White Paper

The Cost of 340B to States in 2025

CHUAN SUN, MS, MA, IQVIA Market Access Technology Solutions
RORY MARTIN, PhD, IQVIA Market Access Technology Solutions

Table of contents

Abstract

The 340B Drug Pricing Program has grown rapidly, increasing the need to understand how its financial effects extend beyond participating covered entities. While hospitals and clinics use 340B discounts to generate spread revenue, those discounts can also displace negotiated manufacturer rebates that otherwise reduce prescription drug costs for employers, enrollees, and taxpayers.

This study estimates the cost of 340B-related rebate displacement to commercial health plans, employers, states, and the federal government using data from 2025. Building on a prior state-level study, we update estimates for employer-sponsored coverage and broaden the scope to include non-group plans and Managed Medicaid plans. We find that commercial-market lost rebates more than doubled from 2023 to 2025, reaching $14.5 billion, while Managed Medicaid rebate displacement added approximately $4.2 billion in combined state and federal costs, for a total estimated cost of $18.7 billion.

The highest per-beneficiary commercial burdens are concentrated in rural states with high 340B exposure, while the largest aggregate losses occur in more populous states. These findings indicate that the 340B program's financial effects extend beyond covered entities to employers, enrollees, state Medicaid programs, and the federal government.

Introduction

Although the 340B Drug Pricing Program ("340B program") is a federal initiative, its financial impact varies substantially by state because of differences in 340B provider participation, contract pharmacy arrangements, payer mix, and local market characteristics. This impact includes 340B spread revenue, which is the difference between a drug's Wholesale Acquisition Cost (WAC) and 340B price and which flows to participating hospitals and clinics, as well as financial costs borne by health plan enrollees, taxpayers, employers, the federal government, and states.

The program's size, spread revenue, and cost to health plan enrollees are substantial. In 2025, 340B sales at list price were $180-200 billion,[1] which, at an average 340B discount of 53%, represents more than $100 billion in 340B spread revenue. Its cost takes several forms, including higher prices due to 340B-driven provider consolidation,[2,3] increased drug utilization,[4] and the loss of negotiated rebates used to reduce the net cost of prescription drugs.[5] In Medicaid, 340B discounts supplant statutory rebates because federal law prohibits duplicate discounts on the same drug unit; in the commercial market, 340B discounts displace commercially negotiated rebates, increasing net drug costs for health plans.

Previous studies have estimated that lost negotiated rebates for commercial plans cost employers and employees around $6 billion annually.[6] Given that sales of 340B drugs at list price grew 20.3% year-over-year in 2025 alone,[1] it is likely this cost has increased.

This study refreshes our prior 2023 state-level analysis by estimating the 2025 cost of 340B-related lost negotiated rebates for commercial plans, including employer-sponsored and non-group coverage, and by estimating the added cost to states and the federal government from lost Managed Medicaid rebates.

Updates from original IQVIA study

In our original study, which was based on 2023 data,[6] we quantified, for the first time at the state level, the cost that the 340B program imposes on private employer-sponsored and state and local government health plans. The current study expands that design to include non-group plans and Managed Medicaid.

Non-group plans

Non-group plans, also known as individual market plans, are health insurance policies purchased directly by individuals and families rather than through an employer or public program such as Medicare or Medicaid. Since 2014, the bulk of this market has been organized under the Affordable Care Act (ACA), which created federal and state-based Health Insurance Marketplaces, commonly referred to as "exchanges" or "Obamacare," and established standardized benefit tiers (Bronze, Silver, Gold, and Platinum), guaranteed issue, community rating, and essential health benefit requirements.[7]

Enrollment in ACA Marketplace plans reached a record of approximately 24 million Americans during the 2025 open enrollment period,[8] supported by enhanced premium tax credits originally enacted under the American Rescue Plan Act and extended through the Inflation Reduction Act. These plans are predominantly

offered by commercial insurers (e.g., Centene, Elevance, UnitedHealthcare, Blue Cross Blue Shield affiliates) and, like employer-sponsored plans, rely on manufacturer rebates negotiated by PBMs to offset drug costs. Because 340B drug discounts displace these rebates in the same way they do for employer-sponsored coverage, the cost burden extends to ACA enrollees and, indirectly, to the federal government through premium tax credits that subsidize their premiums.

Building on prior work,[6] in this study, we add non-group/ACA enrollees as a third group alongside employer-sponsored plans and state and local government plans, providing a more complete picture of how 340B costs are distributed across the commercially insured population.

Managed Medicaid

Medicaid is jointly financed by states and the federal government and is delivered through two primary arrangements: Fee-For-Service (FFS), in which the state pays providers directly for each service, and managed care, in which the state contracts with Managed Care Organizations (MCOs) that receive capitated payments to administer benefits to enrolled beneficiaries. As of 2025, roughly three-quarters of Medicaid beneficiaries nationwide were enrolled in managed care plans, making Managed Medicaid the dominant delivery model in most states.[9] Drug utilization in both FFS and Managed Medicaid is generally eligible for rebates under the Medicaid Drug Rebate Program (MDRP), through which manufacturers provide statutory rebates to states.

