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The Financial Impact to Medicaid from the 340B Drug Pricing Program

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Introduction

In April 2025, BRG researchers published an issue brief on the potential impact to state Medicaid programs from state manufacturer mandate laws involving contract pharmacies in the 340B Drug Pricing Program ("340B program").[1] As presented in the April brief, such mandates would cost Medicaid $1.2 billion more annually, of which $437 million would impact state budgets directly. This July brief explores the 340B program's broader current fiscal impact related to Medicaid.

Fiscal Impact of the 340B Program: Medicaid

The Medicaid program provides healthcare coverage, including prescription drug coverage, to low-income Americans and is paid for jointly by the federal government and states. Nearly all prescription drugs covered by Medicaid are subject to the Medicaid Drug Rebate Program (MDRP). Under the MDRP, pharmaceutical manufacturers are required to pay a rebate for each unit of a covered outpatient drug dispensed to a Medicaid beneficiary in exchange for guaranteed coverage under Medicaid. The amount of the rebate is determined quarterly based on a statutorily defined formula. For most brand drugs, the Medicaid rebate is the greater of 23.1 percent of AMP (average manufacturer price) or the difference between AMP and "best price," plus an inflationary rebate. For some brand drugs, the size of the rebate may even exceed the list price of the drug.[2] Rebates under MDRP are initially collected by states and subsequently shared with the federal government. The share of rebates retained by the state depends on factors including the state's federal medical assistance percentage (FMAP).[3]

Various federal laws prohibit duplicate discounts or rebates, meaning manufacturers do not have to pay a Medicaid rebate on a drug purchased under the 340B program. Because of this, states are not permitted to charge manufacturers for a Medicaid rebate on a drug purchased at the 340B price and dispensed to a Medicaid beneficiary. As the 340B program has expanded, the impact to Medicaid rebate revenue has become more significant.

Medicaid rebates offset reimbursement paid to pharmacies, either directly under a fee-for-service (FFS) model or indirectly through a managed care plan. Federal regulations require states using FFS models to reimburse pharmacies at actual acquisition cost (i.e., the discounted 340B price plus a dispensing fee).[4] The loss of rebate revenue for 340B drugs for medicines reimbursed through FFS Medicaid is thus offset by reduced reimbursement.

In contrast, managed care plans administering Medicaid benefits typically reimburse pharmacies at a rate negotiated between the plan and the pharmacy. This rate typically exceeds the discounted 340B price, with the difference accruing to covered entities and contract pharmacies in the form of drug margin.

1 Blalock, Eleanor, and Carlee Launsbach, *The Financial Impact to Medicaid from Contract Pharmacy 340B Manufacturer Mandates,* BRG issue brief (April 2025). https://media.thinkbrg.com/wp-content/uploads/2025/04/09072117/PhRMA-Medicaid-State-Rebates-Whitepaper-2025_F.pdf

2 As of 2024, the Medicaid rebate may exceed the AMP of a drug, meaning the net price paid by Medicaid becomes negative. Elizabeth Williams, "What Are the Implications of the Recent Elimination of the Medicaid Prescription Drug Rebate Cap?" KFF (January 16, 2024). https://www.kff.org/policy-watch/what-are-the-implications-of-the-recent-elimination-of-the-medicaid-prescription-drug-rebate-cap/

3 The Affordable Care Act (ACA) increased the minimum rebate liability for brand drugs and permitted the federal government to collect any incremental rebates attributable to this increase (subject to certain CMS rules) without sharing with states. MACPAC, "Medicaid Payment for Outpatient Prescription Drugs" (May 2018). http://www.macpac.gov/wp-content/uploads/2015/09/Medicaid-Payment-for-Outpatient-Prescription-Drugs.pdf

4 42 CFR 447.512(b) (2018).

