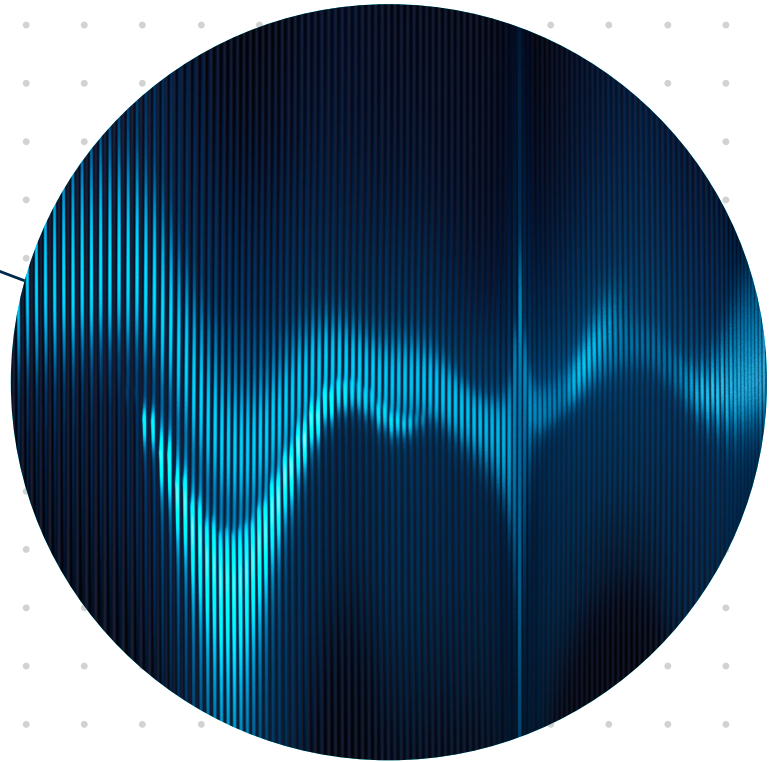


October
2026



The Size of the 340B Program

Patient and Payer Spending on Drugs
Purchased through the 340B Program
Reached \$244 Billion in 2025

PREPARED BY:

Eleanor Blalock
Director
eblalock@thinkbrg.com

Carlee Launsbach
Senior Associate
claunsbach@thinkbrg.com

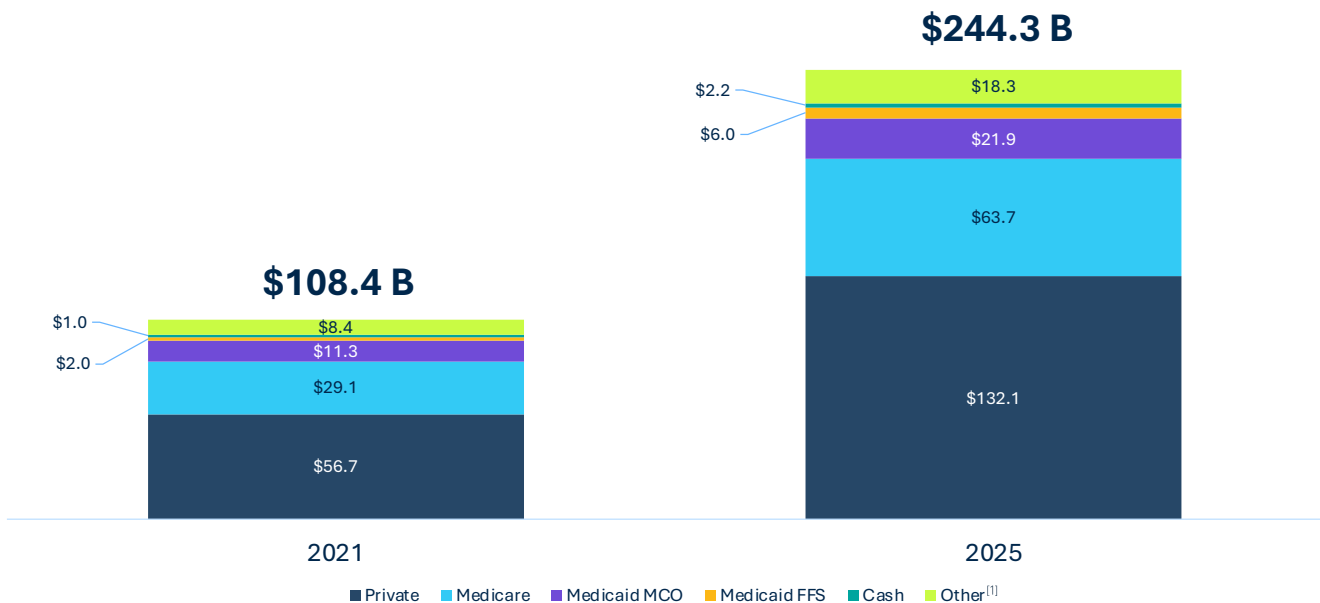
Background

In 2025, 340B Drug Pricing Program (“340B program”) sales totaled \$102.1 billion measured at the discounted 340B price.¹ This represents significant growth over prior years, with 340B sales growing by 152 percent between 2020 and 2025,² during which period net sales of all drugs in the US grew by only 56 percent.³ Despite this growth, metrics focused on sales at the 340B price substantially understate the true size of the program. In 2025, 340B prices were, on average, 57 percent below list prices,⁴ and the discounted 340B price for some products was as low as one cent. This study calculates the total amount the US healthcare system spends on drugs purchased at the 340B price along with the margin earned by covered entities and their partners (pharmacies, technology vendors, etc.) on those sales. See the appendix for methodology.

Total Spending on 340B Drugs

We estimate that covered entities received approximately \$244.3 billion in reimbursement from payers and patients in 2025 for drugs purchased through the 340B program.⁵ This reimbursement is distributed among Medicare, private/commercial insurance, Medicaid Fee-for-Service (FFS), Medicaid managed care organizations (MCOs), self-pay (cash) customers, and others.

Figure 1: Total Spending by Payers and Patients on 340B Drugs by Payer Type (in billions), 2021 vs. 2025*



*Components may not sum up to the total due to rounding.

[1] “Other” payers can include Department of Defense, Children’s Health Insurance Program, workers’ compensation, and other special payment programs.

- 1 The US Health Resources and Services Administration (HRSA) reports \$100.0 billion in 340B sales for 2025 based on incomplete data provided by Apexus, the 340B prime vendor. HRSA Office of Pharmacy Affairs (OPA), “2025 340B Covered Entity Purchases” (July 2026). <https://www.hrsa.gov/opa/updates/2025-340b-covered-entity-purchases>; The data reported by Apexus were assumed to include 98 percent of total 340B drug sales at the 340B price. This is a conservative estimate given historical Medicare Payment Advisory Commission (MedPAC) reporting that Apexus data accounts for 90 to 95 percent of total 340B sales. See MedPAC, *Report to the Congress: Overview of the 340B Drug Pricing Program* (May 2015). https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/may-2015-report-to-the-congress-overview-of-the-340b-drug-pricing-program.pdf
- 2 HRSA OPA reported 340B sales at the net price of \$100.0 billion for 2025 compared to \$39.7 billion in 2020. HRSA (2026); CBO, “Growth in the 340B Drug Pricing Program” (September 10, 2025). <https://www.cbo.gov/system/files/2025-09/60661-340B-program.pdf>
- 3 IQVIA Institute, *U.S. Medicine Use Trends 2026* (April 2026). <https://www.iqvia.com/insights/the-iqvia-institute/reports-and-publications/reports/us-medicine-use-trends-2026>
- 4 Estimate developed based on analysis of publicly available data on historical list prices, inflation, and commercial discounting.
- 5 This amount does not incorporate offsetting retrospective discounts to payers or patients, such as those under the Medicare coverage gap program, that are paid on 340B drugs. In most cases, retrospective discounts and rebates on drugs purchased at the 340B price are either prohibited by law or manufacturers are not contractually obligated to pay them.