Federal law prohibits duplicate discounts in the form of 340B discounts and Medicaid rebates. Consequently, when a drug is dispensed under the 340B program to a Medicaid beneficiary, the corresponding MDRP rebate is unavailable. The 340B program interacts differently with FFS Medicaid and Managed Medicaid. In FFS Medicaid, states generally identify (or "scrub") 340B claims, reduce reimbursement to reflect 340B acquisition costs, and capture the resulting savings, thereby largely offsetting the lost rebate. In Managed Medicaid, however, reimbursement to covered entities is typically not adjusted in the same manner, and the displaced MDRP rebate therefore represents a cost to the Medicaid program. In this refresh, we quantify Managed Medicaid as an additional cost category, assuming that states using FFS, or those carving out pharmacy benefits from Managed Medicaid back to FFS internalize 340B discounts and lower reimbursements, while Managed Medicaid bears the full loss of the displaced MDRP rebate.

Data and Methods

Data

This study uses public data and IQVIA proprietary data sources, including IQVIA's Longitudinal Access and Adjudication Dataset (LAAD) for pharmacy claims, IQVIA's DDD subnational sales database, IQVIA's 340B eligibility scores, and public enrollment data for employer-sponsored, state and local government, and non-group plans by state.

Figure 1: Summary list of public and IQVIA data used in the analysis

PUBLIC DATA	IQVIA DATA
State and local government employee populations	LAAD pharmacy claims
Rates of employer-sponsored and non-group insurance by state	340B eligibility scores
Dependent ratios by state	Subnational drug sales
States' Federal Medical Assistance Percentage (FMAP) shares	340B covered entity and contract pharmacy affiliations
	Healthcare provider (HCP) affiliations

LAAD is a national sample of pharmacy claims that includes details about patient cost-sharing as well as plan and payer information. Specifically, the payer element is used to identify managed Medicaid plans for states that have them. While physician-administered drugs may qualify for the 340B program, they fall outside the scope of this analysis. DDD captures wholesaler sell-in data to pharmacies, hospitals, clinics, and other purchasers of drugs. It also captures both Wholesale Acquisition Cost (WAC) and 340B pricing for drugs in scope. 340B eligibility scores estimate the likelihood of a prescription being 340B-eligible by integrating 340B covered entity and contract pharmacy participation data with physician affiliation data. A detailed methodological walkthrough of the analysis is provided below.

Lost rebates by commercial and non-group plans

To quantify rebates lost by commercial and non-group plans, we apply the same methodology developed in our original 2023 study, extended to cover non-group/ACA plans alongside private and public employer-sponsored plans. We start from a per-beneficiary estimate of drug rebates[10] and apply each state's 340B exposure, the share of branded drug utilization flowing through 340B, to determine per-beneficiary rebates displaced by the program. Total lost rebates are obtained by multiplying per-beneficiary lost rebates by the number of beneficiaries in each plan group in each state.

Lost rebates by state Managed Medicaid plans

To estimate Medicaid rebates displaced by 340B, we use LAAD to identify pharmacy claims adjudicated through Managed Medicaid plans and DDD to obtain unit-level WAC and 340B ceiling prices for branded drugs. For each branded claim, we use the per-unit 340B discount, defined as WAC minus the 340B ceiling price, as a proxy for the lost MDRP rebate. This approach likely understates total rebate displacement because it excludes supplemental rebates negotiated by some states and because MDRP rebates can exceed AMP, reducing Medicaid's net cost to zero or below, while 340B ceiling prices cannot fall below $0.01 under penny pricing.

Because claim-level 340B status is generally unobserved, we apply IQVIA 340B eligibility scores, a proprietary model that estimates the probability that a claim was dispensed under 340B based on provider affiliation, contract pharmacy relationships, drug-specific 340B exposure, and other claim characteristics. We multiply this probability by the per-unit 340B discount and aggregate the results to estimate state-level rebate displacement in 2025.

Medicaid is jointly financed by the federal government and the states through the Federal Medical Assistance Percentage (FMAP), which ranges from 50% in higher-income states to over 75% in some lower-income states; the ACA expansion population receives a 90% federal match.[9] We use these FMAPs to allocate the cost of 340B to the federal government and states separately.

States generally offset 340B-related rebate losses in Fee-For-Service (FFS) Medicaid by identifying 340B claims and adjusting reimbursement to reflect 340B acquisition costs. Several states, including California, New York, Tennessee, West Virginia, and Missouri, have also carved pharmacy benefits out of Managed Medicaid and back into FFS administration. Accordingly, we assume no net 340B-related rebate loss in FFS-only or carve-out states and attribute rebate displacement only to states that continue to administer pharmacy benefits through Managed Medicaid plans.

Limitations

This study has several limitations:

The analysis of the cost of 340B to Managed Medicaid is restricted to drugs adjudicated through pharmacy claims and does not include physician-administered drugs reimbursed through medical claims. Billed and reimbursed amounts for physician-administered drugs vary substantially by 340B status, site of care (hospital outpatient department, physician office, infusion center), and payer, and the lack of consistent reimbursement benchmarks makes generalization unreliable. Because physician-administered drugs account for a meaningful share of 340B utilization, particularly in oncology and specialty therapeutic areas, our estimates likely understate the total cost of 340B to Managed Medicaid plans.