Because managed care plans generally do not reduce reimbursement for 340B drugs—and in some cases are statutorily prohibited from doing so—the loss in rebate revenue from 340B expansion is not offset and drives up the net cost of prescription drug coverage for states and the federal government.[5]

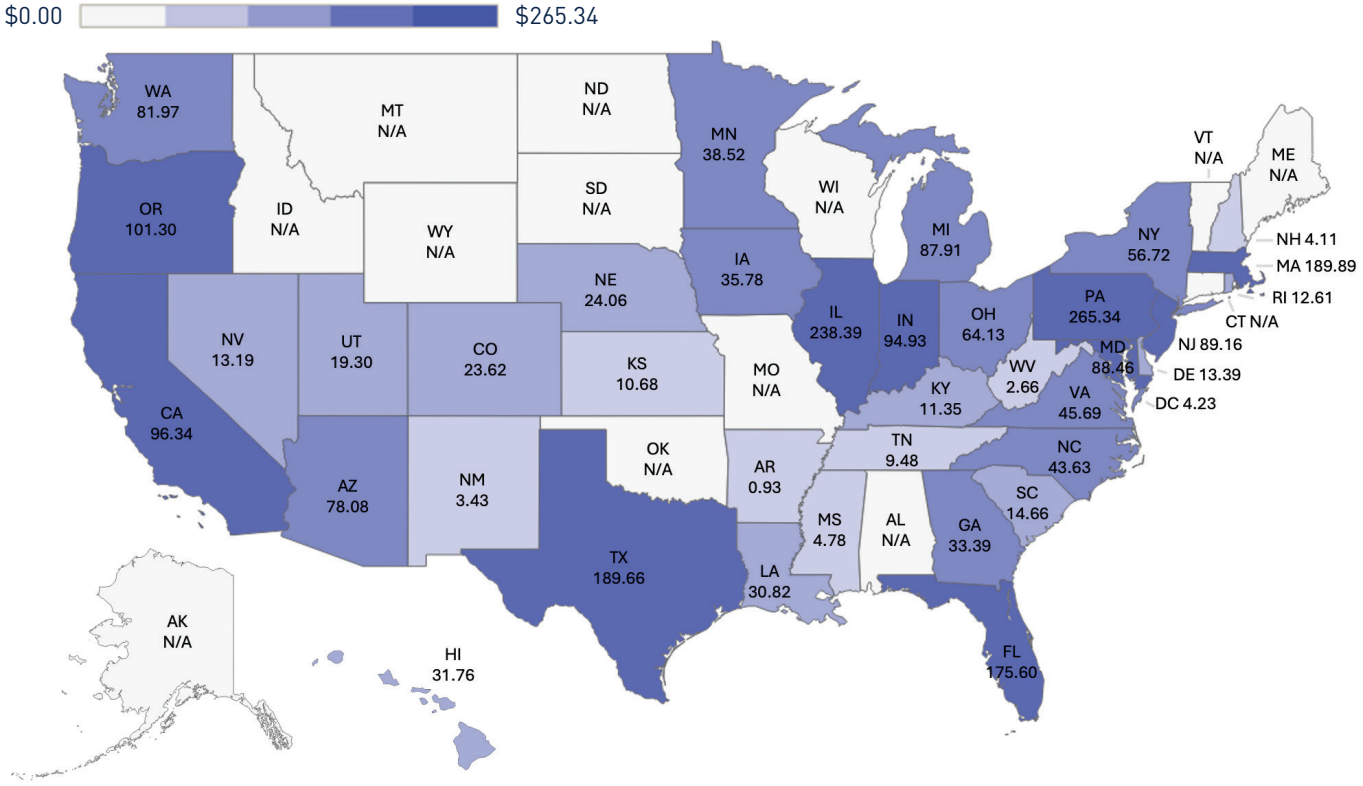
The States of New York and California cited the impact of the 340B program on the cost of prescription drug coverage in Medicaid managed care when those states transitioned some prescription drug coverage out of managed care.[6] For states that permit managed care plans to administer prescription drug benefits, the fiscal impact of the 340B program depends on factors including the states' policies with respect to the use of 340B drugs for Medicaid beneficiaries.

Our impact model, described in further detail in the "Methodology" section of the appendix, accounts for the 340B/Medicaid policies specific to each state. The model finds that, absent the 340B drug pricing program, Medicaid rebates for managed care beneficiaries would have been $6.5 billion higher in 2024. After accounting for the federal government's share of $4.2 billion, the amount of ineligible rebates directly impacting state budgets is $2.3 billion.[7] The states with the highest impact are Pennsylvania ($265 million), Illinois ($238 million), and Massachusetts ($190 million).