Margin Earned by Covered Entities and their Partners

In total, covered entities spent \$102.1 billion to acquire 340B drugs in 2025. The difference between the amount 340B covered entities spent to acquire the drugs and amount they were reimbursed for these drugs (“340B drug margin”) equates to \$142.2 billion. Between 2021 and 2025, covered entity 340B drug margin more than doubled. The 340B drug margin is retained by covered entities as net revenue or provided as compensation to their contract pharmacy partners, technology vendors, and consultants.

Figure 2: Total Spending on 340B Drugs by Payers and Patients (in billions), 2021 vs. 2025

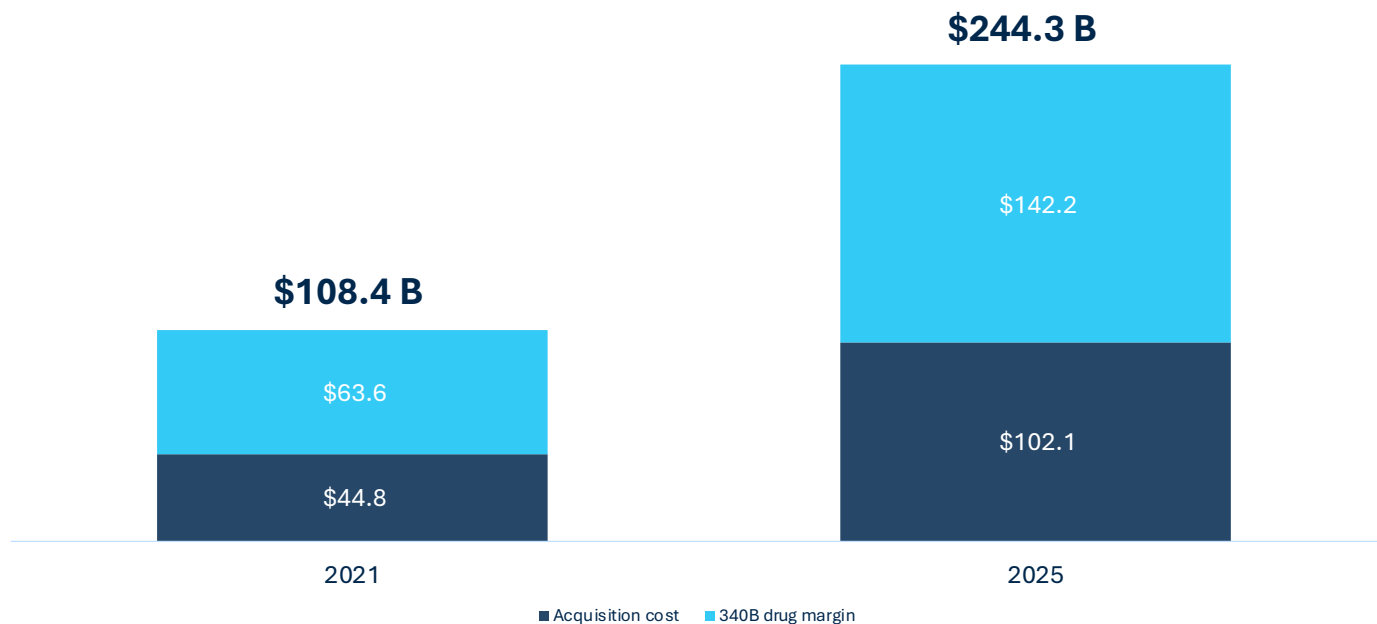


Figure 3 shows the breakdown of the 340B drug margin based on the payer that provided reimbursement. In 2025, private/commercial payers paid for the largest share (63 percent) of 340B drug margin, followed by Medicare (25 percent), Medicaid MCO (7 percent), and other payers (5 percent). Medicaid FFS generates no margin, as Medicaid FFS reimburses for 340B drugs at the 340B acquisition cost. In July 2026, CMS proposed reducing Medicare Part B reimbursement for 340B drugs. If finalized, this would reduce the Medicare portion of this margin in 2027.