LAAD provides broad visibility into pharmacy claims, with coverage that varies across states and payer types. Managed Medicaid plan representation also varies by state and MCO participation. Because this analysis reports observed claims without projecting to state-level totals, results for states should be interpreted as conservative lower-bound estimates rather than full market totals.

We assume that state FFS Medicaid programs always identify (or "scrub") 340B claims and lower reimbursement to acquisition cost, thus internalizing the savings and offsetting the displaced MDRP rebate. In practice, scrubbing is imperfect: states vary in the rigor of their identification processes, in their use of claim-level modifiers, and in their reconciliation with covered entities. To the extent that scrubbing is not 100%, state FFS Medicaid programs may overpay for drugs purchased at 340B prices; and drug manufacturers may be led into paying unlawful duplicate discounts on the same drugs.

We use the state of the dispensing pharmacy to determine the cost to a state's employers and enrollees. To the extent that some 340B covered entities utilize large-scale mail-order pharmacies or alternative distribution model (ADM), which may ship drugs across state lines, 340B exposure and the resulting costs may be understated in ship-to states and overstated in ship-from states.

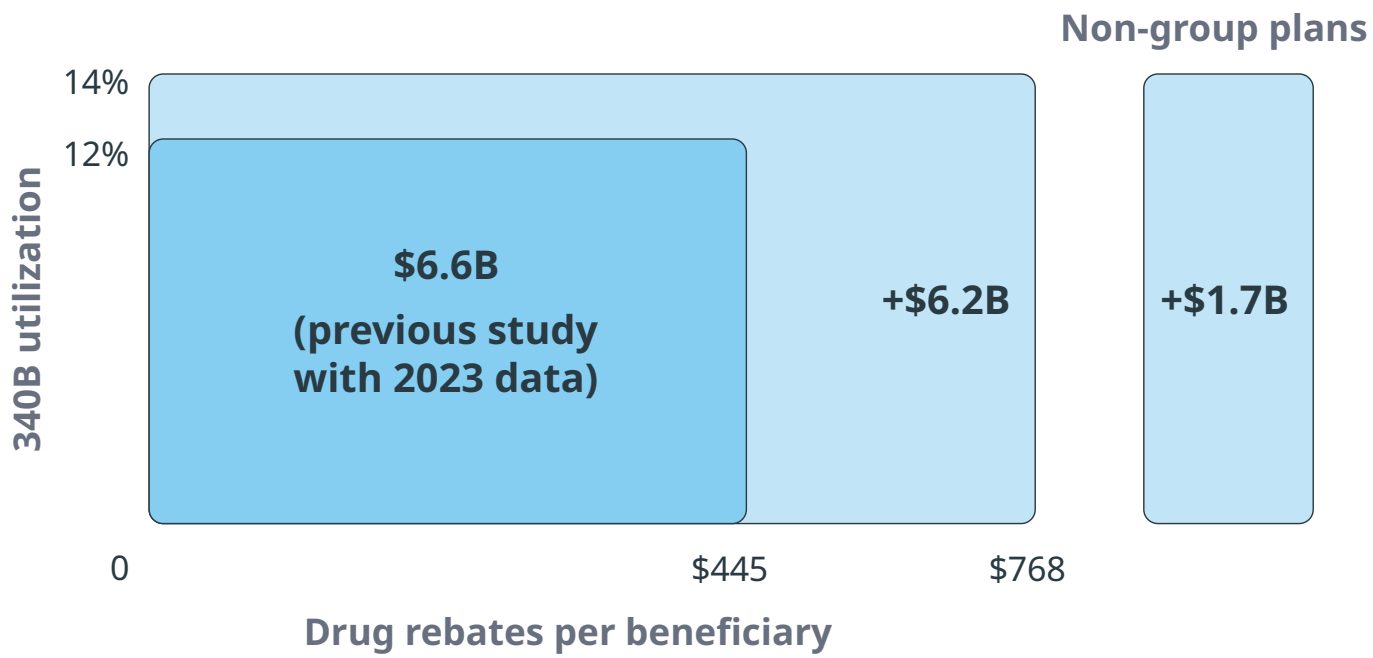
Findings

Growth of total cost: 2023 to 2025

Between 2023 and 2025, 340B continued to expand rapidly, with material consequences for the commercial insurance market. During the same period, average 340B utilization grew from 12%[6] to 14% of branded drug volume nationally, reflecting growth in covered entities, contract pharmacy arrangements, and state contract pharmacy mandates that prohibit manufacturer restrictions on contract pharmacy use. Because per-beneficiary manufacturer rebates also rose over the period, each percentage point of 340B exposure displaced more rebate dollars in 2025 than in 2023.

The cost to the commercial market rose accordingly. Lost rebates to employer-sponsored plans nearly doubled, from $6.6 billion in 2023 to $12.8 billion in 2025, with growth across virtually all states. In this refresh we also quantify, for the first time, the cost borne by non-group/ACA plans, which added $1.7 billion in 2025. Aggregating across private employer-sponsored, state and local government employer-sponsored, and non-group commercial plans, total commercial-market lost rebates reached $14.5 billion, more than double the 2023 estimate.

