generally required to report on how they chose to use 340B revenues and are not required to meet any additional requirements to improve access for low-income patients, this analysis relied on FAPs as an imperfect proxy for patient affordability practices. Although FAPs are one of the few publicly available measures of hospitals' affordability practices, they provide only a limited view of whether 340B benefits reach patients through reduced out-of-pocket costs or other forms of financial assistance. As congressional interest in the unrestricted growth, lack of accountability, and fraud/abuse in the 340B program grows and legislative reform is pursued, increased transparency in these data elements are essential.

The variation in 340B hospitals' financial assistance policies identified in this analysis suggest that stronger transparency requirements and clearer patient-affordability protections should be included in 340B reform legislation to both improve policymakers' ability to assess the program's impact and help ensure that 340B benefits are more consistently directed to the low-income and vulnerable populations it is intended to support.

NCLC offers a variety of state level recommendations specific to improving FAPs and debt collection policies. Those recommendations include, but are not limited to, clearly stating minimum eligibility criteria for free and discounted care, methods for applying for financial assistance, and providing a billing and collections policy that includes actions that a hospital may take if a patient is unable to pay for care.[13]

Research Agenda

Further evaluation using the CPHLR data could examine how hospitals benefiting from the 340B drug discount program address payment for care delivered to low-income and other patients eligible for

financial assistance related to their care. Specifically, this dataset can help identify challenges to accessing financial assistance that patients may be facing, including but not limited to income limits, eligibility criteria, asset tests, duration of financial assistance, and procedures for appealing denials. This dataset can also help identify variations in debt collection policies among hospitals that may be detrimental to patients. The potential exists to track a broader set of hospital policies beyond this initial sample of FAPs and debt collection policies using policy surveillance over time to determine if substantive changes in these policies may impact patient access to care. Because these FAPs alone do not capture patients' experiences navigating the financial assistance application process, additional research into the patient experience could help identify administrative barriers that are not readily apparent by analyzing FAPs.

Further comparative research between 340B and non-340B hospital FAPs could help identify variations in charity care or other financial assistance offerings between these hospital types.

Conclusions

Systematically examining financial assistance policies and debt collection policies at 340B hospitals can highlight barriers to patients accessing care that may be addressed at the state and federal levels. The broad range of FAP policies in place at 340B hospitals suggests limitations in how the 340B program savings are used to help patients, specifically regarding affordability of medicines for low-income populations.

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