We assume that covered entities earn no margin on prescriptions dispensed to self-pay (cash) patients. While evidence suggests covered entities are not regularly passing through the 340B price to cash pay customers, the lack of comprehensive data reporting makes it impossible to estimate the revenue (if any) that covered entities are collecting from these patients.

Figure 3: Breakdown of Margin on 340B Drugs by Payer Type (in billions), 2021 vs. 2025*

	2021	2025
Private/ Commercial	\$38.5	\$89.6
Medicare	\$16.2	\$35.3
Medicaid MCO	\$5.9	\$10.6
Other ^[1]	\$3.0	\$6.6
Total Margin on 340B Drugs	\$63.6	\$142.2

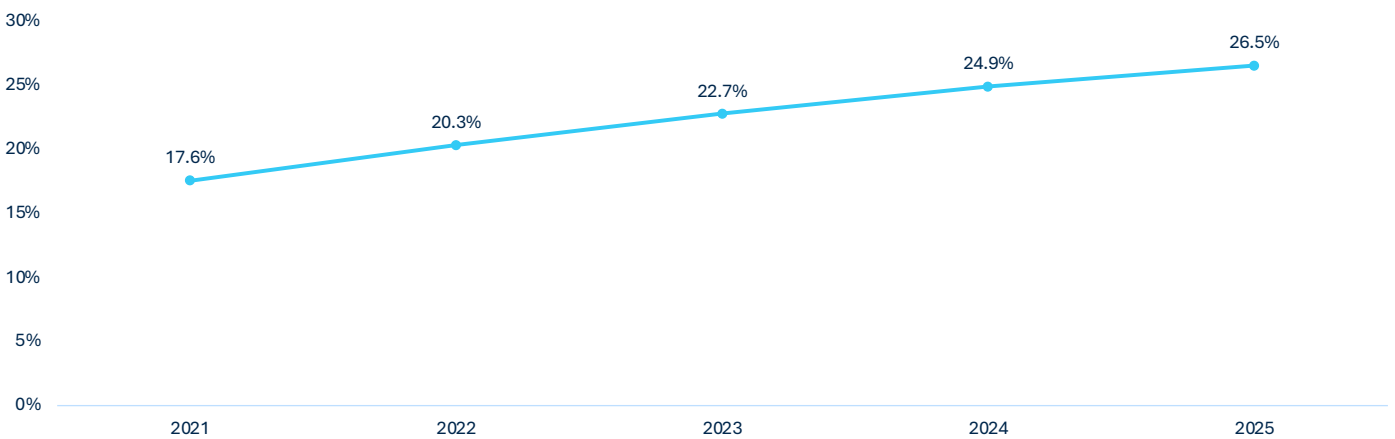
*Components may not sum up to the total due to rounding.

[1] "Other" payers can include Department of Defense, Children's Health Insurance Program, workers' compensation, and other special payment programs.

340B as Percentage of Market

Expressed as a percentage of total net spending by payers and patients on pharmaceuticals in the US, 340B prescriptions account for 27 percent of the overall market, a share that has increased by nearly 9 percentage points since 2021.

Figure 4: 340B Share of Net Spending on Pharmaceuticals in the US



Conclusion

The 340B program continues to grow rapidly. The nonpartisan Congressional Budget Office (CBO) reported that this growth has been driven mostly by 1) vertical integration of hospitals and off-site clinics, 2) increased participation of hospitals following implementation of the Affordable Care Act, and 3) increased use of contract pharmacies.⁶

However, detailed data on the program is limited. No comprehensive public reporting shows the size of 340B drug margin or how it is utilized. The lack of transparency into the magnitude and distribution of 340B drug margin confounds any assessment of program benefits versus costs.