Figure 2: Cost of 340B to commercial plans 2025 vs. 2023 growth



Cost to states

Among the 50 states and the District of Columbia (DC), 47 states had higher 340B utilization in 2025 than in 2023. Because average manufacturer rebates also increased over the period, every state and DC had higher per-beneficiary lost rebates for commercial plans in 2025.

Figure 3.1: 340B per-beneficiary lost rebates for the 50 states and DC. State code is included for cross-reference with the Managed Medicaid table

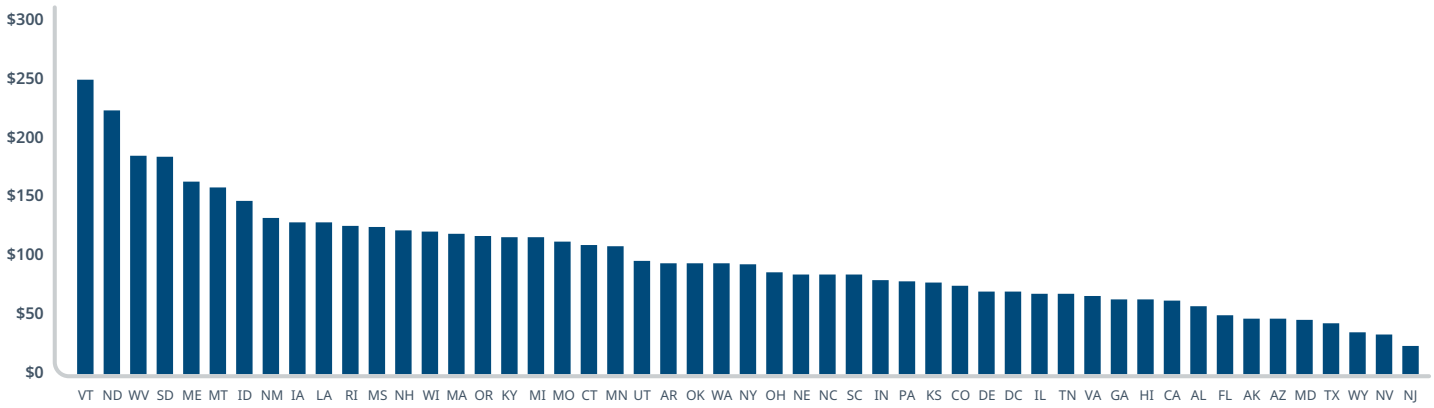


Figure 3.2: Detail table with 340B utilization, per-beneficiary lost rebates, and total lost rebates by state for the 50 states and DC. State code is included for cross-reference with the Managed Medicaid table. % 340B utilization is estimated using a combination of claims and drug sales. Per-beneficiary lost rebates depend on % 340B utilization in each state

STATE	STATE CODE	% 340B UTILIZATION	LOST REBATE	
			PER BENEFICIARY ($)	TOTAL ($M)
Alabama	AL	10%	60	158
Alaska	AK	8%	49	17
Arizona	AZ	8%	49	184
Arkansas	AR	17%	98	139
California	CA	11%	65	1,301
Colorado	CO	13%	78	263
Connecticut	CT	20%	114	223
Delaware	DE	13%	73	39
District of Columbia	DC	13%	73	28
Florida	FL	9%	52	617
Georgia	GA	11%	66	393
Hawaii	HI	11%	66	48
Idaho	ID	27%	153	168
Illinois	IL	12%	71	503
Indiana	IN	14%	83	307
Iowa	IA	23%	134	239
Kansas	KS	14%	81	138
Kentucky	KY	21%	121	260
Louisiana	LA	23%	134	267
Maine	ME	29%	170	120
Maryland	MD	8%	48	169
Massachusetts	MA	21%	124	495
Michigan	MI	21%	121	649
Minnesota	MN	20%	113	378
Mississippi	MS	22%	130	178
Missouri	MO	20%	117	393
Montana	MT	29%	165	95
Nebraska	NE	15%	88	100

STATE	STATE CODE	% 340B UTILIZATION	LOST REBATE	
			PER BENEFICIARY ($)	TOTAL ($M)
Nevada	NV	6%	35	58
New Hampshire	NH	22%	127	106
New Jersey	NJ	4%	25	137
New Mexico	NM	24%	138	107
New York	NY	17%	97	940
North Carolina	NC	15%	88	492
North Dakota	ND	40%	233	111
Ohio	OH	16%	90	564
Oklahoma	OK	17%	98	188
Oregon	OR	21%	122	266
Pennsylvania	PA	14%	82	566
Rhode Island	RI	23%	131	74
South Carolina	SC	15%	88	242
South Dakota	SD	33%	192	101
Tennessee	TN	12%	71	268
Texas	TX	8%	45	746
Utah	UT	17%	100	236
Vermont	VT	45%	260	88
Virginia	VA	12%	69	326
Washington	WA	17%	98	432
West Virginia	WV	34%	193	157
Wisconsin	WI	22%	126	430
Wyoming	WY	6%	37	12

As shown in Figure 3.1 and 3.2, 340B utilization varies by more than tenfold across states, from 4% in New Jersey to 45% in Vermont. Per-beneficiary lost rebates closely track 340B utilization, ranging from $25 in New Jersey to $260 in Vermont. Aggregate losses, however, are driven primarily by state population size: California, New York, Texas, Michigan, Florida, Pennsylvania, Ohio, Illinois, Massachusetts, and North Carolina together account for the majority of national lost rebates. These patterns reinforce the central finding from the original study: 340B's commercial-market cost is geographically uneven, with rural-state workers bearing disproportionate per-person costs and large-state populations driving the bulk of the national total.