The appendix contains the total ineligible Medicaid rebates in managed care and the share of ineligible rebate estimates by state.

Figure 1: Managed Medicaid Rebates Ineligible Due to the 340B Drug Pricing Program ($M)

Ineligible Medicaid Rebates in Managed Care (Millions)



5 Some states expressly prohibit managed care plans from reimbursing for 340B drugs at the 340B discounted price. Ryan White Clinics for 340B Access, "State Laws Prohibiting Discriminatory Reimbursement (June 2023)." https://rwc340b.org/wp-content/uploads/2023/07/Condensed-Chart-340B-Discriminatory-Reimbursement-Laws-D0848211-15.pdf

6 Ellen Gabler, "How a Company Makes Millions Off a Hospital Program Meant to Help the Poor," *New York Times* (January 16, 2025). https://www.nytimes.com/2025/01/15/us/340b-apexus-drugs-middleman.html; California Legislative Analyst's Office (LAO), *Analysis of the Carve Out of Medi-Cal Pharmacy Services From Managed Care* (April 2019). https://lao.ca.gov/Publications/Report/3997. Both California and New York have retained coverage of physician-administered drugs within managed care. California Medical Association, "Medi-Cal managed care plans inappropriately denying claims for physician administered drugs" (2022). https://www.cmadocs.org/newsroom/news/view/ArticleId/49636/Medi-Cal-managed-care-plans-inappropriately-denying-claims-for-physician-administered-drugs#:~:text=-Medi%2DCal%20managed%20care%20plans%20are%20required%20to%20retain%20physician,available%20as%20a%20pharmacy%20benefit. New York State Department of Health, "Transition of the Pharmacy Benefit from Managed Care (MC) to Fee-For-Service (FFS)" (2021). https://health.ny.gov/health_care/medicaid/redesign/mrt2/pharmacy_transition/pharm_carve_out_faq.htm

7 KFF, Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier (2023). https://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D. We assume no additional federal offset of rebates. The federal offset is only applicable if the "best price" of a drug is less than 23.1 percent below AMP, and the average Medicaid "best price" across top selling brands is 41 percent below AMP. CBO, "A Comparison of Brand-Name Drug Prices Among Selected Federal Programs" (February 2021). https://www.cbo.gov/publication/57007#_idTextAnchor029

Conclusion

Based on our analysis, reductions in rebate revenue for managed care beneficiaries due to 340B program use generate a substantial federal and state budgetary impact. Our analysis does not account for other pathways through which the 340B program may be contributing to increased spending in Medicaid. The 340B program has been associated with a shift in care toward hospitals, for example—generally a higher-cost setting.[8] Additionally, researchers have found evidence that 340B covered entities tend to use more and/or more costly drugs for their patients, potentially because 340B drug margin (the difference between acquisition cost and reimbursement) is often greater for more expensive medicines.[9]

8 Jung, Jeah, Wendy Y. Xu, and Yamini Kalidindi, "Impact of the 340B Drug Pricing Program on Cancer Care Site and Spending in Medicare," *Health Services Research* (January 22, 2018). https://onlinelibrary.wiley.com/doi/10.1111/1475-6773.12823; Fitch, Kathryn, Pamela M. Pelizzari, and Bruce Pyenson, *Cost drivers of cancer care: A retrospective analysis of Medicare and commercially insured population claim data 2004-2014, Milliman* (April 2016). https://www.milliman.com/en/insight/cost-drivers-of-cancer-care-a-retrospective-analysis-of-medicare-and-commercially-insured

9 US GAO, *Medicare Part B Drugs: Action Needed to Reduce Financial Incentives to Prescribe 340B Drugs at Participating Hospitals* (June 5, 2015). https://www.gao.gov/products/gao-15-442; Hunter, Michael T., Katie Holcomb, and Carol Kim, *Analysis of 2020 Commercial Outpatient Drug Spend at 340B Participating Hospitals, Milliman* (September 2022). https://edge.sitecorecloud.io/millimaninc5660-milliman6442-prod27d5-0001/media/Milliman/PDFs/2022-Articles/9-13-22_PhRMA-340B-commercial-analysis.pdf; Horn, Danea, "The incentive to treat: Physician agency and the expansion of the 340B drug pricing program," *Journal of Health Economics 101* (February 3, 2025). https://www.sciencedirect.com/science/article/abs/pii/S0167629625000050