⁶ CBO (2025).

Appendix: Methodology

To estimate reimbursement for 340B drugs, we began with 340B sales at the discounted 340B price and disaggregated them between retail and non-retail components, based on analysis of likely 340B claims within Medicare data.⁷ 340B prices were calculated by drug using a statutory formula derived from two pricing metrics central to the Medicaid Drug Rebate Program (MDRP):

1. **Basic Medicaid rebate:** equal to the greater of 23.1 percent of average manufacturer price (AMP) or the difference between AMP and “best price”⁸
2. **Consumer Price Index (CPI) penalty:** a price inflation penalty that grows as price increases for a drug exceed the rate of inflation⁹

Using these components, the 340B ceiling price is equal to AMP less the statutory Medicaid rebate, less the inflationary penalty. Depending on the competitive dynamics that exist in any therapeutic category, the 340B ceiling price, when calculated as defined by statute, could fall below \$0.00. In these instances, the price is reset to \$0.01 as part of a concept known as “penny pricing.”¹⁰

The 340B discount is then calculated by comparing the estimated 340B price with the list price (WAC) for the same drug. Our final estimated 340B discount represents the weighted average of these drug-level discounts, with weights based on each drug’s volume.¹¹ A discount estimate is calculated and applied separately for the retail and non-retail components of the 340B program, to estimate those components’ size at WAC.

7 340B sales from HRSA (2026).

8 The basic Medicaid rebate is the greater of the base Medicaid rebate (23.1 percent of AMP) or the “best price” discount, which represents the discount from AMP of the lowest available price offered by the pharmaceutical manufacturer to a best-price eligible entity. The lowest available price is typically the difference between the WAC and the largest rebate offered to commercial health plans. As rebate data is proprietary, we relied on public disclosures of average rebates by the US Government Accountability Office for Medicare Part D and the typical ratio between average rebate and best price by the CBO to arrive at a proxy for the best price. US Government Accountability Office, *Medicare Part D: CMS Should Monitor Effects of Rebates on Plan Formularies and Beneficiary Spending* (September 2023). <https://www.gao.gov/assets/gao-23-105270.pdf>; CBO, “A Comparison of Brand-Name Prices Among Selected Federal Programs” (February 2021). <https://www.cbo.gov/publication/57007>.

9 We relied on the Elsevier Gold Standard Drug Database to determine the WAC for each drug at launch and as of 2025. We assumed the AMP to be 91 percent of WAC both at launch and in 2025. Inflation data (without seasonal adjustments) was collected from the Bureau of Labor and Statistics and used to establish the allowable increase in AMP for each product. The CPI penalty was calculated as the difference between the allowable AMP in 2025 versus the estimated 2025 AMP derived from the Gold Standard pricing data. CBO (2021).

10 Federal Register, “340B Drug Pricing Program Ceiling Price and Manufacturer Civil Monetary Penalties Regulation,” final rule, 82 FR 1210 (January 5, 2017). <https://www.hrsa.gov/sites/default/files/hrsa/opa/federal-register-1-5-2017.pdf>

11 Volume based on drugs’ Medicare Part B spending and total reimbursement from Medicaid according to CMS state drug utilization data. CMS, “Medicare Quarterly Part B Spending by Drug” (2025). <https://data.cms.gov/summary-statistics-on-use-and-payments/medicare-medicaid-spending-by-drug/medicare-quarterly-part-b-spending-by-drug/data>; Medicaid, “State Drug Utilization Data” (last updated September 23, 2026). <https://www.medicaid.gov/medicaid/prescription-drugs/state-drug-utilization-data>