Cost to Managed Medicaid borne by states and the federal government

As detailed in the methodology section, we estimate lost rebates to Managed Medicaid only in states that continue to administer pharmacy benefits through managed care. FFS-only and pharmacy carve-out states are assumed to have no net loss on 340B drugs.

Figure 4: State share, federal share, and combined state and federal cost of 340B to Managed Medicaid. "FFS-only" indicates the state has no Managed Medicaid plans. "Carve-out" indicates the state carved pharmacy benefits from Managed Medicaid back to FFS. "Insufficient data" indicates observed claims were too limited to support a meaningful estimate. Numbers in each column are rounded separately

STATE	STATE CODE	STATE ($M)	FEDERAL ($M)	STATE + FEDERAL ($M)
Alabama	AL	FFS only		
Alaska	AK	FFS only		
Arizona	AZ	29	56	84
Arkansas	AR	1	2	3
California	CA	Carve-out		
Colorado	CO	2	3	5
Connecticut	CT	FFS only		
Delaware	DE	8	12	20
District of Columbia	DC	1	3	4
Florida	FL	47	62	109
Georgia	GA	3	6	9
Hawaii	HI	3	4	7
Idaho	ID	Insufficient data		
Illinois	IL	286	400	686
Indiana	IN	39	93	132
Iowa	IA	40	87	127
Kansas	KS	8	13	21
Kentucky	KY	53	166	219
Louisiana	LA	123	334	457
Maine	ME	FFS only		
Maryland	MD	17	23	40
Massachusetts	MA	139	139	278
Michigan	MI	89	206	296
Minnesota	MN	69	89	158
Mississippi	MS	Insufficient data		
Missouri	MO	Carve-out		
Montana	MT	Insufficient data		
Nebraska	NE	10	17	27

STATE	STATE CODE	STATE ($M)	FEDERAL ($M)	STATE + FEDERAL ($M)
Nevada	NV	5	10	15
New Hampshire	NH	7	10	17
New Jersey	NJ	20	28	48
New Mexico	NM	7	22	29
New York	NY	Carve-out		
North Carolina	NC	54	123	177
North Dakota	ND	FFS only		
Ohio	OH	142	322	464
Oklahoma	OK	10	24	34
Oregon	OR	13	27	40
Pennsylvania	PA	78	129	207
Rhode Island	RI	9	14	23
South Carolina	SC	8	18	25
South Dakota	SD	FFS only		
Tennessee	TN	Carve-out		
Texas	TX	68	102	170
Utah	UT	7	15	21
Vermont	VT	FFS only		
Virginia	VA	61	94	155
Washington	WA	38	53	91
West Virginia	WV	Carve-out		
Wisconsin	WI	Carve-out		
Wyoming	WY	FFS only		
Total		**1,491**	**2,705**	**4,196**

Figure 4 reports the estimated cost of 340B to Medicaid by state, separated into the state share, federal share, and combined state and federal total. Eight states operate FFS-only Medicaid pharmacy benefits and therefore bear no Managed Medicaid rebate displacement under our assumptions; six states have carved pharmacy benefits out of managed care and back to FFS; and three states had insufficient data for reliable estimation. Among the remaining states, combined state and federal costs total approximately $4.2 billion in 2025, including about $1.5 billion borne by states and $2.7 billion borne by the federal government through FMAP. The largest absolute losses are concentrated in populous Managed Medicaid states with high 340B exposure, led by Illinois, Ohio, Louisiana, Michigan, and Massachusetts.

Sensitivity analysis

Figure 5 reports how the national 340B utilization rate and total lost rebates vary by how the 340B utilization is measured. The main analysis combines claim-level IQVIA 340B eligibility scores with the share of 340B sales captured in IQVIA DDD, yielding a national 340B utilization rate of 14% and total commercial-market lost rebates of $14.5 billion. Using 340B eligibility scores alone produces a lower estimate of 11% and $10.5 billion because the scores in this study are derived from pharmacy claims and treat each claim equally, which can underweight high-priced specialty drugs that account for a disproportionate share of rebate dollars. Using DDD sales alone produces a higher estimate of 18% and $18.5 billion because DDD measures 340B-priced sales by WAC dollars and includes both pharmacy and medical

channels. However, DDD is a wholesaler-level view that cannot identify payer or patient populations, so some 340B-priced inventory may have been dispensed to Medicaid, Medicare, or uninsured patients rather than commercially insured patients.