Appendix

Table A1: Managed Medicaid Rebates Ineligible Due to 340B Drug Pricing Program ($M estimated as of 2024)

State/District	Total Ineligible Managed Medicaid Rebates	Ineligible Managed Medicaid Rebates (state share)
Alabama	N/A*	N/A
Alaska	N/A	N/A
Arizona	322.1	78.1
Arkansas	4.2	0.9
California	220.0	96.3
Colorado	53.9	23.6
Connecticut	N/A	N/A
Delaware	37.9	13.4
District of Columbia	17.8	4.2
Florida	520.3	175.6
Georgia	120.2	33.4
Hawaii	84.1	31.8
Idaho	N/A	N/A
Illinois	544.3	238.4
Indiana	337.4	94.9
Iowa	116.7	35.8
Kansas	31.4	10.7
Kentucky	52.5	11.3
Louisiana	116.2	30.8
Maine	N/A	N/A
Maryland	202.0	88.5
Massachusetts	433.5	189.9
Michigan	302.2	87.9
Minnesota	89.6	38.5
Mississippi	30.0	4.8
Missouri	N/A	N/A
Montana	N/A	N/A
Nebraska	67.0	24.1
Nevada	42.4	13.2
New Hampshire	9.4	4.1
New Jersey	203.6	89.2
New Mexico	16.7	3.4
New York	129.5	56.7
North Carolina	167.2	43.6
North Dakota	N/A	N/A
Ohio	212.2	64.1
Oklahoma	N/A	N/A
Oregon	302.6	101.3
Pennsylvania	634.8	265.3

State/District	Total Ineligible Managed Medicaid Rebates	Ineligible Managed Medicaid Rebates (state share)
Rhode Island	31.7	12.6
South Carolina	63.1	14.7
South Dakota	N/A	N/A
Tennessee	34.2	9.5
Texas	559.0	189.7
Utah	69.2	19.3
Vermont	N/A	N/A
Virginia	105.9	45.7
Washington	187.1	82.0
West Virginia	13.5	2.7
Wisconsin	N/A	N/A
Wyoming	N/A	N/A
Total	**$6,485.0**	**$2,329.9**

** "N/A" indicates that the structure of these states' Medicaid programs means that they do not incur costs due to the 340B program.*

Methodology

States use a variety of methods to ensure that they do not attempt to collect Medicaid rebates for 340B-purchased drugs. To accomplish this, the state must identify prescription drug claims for which a 340B drug was used. Because states face challenges in mandating a 340B identification requirement, some states simply prohibit the dispensing of 340B-purchased drugs to Medicaid beneficiaries.[10]

These prohibitions on 340B dispensing, also known as "carve-outs," may apply only to certain types of Medicaid utilization within a state. For example, a state may allow 340B dispensing for Medicaid FFS but not for managed care. Similarly, a state may allow 340B dispensing at covered entity–owned pharmacies but not at contract pharmacies. Based on review of publicly available 340B policies from state Medicaid agencies, we limited our analysis to states and sites of care where 340B drugs may be dispensed to managed Medicaid beneficiaries.

We constructed a model that estimates Medicaid rebates that are made ineligible because they were purchased at the 340B discounted price. The model is based on a BRG forecast of 340B program size as of 2024.[11] The model relies on other inputs collected from the Health Resources and Services Administration (HRSA), Congressional Budget Office (CBO), and Centers for Medicare & Medicaid Services (CMS), along with BRG estimates, to determine the share of 340B-purchased drugs dispensed to managed Medicaid beneficiaries and quantify the potential Medicaid rebates that would be paid on those drugs if they were not 340B. We assume that managed care plans do not reduce reimbursement for 340B drugs, such that rebate losses on those drugs translate one-for-one to increased net costs.

10 US GAO, *340B Drug Discount Program Oversight of the Intersection with the Medicaid Drug Rebate Program Needs Improvement* (January 2020). https://www.gao.gov/assets/gao-20-212.pdf

11 BRG, *340B Program at a Glance: 2025* (2025). https://media.thinkbrg.com/wp-content/uploads/2025/02/19075246/340B-Program-at-a-Glance-2025_F.pdf

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