Within each drug type, sales were then apportioned by payer type. Retail sales were apportioned based on assumptions derived from Minnesota's 340B Covered Entity Report for 2024.¹² We assume that 5 percent of retail sales are dispensed to cash/self-pay patients. Non-retail sales were apportioned by payer based on assumptions derived from Centers for Medicare and Medicaid Services (CMS) national health expenditure (NHE) data.¹³

Other than Medicaid FFS and cash prescriptions, which we assume are reimbursed at cost, we assume that all other retail prescriptions are reimbursed at WAC. Non-retail reimbursement was estimated separately for private insurers, Medicare, Medicaid, and other payer types, based on typical reimbursement rates relative to acquisition cost by payer type and site of care. For private insurers, we assume a ratio of 3.08 between reimbursement and the 340B price, as reported in prior research.¹⁴

Total net spend by payers and patients on pharmaceuticals was derived based on CMS NHE data on total retail drug spend, supplemented with an analogous estimation of total net non-retail drug spend, consistent with a methodology previously utilized by Altarum.¹⁵ To calculate total net spend by payers and patients on 340B drugs, we estimate an offset to pharmacy and provider reimbursement related to Medicare Part D coverage gap discounts, but assume no other offsets to reimbursement.

12 Minnesota Department of Health, 340B Covered Entity Report (November 25, 2024). <https://www.health.state.mn.us/data/340b/docs/2024report.pdf>

13 CMS, "NHE Fact Sheet" (last modified June 24, 2026). <https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/nhe-fact-sheet>

14 James C. Robinson, Christopher Whaley, and Sanket S. Dhruv, "Hospital Prices for Physician-Administered Drugs for Patients with Private Insurance," *N Engl J Med* 390:4 (January 25, 2024): 338–45 (Table 2). DOI: 10.1056/NEJMsa2306609. <https://www.nejm.org/doi/pdf/10.1056/NEJMsa2306609>

15 Charles Roehrig and Ani Turner, Projections of Non-Retail Drug Share of National Health Expenditures, Altarum (2022). <https://drugchannelsinstitute.com/files/Projections-of-Non-Retail-Drug-Share-of-NHE-2022.pdf>

KEY PROFESSIONALS



Eleanor Blalock
Director
eblalock@thinkbrg.com



Carlee Launsbach
Senior Associate
claunsbach@thinkbrg.com

BRG combines world-leading academic credentials with world-tested business expertise, purpose-built for agility and connectivity, which sets us apart—and gets you ahead.

Our top-tier professionals include specialist consultants, industry experts, renowned academics, and leading-edge data scientists. Together, they bring a diversity of proven real-world experience to economics, disputes, and investigations; corporate finance; and performance improvement services that address the most complex challenges for organizations across the globe.

Our unique structure nurtures the interdisciplinary relationships that give us the edge, laying the groundwork for more informed insights and more original, incisive thinking from diverse perspectives that, when paired with our global reach and resources, make us uniquely capable to address our clients' challenges.

VISIT [THINKBRG.COM](https://www.thinkbrg.com) TO LEARN MORE.

Copyright ©2026 by Berkeley Research Group, LLC. Except as may be expressly provided elsewhere in this white paper, permission is hereby granted to produce and distribute copies of individual works from this publication for nonprofit educational purposes, provided that the author, source, and copyright notice are included on each copy. This permission is in addition to rights of reproduction granted under Sections 107, 108, and other provisions of the US Copyright Act and its amendments.

Disclaimer: The opinions expressed in this publication are those of the individual author(s) and do not represent the opinions of BRG or its other employees and affiliates. This study was funded by the Pharmaceutical Research and Manufacturers of America. The information provided in the publication is not intended to and does not render legal, accounting, tax, or other professional advice or services, and no client relationship is established with BRG by making any information available in this publication, or from you transmitting an email or other message to us. None of the information contained herein should be used as a substitute for consultation with competent advisors.