The main analysis falls between these two alternative measurement approaches, suggesting that the headline $14.5 billion estimate is not driven by a single input choice. These scenarios imply a plausible range of approximately $10.5 billion to $18.5 billion, depending on whether exposure is measured using claim-level 340B Scores alone or sales-based DDD data alone.

Figure 5: National 340B utilization and lost rebates under the main analysis and alternative scenarios. "Main analysis" reports the results presented in the Findings section; "340B scores only" estimates state and national 340B utilization solely from 340B eligibility scores; and "Drug sales only" estimates state and national 340B utilization solely from DDD drug sales data

SCENARIO	NATIONAL 340B % UTILIZATION	NATIONAL LOST REBATES ($B)
Main analysis	14%	14.5
340B scores only	11%	10.5
Drug sales only	18%	18.5

Discussion

This study shows that the rapid growth of the 340B program has been accompanied by an even more rapid increase in the cost burden associated with displaced manufacturer rebates. The program displaced approximately $6.6 billion in negotiated rebates for employer-sponsored plans in 2023, which nearly doubled to $12.8 billion in 2025. When non-group and ACA plans are included, the figure becomes $14.5 billion. This increase reflects both growth in 340B utilization and expansion of the broader U.S. drug market, which increased the pool of negotiated rebates vulnerable to displacement.

As seen in this study (and others[11]), lost rebates span employer-sponsored plans, non-group plans, and Managed Medicaid, meaning that the cost of lost rebates affects employers, states, and the federal government. Although Medicare Part D is outside the scope of this study, similar dynamics may also affect Part D plans and enrollees.[12,13]

This study updates and extends our original study along three dimensions: a higher national number for lost commercial-market rebates, a state-level distribution that remains highly uneven, and a sensitivity analysis that brackets the headline within a meaningful range. We situate these findings within the broader policy and structural environment below.

Contract pharmacy growth is a driver of 340B utilization.[14] Since HRSA's 2010 guidance permitting unlimited contract pharmacies, the number of 340B contract pharmacy arrangements has grown from approximately 500 to nearly 35,000, a nearly 70-fold increase, while the number of covered entities has only tripled.[15,16,17] Each additional contract pharmacy can route more commercial volume through 340B pricing, mechanically expanding the program's commercial-market footprint independent of any change in safety-net mission.[18,19]

State legislation is reshaping the 340B landscape faster than federal policy.[15,20] Manufacturer restrictions on contract pharmacy arrangements began in mid-2020 with Eli Lilly. States have responded with contract pharmacy access laws prohibiting such restrictions: six states enacted them in 2024, joining Arkansas and Louisiana, and a record 13 states enacted them in 2025, with more than 20 states introducing bills. Concurrently but in the opposite direction, six states have carved pharmacy benefits out of managed care and back to FFS.[9] The two trends pull in opposite directions: commercial-side mandates broaden 340B's footprint, while Medicaid carve-outs narrow the share of rebate displacement borne directly by state Medicaid programs.

State premium differentials may compound the per-beneficiary burden.[2] Employer-sponsored healthcare costs have long been higher in rural states due to limited insurer competition and provider consolidation. A Commonwealth Fund analysis found that combined family premium contributions and deductibles now exceed 10% of median household income in 19 states, concentrated in Southern and rural states.[21] Because per-beneficiary 340B rebate displacement is also concentrated in higher-exposure rural states, these populations may face overlapping sources of cost pressure.[22]

Within-state rural-versus-urban heterogeneity remains an unmeasured dimension. Our state-level totals may mask sub-state variation driven by differences in covered entity mix, contract pharmacy density, and specialty pharmacy penetration.[18,19] Future studies using county- or MSA-level data would be particularly valuable for large mixed-geography states.

Covered entity alternative distribution models (ADMs) and large-scale mail-order pharmacies may distort geographic attribution. Cross-state shipping from centralized pharmacy hubs can help explain the difference between our claim-level and sales-based estimates.[19] Stronger reporting requirements for covered entities and contract pharmacies would narrow this range and allow future studies to assign costs more accurately to the states and populations affected.[15,23]

In summary, this refresh of our prior study, which measured 2023 rebate displacement, shows that the 340B program's growth is associated with substantial and geographically uneven increases in lost rebates. In 2025, we estimate that 340B displaced $14.5 billion in commercial-market rebates and an additional $4.2 billion in Managed Medicaid rebates, for a combined total of $18.7 billion borne by employers, enrollees, states, and the federal government. These findings suggest that 340B's financial effects extend well beyond covered entities and manufacturers, underscoring the need for greater transparency into how program savings are generated, retained, and passed through to patients.

References

1. Martin R, Karne H, and Zeng S. The size and growth of the 340B program in 2025. IQVIA. 2026.
2. Masia N, Motyka J, Westrich K, and Campbell J. The 340B Drug Pricing Program and commercial insurance premiums. Health Capital Group. 2025.
3. Nikpay S, Buntin M, Conti R. Relationship between initiation of 340B participation and hospital safety-net engagement. Health Serv Res. 2020;55(2):157-169.
4. Horn D and Shulman K. Impact of 340B exposure on treatment utilization and cost for Medicare patients with cancer. Health Services Research. 2026;61(1).
5. Sun C, Zeng S, and Martin R. The cost of the 340B program part 1: self-insured employers. IQVIA. 2024.
6. Sun C, Zeng S, and Martin R. The cost of the 340B program to states. IQVIA. 2025.
7. Norris L. Individual Health Insurance Under Obamacare. HealthInsurance.org. September 2023.
8. Ortaliza J, Lo J, and Cox C. Enrollment growth in the ACA Marketplaces. Kaiser Family Foundation. April 2, 2025.
9. Medicaid and CHIP Payment and Access Commission. MACStats: Medicaid and CHIP Data Book. February 2026.
10. Milliman. 2025 Milliman Medical Index. July 30, 2025.
11. Blalock E and Launsbach C. The financial impact to Medicaid from the 340B Drug Pricing Program. Berkeley Research Group. 2025.
12. Martin R, Sarraille W, and Illich K. Do patients receive 340B drug discounts at the contract pharmacy counter?. IQVIA. 2025.
13. Fusco N, Sils B, Graff J, Kistler K, and Ruiz K. Cost-sharing and adherence, clinical outcomes, health care utilization, and costs: a systematic literature review. J Manag Care Spec Pharm. 2023.
14. Martin R and Karne H. The size and growth of the 340B program in 2024. IQVIA. 2025.
15. U.S. Senate Committee on Health, Education, Labor, and Pensions. Majority Staff Report: Congress must act to bring needed reforms to the 340B Drug Pricing Program. April 25, 2025.
16. U.S. Health Resources and Services Administration. 2024 340B Covered Entity Purchases. HRSA. 2025.
17. Sarraille W, Zeng S, and Martin R. A look at middlemen fees in the 340B Drug Discount Program. Law360. 2025.
18. Lin J, Li P, Doshi J, Desai S. Assessment of US Pharmacies Contracted With Health Care Institutions Under the 340B Drug Pricing Program by Neighborhood Socioeconomic Characteristics. JAMA Health Forum. 2022.
19. Coughlin M and Mishra D. Local population characteristics and access equity of 340B contract pharmacies. Health Affairs Scholar. 2025;3(7).
20. Nikpay S, Reinke M, and Quinones N. Stretching Scarce Authorizing Legislation as Far as Possible: A Legislative History of the 340B Drug Pricing Program. The Milbank Quarterly. 2026.
21. Kolb K, Radley D, and Collins S. Is employer coverage affordable? How the states stack up. Commonwealth Fund. February 11, 2026.
22. Sparks G, Lopes L, Montero A, Presiado M, and Hamel L. Americans' challenges with health care costs. Kaiser Family Foundation. 2025.
23. Minnesota Department of Health. 340B covered entity report. 2026.

Appendix

Figure A1. 340B prescribers, facilities, and drug purchases in each state and DC in 2025. 340B prescribers: any prescriber that is estimated to have written a 340B-eligible claim in 2025. 340B facilities: based on 340B "parent" facilities, not satellite sites or contract pharmacies. 340B drug purchases: 340B drug purchases at Wholesale Acquisition Cost (WAC). % growth is measured over 2023 numbers

STATE	STATE CODE	340B PRESCRIBERS		340B FACILITIES		340B DRUG PURCHASES	
		COUNT	% GROWTH	COUNT	% GROWTH	$M	% GROWTH
Alabama	AL	27,499	-8%	1,830	5%	2,466	42%
Alaska	AK	1,901	18%	48	20%	106	14%
Arizona	AZ	162,070	38%	3,138	12%	2,612	23%
Arkansas	AR	12,759	28%	363	36%	1,458	46%
California	CA	95,997	21%	2,287	24%	15,903	46%
Colorado	CO	16,166	11%	416	30%	2,394	19%
Connecticut	CT	20,413	13%	211	-3%	3,059	53%
Delaware	DE	41,740	68%	1,494	70%	531	-29%
District of Columbia	DC	5,318	24%	119	19%	432	35%
Florida	FL	99,610	45%	3,140	21%	9,231	32%
Georgia	GA	23,309	8%	505	28%	4,722	37%
Hawaii	HI	3,488	3%	144	1%	604	64%
Idaho	ID	8,985	10%	302	19%	1,196	40%
Illinois	IL	233,389	30%	3,261	8%	5,697	45%
Indiana	IN	263,801	16%	3,270	9%	3,963	10%
Iowa	IA	18,340	15%	484	7%	1,834	39%
Kansas	KS	34,934	15%	2,156	14%	2,155	44%
Kentucky	KY	26,367	12%	547	15%	4,489	33%
Louisiana	LA	18,242	18%	618	13%	3,926	40%
Maine	ME	10,875	30%	222	15%	1,060	40%
Maryland	MD	21,628	9%	306	4%	2,107	45%
Massachusetts	MA	46,025	23%	1,013	24%	5,496	47%
Michigan	MI	79,520	12%	2,546	14%	6,023	45%
Minnesota	MN	24,556	34%	627	38%	3,463	73%
Mississippi	MS	23,805	4%	1,164	4%	2,067	43%
Missouri	MO	25,144	19%	713	16%	4,111	61%
Montana	MT	5,700	11%	277	-11%	820	63%
Nebraska	NE	9,527	40%	505	27%	993	84%
Nevada	NV	28,187	1%	1,660	-7%	528	22%

STATE	STATE CODE	340B PRESCRIBERS		340B FACILITIES		340B DRUG PURCHASES	
		COUNT	% GROWTH	COUNT	% GROWTH	$M	% GROWTH
New Hampshire	NH	16,637	23%	390	10%	976	113%
New Jersey	NJ	235,525	9%	3,123	5%	1,879	27%
New Mexico	NM	8,316	26%	290	34%	855	20%
New York	NY	90,433	28%	1,159	-3%	14,857	62%
North Carolina	NC	55,427	26%	1,908	27%	8,154	56%
North Dakota	ND	4,341	5%	320	10%	1,142	38%
Ohio	OH	63,013	23%	1,288	14%	7,679	39%
Oklahoma	OK	11,792	57%	379	44%	2,059	48%
Oregon	OR	19,363	2%	515	18%	2,514	47%
Pennsylvania	PA	219,928	20%	3,165	9%	12,064	90%
Rhode Island	RI	10,949	24%	195	35%	991	79%
South Carolina	SC	22,769	9%	830	70%	3,445	38%
South Dakota	SD	4,297	1%	255	-7%	1,070	28%
Tennessee	TN	58,301	33%	2,341	13%	4,916	28%
Texas	TX	102,895	26%	3,017	13%	7,252	15%
Utah	UT	8,673	10%	320	12%	1,680	81%
Vermont	VT	7,338	5%	270	17%	766	31%
Virginia	VA	25,856	14%	592	0.3%	3,633	53%
Washington	WA	36,178	35%	1,201	59%	3,675	35%
West Virginia	WV	15,140	12%	590	9%	1,934	36%
Wisconsin	WI	27,859	27%	666	29%	4,163	56%
Wyoming	WY	2,875	3%	168	-3%	39	-20%

About the authors

CHUAN SUN, MS, MA
IQVIA Market Access Technology Solutions

Chuan comes from a mixed background of economics, data science, and finance. His passion is to combine different data sources to derive insights about the U.S. healthcare system.

RORY MARTIN, PHD
IQVIA Market Access Technology Solutions

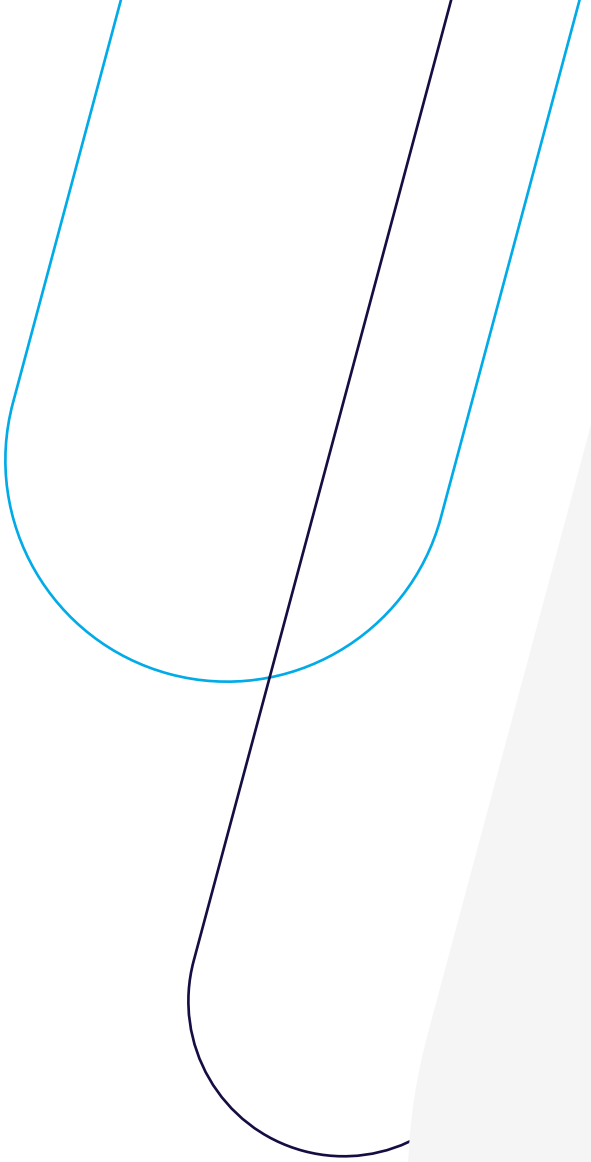
Rory specializes in applying real-world data to health care analytics and health policy analysis. His recent work has focused on the financial impact of rebate models used in the 340B program and the effectuation of maximum fair price in Medicare Part D. He has been an invited speaker at the FDA's Center for Drug Evaluation and Research (CDER).

Acknowledgements

We thank Kenneth Finegold, Yevgeniy Feyman, Kimberly Westrich and Luke Greenwalt for their helpful comments.

Funding

This study was supported by the National Pharmaceutical Council, which reviewed the manuscript and provided feedback, but had no role in data collection, analysis, or the decision to publish. Full editorial control was retained by IQVIA.



CONTACT US

iqvia.com